"Spiritual Challenges in Healthcare today"
Address to the 'Faith in Health' conference
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From my earliest childhood faith and health – or rather religion and medicine - have always gone hand in hand. My father was a doctor. His father was a doctor. My uncle was a priest. The boys in the family became either doctors or priests. Priests were always visiting our home.

My father came to this country from Ireland in the early part of the last century. He took over a medical practice in Reading in 1919, and he was a sole practitioner, at least in the early years. My childhood memories are of "Old doctoring" if you like. At that time the doctor's role extended well beyond the boundaries of illness and disease to involve all sorts of other aspects of life as well. He knew the families in his care. He visited them often. When his patients were in hospital they remained in his care and he would visit them there too. He earned a living from the panel patients and the private patients, and would often waive the bill – much to my mother's annoyance when she was trying to bring up 5 children.

This family and community experience led me to think of the vocation of being a doctor and of being a priest as in many ways similar callings. Each took years of training, and led to a life of service in the community, a close involvement in the lives of families especially in times of illness and death. Both required a degree of selflessness. Both, it seemed to me from those I knew and admired , were hard, self- sacrificial, but also richly rewarding ways of being called to love deeply.

And I have never lost a sense that the vocation to serve others in healthcare – and not just as a doctor but whether it be as a nurse, a manager, a porter, a physiotherapist, a chemist, a social worker, or a hospital chaplain – these are all noble and priestly callings, a way of service that calls us to become more fully human.

Of course the world today is very different. In fact when the National Health Service was founded – 60 years ago – my father was opposed to it. He had by then built up a successful GP practice. He was able in his own way to subsidise those who could not afford treatment so that they got it. There was I suppose the not unreasonable fear of the state taking over. Of course he came round later, and by the time he retired had become a firm supporter of the NHS

Looking back in the archives of Archbishop's House, I find that it is not just my father who had a problem at the time. There is some rather frank correspondence in 1947 between Cardinal Griffin and the Secretary of State for Health, Aneurin Bevan. You might think that the Bishops, recognising the profound moral imperative that impelled the campaigners for the NHS, would have welcomed and supported the reform without reserve. You would be wrong. In October 1947 my predecessor wrote to Mr Bevan: "the bishops are concerned because it would appear that the National Health Service Act leaves no room for Catholic Hospitals and as these have been running successfully for so many years they are not prepared to allow them to be transferred without satisfactory guarantees that their Catholic character shall be preserved." Which just goes to show that there is nothing new under the sun!

But of course this does serve to remind us that the Catholic Church, especially through the religious orders of nursing sisters, has always seen the vocation to care for the sick as a primary expression of its Gospel mission. In terms of the social teaching of the Church the objection was one based on 'subsidiarity' – should the state be taking over the management of voluntary hospitals that in many cases were superbly run with a deeply Catholic ethos?

The early years for the NHS were not easy, but over time the reform settled in and of course became - rightly - a source of pride for the whole country. Aneurin Bevan's cry that "we are all equal in the face of illness" inspired generations to see their vocation and calling in serving others through working in healthcare. It has been remarkably enduring.

60 years on, the NHS faces a range of very different and difficult challenges such as how to reduce the inequalities in health, how to cope with constantly rising public expectations, or how to ration scarce resources between competing needs. But there are other perhaps even deeper challenges to do with ethos and values underlying what such a service exists to do, which perhaps bear reflection and exploration in our gathering. And it is very striking that this week's major report from Lord Darzi on the future of the NHS, "High quality care for all", emphasises the need for the service to focus on enhancing the quality of care "with patients treated with compassion, dignity and respect".

What I would like to do this morning is two things. First of all, to go the Gospel and reflect with you on some insights which it seems to me are gifts which faith brings and which might have some particular relevance today as we think about the role of healthcare work in the fast changing world of the NHS. Second, I would like to say a brief word about two areas – palliative care and chaplaincy work where it seems to me there is a particular connection to be made between faith and health.

For anyone who picks up the Gospel stories for the first time, one thing that is immediately striking is the constant references to healing. The healing miracles of Jesus are absolutely central to his ministry. And there are two things about them which are particularly significant. First of all, they are always personal. Jesus never healed a crowd. The healing miracles he performed were always the result of personal encounters. And secondly, they relate not only to the physical or mental illness itself but to the faith of the person who is ill – or sometimes the faith of those who bring the ill person to Jesus - as in the case of the paralytic lowered through the roof. Jesus's acts of healing are restorative spiritually as well as physically and mentally. "Your faith has made you whole". The result of the encounter with Jesus is that through His actions God's kingdom is revealed and the person restored – made whole – renewed in God's image.

