

SECOND NORMAN AUTTON MEMORIAL LECTURE

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Pastoral Theology in Healthcare, who cares anyway?

I begin by expressing my deep sense of privilege at being asked to deliver this memorial lecture today. Canon Autton has had a profound and lasting impact on pastoral care and caregivers, which continues to be reflected and celebrated in these lectures.

Now to the title, *Pastoral Theology in Healthcare, who cares anyway?* The last three words, 'who cares anyway', might well appear to be a rather cynical throwaway aside, but they do reflect one particular attitude, often strongly expressed, namely that theology and theological reflection, has little or, indeed, absolutely nothing at all to do with pastoral care delivery in any context, healthcare included. Such an attitude is itself based upon, and directly arises out of, a particular analysis of the nature of theology. Such an analysis regards theology as primarily substantive, quantitative and static. It is a 'body' of knowledge, exclusively and finally gained at some point in the past, a point set firmly within a University, and / or Theological College, which is to be used, if at all, sparingly and defensively in present pastoral situations. There are two possible consequences of such an analysis. Either the holder of such an analysis will in some way select those pastoral situations in which he or she is prepared to be involved, rejecting those which are too much of a threat to their theology, or, even if he or she is prepared to be pastorally involved, such an involvement will contain a considerable degree of 'editing' of the full reality and comprehensiveness of the situation, an 'editing' dependent upon, and defending at all costs, an *a priori* theological position.

I admit to an element of caricature in this description of theology, those who hold it, and its consequences. It is, however, as in all caricatures, not without its truth. With respect, I want to suggest, that such an analysis of theology, and its consequences, simply will not do in the delivery of effective, comprehensive and honest pastoral care in the healthcare setting, or indeed anywhere else. What, rather, I would suggest we need, is an analysis of theology, which is, in pastoral situations, contemporary, dialogical and processive, in both theory and practice. In other words, what we need in pastoral healthcare, is an analysis, and consequent attitude which, whilst acknowledging and respecting the individual and corporate theological insights of our faith community, much of it as past inheritance, does not view these in static terms, nor in terms of a one way imposition upon pastoral situations. Rather, what I would suggest we need, is a theological model, which, in both theory and practice, is prepared to be open to proportionate, redefinition, reformulation, and reapplication. These three Rs will, in the vision and practice of the Healthcare Chaplain, directly arise from, and be dependent upon, her or his preparedness to view theology as an ongoing process which mutually and with equal informative authority, correlates past inheritance with present pastoral insight and challenge. Such a preparedness will be, in turn, dependent upon the vision which the Healthcare Chaplain holds regarding the activity, location, temporality and revelation of the Divine,

What I hope, I have, with some degree of conviction and, perhaps, success proposed is, first that a definitive element of pastoral care, if it is to be comprehensively and truly pastoral, must contain and practice, a visionary, prayerful, and intellectual theology, which, whilst taking due regard of, and allowing due authority to, the past is not without remainder confined to it. Second, that such a theological enterprise, must be open and responsive to the full reality and challenge of an individual and discrete pastoral situation, responding to it as an authoritative and focussed revelation of the Divine nature and purpose in the here and now.

I want to move to outlining certain theological themes, and making certain tentative suggestions within them, which seem particularly, though, of course, not exclusively, relevant to Healthcare Chaplaincy, in both theory and focussed practice and, indeed challenge.

1. THE DIVINE AS CREATOR AND SUSTAINER

All Faiths have a vision of, and appropriate attitudes and action based upon, the creative activity of the Divine. There are, of course, differences.

For the Christian, God creates *ex nihilo*, 'out of nothing', out of Divinity Itself. This means that all physical matter, partakes of the Divine.

What of course this does not mean is that all physical matter is itself Divine, what it does mean is that the Divine is 'in' all of it, the technical term if you want it is 'Panentheism'. Medicine deals with physical matter.

Directly arising out of this theological vision are, for those who hold it, attitudes towards, for instance, human tissue retention and reverent disposal, and organ donation and transplantation.

2 HUMAN BEINGS ARE CREATED IN THE IMAGE OF THE DIVINE

All Faiths have a vision of what this means in both theory and practice. There are, of course, differences.

Directly dependent upon the content of this view and the posited consequences, are attitudes towards

a. The meaning and practical consequences of the concept of Human Beings as 'co-creators'. Do we mean that the Divine has set, fixedly and predestinationally, the parameters and limits of what we mean by creation, in a way which absolutely excludes any human activity, or in a way which, even if human activity is to be regarded as part of what we know as Divine creativity, such involvement is merely a reactive cosmetic rearrangement of a fixed and limited given? On the other hand, do we mean that human beings, as created in the image of the Divine, actually play a meaningful, innovative and risky part in the present and future creative activity of the Divine? A part which involves actual innovation and insight.

