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## Beguiling Religion: The Bifurcations and Biopolitics of Spirituality and Medicine

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M. THERESE LYSAUGHT



## 7. BEGUILING RELIGION

### *The Bifurcations and Biopolitics of Spirituality and Medicine<sup>1</sup>*

In an article entitled “Meeting My Mother Again,” John Carmody, once an ordained Catholic priest but now twenty years estranged from the church, chronicles his experience of dying of cancer. As he lay in his hospital bed, a priest appears and asks if he wishes to be anointed. “With no thought,” he says “yes.” The sacrament surprises him. “It began almost shamefully casually,” he admits, yet it proved to be, in his words, “the most moving moment in my month’s stay in the hospital.” “Indeed” he notes, it “lodged itself among the half-dozen most moving religious experiences in my life.”<sup>2</sup> This from what he describes as “a spare, adapted version of the church’s ancient ritual” and “at most ten minutes of unpretentious prayer.”

From the perspective of patients and families, anointing of the sick is a powerful religious practice. Again and again, Carmody’s experience is echoed in the corridors of medicine. Every day in the twenty-first-century United States, this scenario is repeated—in hospitals, in hospices, sometimes in parishes, sometimes in homes. Christians faced with serious or mortal illness summon their pastor or a priest on staff, and sometimes surrounded by family and friends, sometimes accompanied by health care professionals, they are prayed over, prayed with, and allow oil to be applied to their foreheads, their hands, other bodily sites of pain.

In my own life, anointing has surfaced in unexpected places. My own children, born eight weeks early, were anointed on their second day of life by a Catholic priest in a Seventh-Day Adventist hospital. I have been particularly struck and moved by the stories of three of my friends, three (academic) women, who are each equally ambiguous about the church. On separate occasions each of these friends have testified to me—unprompted and unaware of the centrality of anointing to my research agenda—of how strikingly powerful their own participation in the sacrament of anointing proved to be as each sat by the side of her dying mother. For each, anointing proved to be deeply moving in ways they could scarcely articulate.

Stories and experiences like these—of the power of religious practices, especially for those experiencing illness or negotiating dying—have fueled the recent exponential growth in the scholarship and literature surrounding the relationship of spirituality, theology, health, and medicine. As a theologian, I should be encouraged by this interest and the ways that it might renew the long-standing relationship between faith and medicine, a relationship that flourished for 1,500 years in the West but with the emergence of modernity became constructed as a conflict.<sup>3</sup> Yet as a theologian who studies the anointing of the sick, I must confess that the field of spirituality and medicine—indeed, the biopsychosocialspiritual model as a whole—gives me great pause.<sup>4</sup> For this model and this newly emergent field as a whole are structured by assumptions, norms, and terminology that marginalize and relativize a practice like anointing.

On the one hand, the practice of anointing of the sick is not a “spiritual” practice—it is a “religious” practice. It remains one of the few spaces where, on a regular basis, in hospitals secular or not, religion *irrupts*—visually, tactilely, practically, publically, olfactorily—into the domain of modern medicine. When it does so, the juxtaposition between high-tech, largely effective medicine and this peculiar hold-over from premodernity can be at best ambiguous or at worst jarring. Picture, if you will, the typical scenario: a priest in clerical garb enters the highly technologized space of a modern hospital room. For a brief



moment, he is allowed to usurp center stage in a sea of medical personnel. He smears oil (hardly a hygienic action) on a body that is likely pumped full of pharmaceuticals, may be tethered to various forms of technology, and has perhaps only a tenuous hold on life. For that brief moment, the priest assumes authority over the space of the hospital room—the physicians and medical staff step back, perhaps uncomfortable or uncertain whether they should be present. He conducts a rite that he, as well as the patient and family, believes has the ability to heal. The philosophers' favorite conceit—the hypothetical visitor from Mars beamed into a contemporary hospital room—would no doubt perceive this performance as extraordinarily strange and out of place.<sup>5</sup> It is permitted, we know, if the patient wishes to have it, as a way of finding meaning or coping, but the fundamental disconnects between anointing and contemporary medicine are otherwise glossed over in silence.

One might counter that if anointing is best understood as a religious rather than a spiritual practice, then it might be better mapped not to spirituality and medicine but to the subcategory of religion and health. Yet here anointing meets an entirely different set of obstacles. For as we have seen throughout this volume, the subfield of religion and health is largely concerned about efficacy and outcomes. It asks the instrumentalist question: do religious practices (or does religious participation) have a positive or negative effect on health status and health outcomes, on a population basis? Studies seeking to correlate church attendance and overall health status or examining the efficacy of prayer on clinical outcomes are now abundant. Yet as has no doubt been discussed extensively in this volume, to conceive of religious practices in these instrumentalist terms risks deforming their richer meaning, reducing them to, in Andrew Lustig's apt phrase,<sup>6</sup> little more than "health technologies"—useful if they produce a clinically measurable benefit but otherwise suspect or dangerous. According to this logic, we should conduct a clinical trial of anointing of the sick. What if such a study determined that anointed patients had better outcomes—ought physicians offer it as a tool within the medical armamentarium? Or alternatively, what if the study determined that patient outcomes were



worse—should Christian communities stop anointing? Ought it be banned as malpractice from clinical contexts?<sup>7</sup>