The healing miracles are signs that Jesus restores a frail and broken humanity, as persons made in the image of God, drawing those he heals into more fully human relationships with those around them and a restored relationship with God. We are not separate from our bodies, but body and soul together. We cannot be truly healed unless our full humanity is recognised and our inner need of healing addressed. And we cannot be truly healed in a crowd.

Alongside the witness of his miracles of healing, Jesus also taught his followers what they were to do. In the story of the Good Samaritan he made clear that our duty to love our neighbour means attending to the needs of the one who is sick, or ill, who we come across and whose immediate needs we can meet. And in the parable of the Last Judgement in Matthew's Gospel, Jesus identifies himself with those in need "insofar as you did this to the least of these, you did it to me". Hence the Christian obligation to care for the sick, reflected down the centuries in the

work of religious communities and individuals, work which only in recent times in many countries has been brought within the ambit of the state. Even today, in Africa and other parts of the world, the Church remains the major provider of healthcare. But we have to understand what is going on in any encounter of healing in the light of the healing miracles of Jesus. The Church's mission in healthcare only makes sense in this perspective.

It is very striking that despite the great and wonderful work which so many do in our NHS today as in the past, that there seems to be a question about what is at the heart of this service now. I have already mentioned the emphasis placed by Lord Darzi in his report on the quality of care, and the need for care that is personal to each individual. At the annual NHS Confederation Conference last month, one of the key topics set out for discussion in the Futures debate was about Compassion. A very thoughtful paper, entitled "Compassion in Healthcare – the missing dimension of healthcare reform?" starts with this statement:

" Both here and around the world, there is a concern that, despite the increasing scope and sophistication of healthcare, the huge resources devoted to it and the focus on improvement, it is still failing at a fundamental level. Caring and compassion, the basics of care delivery, and the human aspects that define it seem to be under strain."

The paper goes on to affirm the desire of the vast majority of healthcare staff to do their best to serve the patients in their care and to meet their needs , but then notes how the system has evolved to frustrate this. I was very struck by the following comment:

"the acid test for me is the supervisors' response to witnessing a staff nurse sitting quietly with a patient for ten or 15 minutes, to be present and to listen to concerns. In almost all of the hospitals I have worked in, that behaviour would be reprimanded not rewarded".

And it seems to me that this is precisely an area in which faith can help, and its contribution needs to be recognised. I heard the other day of a hospital trust which had received - for the first time in a long time – a number of thank you letters from elderly patients after they had left hospital. And they wanted to thank the recently recruited Philippino nurses who had looked after them, and who had spent time with them caring for them and being with them. It is no secret, I think, within the NHS that the many Catholic trained Philippino nurses who have come to work in the UK have brought with them a different culture and ethos that places a deep respect and attentive care of the whole person at the heart of what they do. This is particularly true of the care of the very old, who as we all know constitute the vast majority of those receiving regular care at home or in hospital.

I have to say that I am sceptical about the extent to which the delivery of compassionate care can be effectively enhanced by having external targets. One suggestion is that there should be " compassion index", where nurses are to be rated according to the levels or care and empathy they give. But compassion can't be 'professionalised' or monitored or indexed - you might have behaviour which can tick boxes, but that won't necessarily be 'compassion' - indeed it might very well be the way to stop it!

So how can a culture of compassion be nurtured? Compassion is a human response. It is a gift, not a skill or something that one can be trained for, although we can practice it and the more we practice it the better we become at it. Compassion is a 'being with' the other in their distress or suffering - it is not passive but active. It may produce material responses which alleviate the stress, or it may just be the gift of a caring and understanding presence. It is the capacity to

recognize fear, anxiety or suffering in another and to imagine what it is like to be this person - it is a profoundly human capacity which goes beyond feelings.

Now it is true that compassion and professionalism do not necessarily always go together: if this was the only choice on offer, we would all probably want our emergency appendicectomy done by the competent but heartless surgeon rather than the kindly but ineffective one. But what is critical is that the culture of healthcare and the NHS remains 'humane' for all who work in it and are treated in it. This can only be done if the underlying vision is not only about professional competency and technical skill. These are the necessary but not sufficient means to a better service. That service has to have a vision of the human person in their wholeness if the best decisions are to be made. And if respect for the whole person is truly at the centre of decision making throughout the service then we will not need to worry too much about measuring compassion, it will be there and evident in everything.