Where we stand in or somehow between, these alternative theological views, will directly affect and effect our view of, for instance, medicine as a researching science and those engaged in such an enterprise.

b. The concept of a human being as autonomous, having rights to consent, dignity, and privacy in life in general and in healthcare in particular.

3 DIVINE CAUSALITY AND ANNUNCIATION

What do we mean, or other people think we mean, when we acknowledge, as we must, if the Divine, in any sense of omnipotence, is to be the Divine, that the Divine 'causes' particular life events, illness included?

Not only a theoretical question, a highly focussed and urgent one in the heartfelt and often angry question, 'Why has God done this to me?'

We may in theory fall behind the traditional distinction between Divine primary as opposed to secondary causation. The Divine creates and sets the world, primarily, within parameters which include risk, suffering, vulnerability and mortality. What the Divine does not interventionally cause is specific and particular, focussed instances of all of these. Is this in both theory and practical pastoral commendation a valid distinction?

If we would claim that such focussed instances of vulnerability and suffering are not in a discrete interventionist sense caused by the Divine, can we then with any theological, or indeed basically philosophical integrity, claim that such discrete instances of vulnerability and suffering might well contain Divine annunciations? Is it possible, both in theory and practice to hold and commend a view that the Divine can announce through a discrete life event, suffering included, without having directly and interventionally caused it?

Even if we regard this as a possibility, how do we ourselves come to terms with, and enable others to so do, with the undoubted and inescapable fact that sometimes, by all that we would regard as reasonable, some suffering and vulnerability visited upon certain people seems totally disproportionate to its annunciatory purpose or potential? I pose the question, I don't have answers.

4 HOPE AND ESCHATOLOGY

One possible answer to the challenges and questions posed by suffering in general, and discrete and acute instances of it, is to resort to Hope and Eschatology.

Eschatology admits of two theological interpretations. It is, on the one hand, undoubtedly about the temporally future 'end of the world' in which all things and all people will be gathered up and, 'God will be all in all'.

It is also derivatively about the depth and significance of the present moment within the present situation. Hope arises from this eschatological reality. It is, paradoxical as it may sound, both the consequence of the eschatological depth of the present situation, and the means and method by which, and through which, that eschatological depth is, courageously and responsively recognised.

The hope needs to be realistic, for true eschatological depth does not arise from unreality. Realistic hope needs careful ministering, a preparedness and ability directly dependent upon our own ability to recognise and to live with the eschatological depth of our own life.

5 THE SOUL

Those engaged in Healthcare Chaplaincy, need to have some idea of, and how to pastorally respond to questions about , the Soul.

What do we mean by the Soul? Is it a substantive, quantitative, volumetric quasi physiological entity, about which it is appropriate to ask and reflect upon questions such as, ‘When and how does it leave the body?’ Not a fictional question,. It was one asked in good faith at the recent Organ Donation Conference in Birmingham. Faith answers were variously based upon substantive and non substantive soul concepts. Nowhere does the abandonment of substantive language seem more dangerous than over descriptions of the Soul, simply because the danger is that in any such abandonment, we forfeit the vital reality, regarding the true status and dignity of human beings, which substantive , volumetric, soul language has enshrined, safeguarded and proclaimed . Perhaps we need to recognise that what we call the soul, is a collective and abstract noun, rather than a singular and substantive one, which defines the unique individuality of every human being in his or her personality and the relationship of that personality to the Divine. To be contemporary, I would want myself to take respectful issue with the Bishop of Durham in his call to rewrite liturgy in respect of those who have died. His claim that we need to talk more about people regarding those who have died, rather than of souls seems, frankly to me, to miss the point, or to be more accurate, to partly miss it. Granted that we need in death as in life to emphasise the collective solidarity and identity of the human race, we need also to emphasise and proclaim human individuality on both temporal sides of the grave or crematorium. Soul language for me as I suspect for many others in healthcare or elsewhere personally and professionally safeguards this emphasis on individuality. I shall continue to use it and to minister it.

6 MULTI-FAITH

One feature of Healthcare Chaplaincy which I suspect, though present in Canon Autton’s time has developed and become well established, is that of multi-faith working and provision. Nowhere, I think, is there a more demonstrable direct and proportionate causal link between theological view and consequent attitude and practice. In this new and welcome situation, each and every Healthcare Chaplain will need to ask herself or himself searching questions regarding their concept of the uniqueness of their Faith, indeed what they mean by uniqueness. Is it an inclusive uniqueness which whilst wishing to maintain a certain distinctiveness for their own revelation of, and response to the Divine, nonetheless sees no contradiction in, at the same time, affirming the dignity and revelatory capacity of other faiths? Or, is what a Healthcare Chaplain means by uniqueness an exclusive concept which cannot acknowledge the value or revelatory capacity of any other Faith? The alternative which a Healthcare Chaplain chooses, will, in turn, directly depend upon his or her vision of the Divine, perhaps particularly in terms of omnipresence.

Six areas and theological themes, issues and challenges, not by any means an exhaustive list, stated by way of illustration. In pastoral situations, their application, in terms of intellect, vision and prayer, will be two way. It will, or at least, should be, the case that existing theological attitudes, stances, beliefs and consequent practice, will

all be open to new revelations of the presence and purpose of the Divine, in discrete, contemporary, and perhaps, seemingly mundane and run of the mill pastoral situations. Theology in Healthcare, needs to be dynamic, moving, proportionately changing and evolving, carrying the best and lasting of past, corporate inheritance into a newly expressed and pastorally ministered future.

Why? *Who cares anyway?* We should care and need to care whether or not theology is a dynamic and informative component in Healthcare Chaplaincy, not only because theology is important in itself, but also and vitally because it forms the basis upon which moral judgements are made regarding the rights and wrongs of how we treat human beings in healthcare as in all other areas of life . ‘Spare the vision and spoil the Ethic’. The depth and comprehensiveness of our theological vision of the Human Being will, directly and proportionately affect and effect what we regard as right and wrong ways to treat them and the physical matter of which they are made. Healthcare Chaplains have an important role in a variety of ways as regards ethical input at their place of work. They need, therefore, to clearly know, and to be able to justify, the theological vision from which they are coming, even if, for the sake of effective communication, they don’t use ostensible theological language.

I want to end with something topical. In doing so, I would like to think that I am being faithful both to the spirit and purpose of these lectures, but also, and more importantly to the spirit, outlook, personality and professional practice of Canon Autton. I believe Norman would have been one of the first to realise and respond such a realisation that theoretical issues and views regarding the nature of Healthcare Chaplaincy are often focussed into hard and sometimes controversial decisions. There has been much recent debate and practical action regarding the ongoing, accredited provision of Chaplaincy training.

Underneath the surface of this debate, there seems to me and others to be, for want of a better word, a philosophical issue regarding the current and future model of Chaplaincy. In particular, the debate, and perhaps, though hopefully, not lasting disagreement, appears to be between those who would wish to stress and provide for those aspects of Healthcare Chaplaincy which are generic, transcending and independent of particular faith emphases, and practices, and those who would, whilst acknowledging the presence and value of the generic features of Chaplaincy, want nonetheless to maintain and provide for the faith element in both the Chaplain and Chaplaincy provision.

Whatever is the future of Chaplaincy training and the sources of its provision, I would with respect want to suggest that it is vital that both aspects of Chaplaincy, the generic and the faith based are held together . The Chaplain is, hopefully, an integrated human being, not by definition to be in certain aspects of his or her ministry, even those which appear to be most generic, divorced from his or allegiance to and sustenance from, his or her faith community I would suggest that, at a time when the National Health Service is laying increasing stress upon the individuality, and cultural and religious identity of patients, it would at best be paradoxical, at worst, fatal, that such cultural and religious individuality be denied in both the model of, and training for, Healthcare Chaplaincy.

To end. I have put the case for the vital presence in Healthcare Chaplaincy of a dynamic model and practice of theology, a practical model which, whilst acknowledging the dutiful need to acknowledge and retain the corporate and individual insights and formulations of the past, is prepared to open them to the challenge and revelation of present pastoral situations.

Healthcare particularly, though not, of course exclusively focuses certain key theological themes, issues, and questions.

It is vital we acknowledge them, challenges and all, for only so will we not only have a dynamic and usable theology, but also, and most importantly, a theology, which is in the right sense, so secure as to allow us to be openly and confidently pastoral in the first place.

A consistent and realistic theological view of the world and of the nature, status and place of human beings within it, will directly effect and enable our ethical debate.

I have urged that training provides an integrated chaplaincy model, which is not only true to the nature of the Chaplain, but also reflects the NHS model of the patient.

I end as I began by expressing, first, my deep and lasting gratitude to Canon Norman Autton for all that he gave in terms of pastoral care insight, of lasting value to those in all areas of pastoral care, not only in hospitals, and, second my sense of privilege to have been asked to deliver this second lecture.