Perhaps the problem with the current culture is that it doesn't trust and therefore it interrupts people's humane instincts and their reason for doing what they do. So if the NHS is serious about promoting compassionate caring – and I hope it is - what is needed is a much deeper reappraisal of the mechanisms of control and delivery which seem to constrict and constrain the ability of staff to care properly, and an honest and searching discussion about underlying culture, values and ethos that the service is actually following. Maybe what is needed to achieve this is less rather than more control. To grow a culture of compassion requires a profound change of mind and heart at many levels. And that cannot be imposed.

I strongly believe that at this juncture in its history, the explicit recognition of the faith commitment of many of those who work in the NHS could help in promoting the necessary cultural change at all levels in the NHS. In the end, people will only provide real care if they genuinely believe the other person matters, and the service has the respect of the person at its heart. And this crucially depends on the operating ethos of the service, which for the NHS as much as for the Church is not so much about what we say, as what we do.

Let me turn now to two areas of work that particularly illustrate this element of humanity at the centre of healthcare. First of all, the care of the dying and terminally ill. One of the great developments of healthcare in recent decades has been the growth of the hospice movement and the increasing recognition given to palliative care, although it is still often described as the Cinderalla service. Palliative care is extremely important because it explicitly recognizes and acknowledges the reality of death and the need to come to terms with it. Our society seems to have an almost obsessive curiosity about death if the number of TV shows featuring forensic examinations of dead bodies is anything to go by. We objectify it to try and tame it. And yet one can detect also an underlying fear of death and dying, which in many ways is still the last great taboo.

What we have to recognize is that in healthcare there are two goods: cherishing life, and accepting death. We should cherish life, and the healthcare service should provide what is needed to heal, restore and promote healthy living. We should also accept death, which means that when a person is dying they are given the care and treatment which is appropriate, and that they their fully human needs – bodily, mental and spiritual - are fully respected. The key point is that these two goods – cherishing life and accepting death - are not in competition. Both matter, and neither need or should be done at the expense of the other. The problem, as I see it, is that we have not yet done enough particularly in training of staff and in the deployment of resources to recognize that dying is not a failure but a human reality that we can and should honour and fully respect in the way people are cared for.

Finally, let me say a word about the distinctive role of NHS chaplaincy and Catholic chaplaincy in particular. This is a tricky subject and the Healthcare Reference Group of our Bishops Conference has in recent years worked hard to address some difficult issues that have arisen. One of the Catholic chaplains was saying the other day that his job title had been changed to "spiritual care giver". Spirituality is 'in' – because it is easy and means what you want it to mean, and religion is 'out' – because it is messy and complicated and potentially divisive. He likened the required approach to spiritual care now as like being given a crossword but told not to use the clues. In encounters with people – deep questions might well surface – but no reference could be made as to where to look for answers or pointers to the truth.

Here I believe is the real tension for faith in health today. Unlike in a Catholic hospital or caring setting, sometimes what would otherwise be explicit has to remain implicit. We live at a time of deep confusion and soul searching, in which profound questions of meaning and purpose swirl around. The NHS it seems to me is on a trajectory which risks losing the capacity for spiritual questions of people to be addressed with any integrity by chaplains. We must do all we can to ensure that the dimension of religious faith is recognized for what it is and not distorted into something else.

And what will help for those of faith is to find ways in which to deepen the connection between your faith and professionalism in healthcare. This year is the 150th anniversary of the appearances of Our Lady to St Bernadette. Our diocesan Lourdes pilgrimages provide a wonderful way in which many of our Catholic nurses and doctors are nourished and affirmed in their professional vocation. Here the full richness of the mystery of suffering and death are suddenly explicit, and the central place of those who are ill or suffering re-sets the frame of reference for what the ministry of healthcare truly involves. "This is what is most real, and this is how we should try and live", we say to ourselves on the way home.

Doing that is far from easy, and we none of us can do it alone. That is why I am greatly encouraged by the formation of the Catholics in Healthcare network, and its linking into and support of the existing guilds. The Catholics in Healthcare stand at the NHS Confederation conference last year and again this year provoked a good deal of surprise and interest. Those who came to it were adamant in encouraging us. They said that the Church needs to be more visible , and we need to be courageous in standing up for the values we believe to be true - not only for the ethical principles of life, fundamental as those are of course - but also for the ethical foundation of profound respect and care for the person in need. In this way we can best try and bring faith and health together. And of course they belong together. For the paradox of our faith is that it is through that service of others – and in fact only through that service of others - that any of us can come to that fullness of life to which we are all called.