In short, a traditional religious practice like anointing of the sick, practiced within the Christian tradition for millennia, fits tenuously at best with the framework provided by the emerging discipline of spirituality and medicine and, in fact, highlights serious problems with the philosophical infrastructure that frames the rules for conceptualizing—and practicing—religion and spirituality in the clinical setting today. I will argue that the theoretical shape of this discourse is deeply problematic for those who take religious practices seriously for at least three reasons. First, it relies on well-deconstructed dualisms, dichotomies, or binaries—a conceptual infrastructure that has been effectively debunked by most feminist, postmodern, and other contemporary philosophers. Such dualisms, as we will see, serve to position religion such that it lies on the nonnormative side of the divide—thereby devaluing and disempowering religion *vis a vis* spirituality. Second, I will argue that the discourse on spirituality and medicine emerged when it did and in the way it did because it provided a crucial component of the consolidation of the biopolitical character of modern medicine. As we will see, thirdly, this aspect of the field of spirituality and medicine mirrors a similar trend seen in the field of bioethics. The biopsychosocialspiritual model in medicine emerged alongside the field of bioethics in the mid-to-late 1970s, both serving to effectively marginalize religion, theology, and modes of substantive rationality except where they could be transformed into instrumental modalities. In the end, I will propose that, properly understood, the practice of anointing—as well as other authentic religious practices—ought well be seen as deeply subversive of the configuration of contemporary accounts of spirituality and medicine.

**BINARIES, BIFURCATIONS, DICHOTOMIES, AND DUALISMS:  
THE PHILOSOPHICAL POSITIONING OF RELIGION**

The literature on spirituality and medicine or religion and health is structured according to now well-deconstructed dualisms, dichoto-



mies, or binaries.<sup>8</sup> This is not a little ironic, insofar as the turn to the biopsychosocialspiritual model in the 1970s was proposed as a way to overcome a number of dichotomies or binary oppositions deemed problematic in twentieth-century medicine, particularly its reductionistic materialism found in its focus on the body as a machine.<sup>9</sup> In the following section, I sketch four intertwined dualisms that shape the field of spirituality and medicine: (1) form versus content (or substance or matter), (2) mind versus body, (3) subjective versus objective, and (4) private versus public.<sup>10</sup> As with most dualistic structures, one pole of each binary is consistently privileged as normative—in this case, it is the formal, the mental, the subjective, the private that merits positive valuation. Not surprisingly, these emerge as the characteristics of “spirituality.” More or less subtly, the opposite pole—that which maps content, body, objectivity, and public—is devalued, positioned, carefully delimited, and circumscribed. It is here that we find “religion,” including substantively religious practices like the anointing of the sick. Although each of these binaries could be described in much greater detail and a legion of examples educed from the literature in support, allow me to briefly summarize each.

### Spirituality as Formal

The distinction between form and matter (or form/content or form/substance) has a long history within the Western philosophical tradition. While the meaning of the terms and relationships between them shifted from Plato to Aristotle to Descartes to Hobbes to the logical empiricists and beyond, it is Kant’s revision of the terms that continues to inform contemporary discourse. Formal entities are, for Kant, abstract, necessary, universal concepts, forms of intuition, innate in the human mind, and, importantly, independent of human experience (therefore *a priori*). They are true for everyone, everywhere regardless of content. Mathematical truths, for example, are formal:  $2 + 2$  always equals 4 independent of the things added, whether one is counting boxes, money, or human beings.

Assertions of the formal, *a priori* nature of spirituality are ubiqui-



tous within the field of spirituality and medicine. Christina Puchalski, an internist and geriatrician who has pioneered the practice of spiritual assessment, especially in end-of-life care, succinctly captures this conviction:

I see spirituality as that which allows a person to experience transcendent meaning in life. This is often expressed as a relationship with God, but it can also be about nature, art, music, family or community—whatever beliefs and values give a person a sense of meaning and purpose in life.<sup>11</sup>

Chaplain Thomas St. James O'Connor concurs, finding among his research subjects: "All believe that everyone is spiritual *whether that person recognizes it or not*, for meaning-making is an essential part of being human."<sup>12</sup> Or, finally, palliative care physician Tomasz R. Okon notes that for the literature on spirituality and medicine: "Regardless of one's particular spiritual orientation, every individual has to make a decision as to whether one's life has meaning and value that extends beyond self, life and death. Even a focused and resolute answer negating such meaning places one in relation to the transcendent."<sup>13</sup>

In other words, try as one might, one cannot escape being spiritual. This, of course, is a Kantian sort of claim, a formal claim—it holds that spirituality is a fundamental, inalienable human category, something fundamental to who we are as human persons. It holds that spirituality is a neutral, universal constituent of human being; its content doesn't matter.<sup>14</sup> In this way, spirituality holds a similar position to that of the faculty of autonomy in bioethics. It is this formal nature that allows "spirituality" to be assessed more or less scientifically.

One can, of course, escape being religious. Religions are clearly not universal, necessary, innate. They are particular and chosen; one is initiated into a religion through a series of rites or practices. One might convert from religion A to religion B, one's Catholicism might lapse, or one might decide to declare oneself an agnostic or atheist. Religions are, by definition and at times by proclamation, particular, defined by highly contingent histories (e.g., the Incarnation, Gautama's decision to seek Enlightenment). Religions are, if anything, defined by their



content and substantive claims—their particular beliefs, practices, histories, convictions, and communities.

Thus, in casting spirituality as part of the transcendental *a priori* structure of the human person, the field of spirituality and medicine creates problems for religion. While required to respect that all persons are spiritual, health care professionals must remain skeptical or agnostic about particular religious claims and practices. But, as with all formal claims, this approach also creates problems for spirituality. As Wilfred McSherry and Keith Cash note in their 2004 comprehensive review of the taxonomy of the language of spirituality: “the term ‘spirituality’ as used within nursing is problematic and in danger of becoming so broad and empty that it is meaningless,” and that “a universal definition of spirituality may be theoretically and culturally impossible.”<sup>15</sup>

#### Spirituality as a Mental Construct

Advocates of spirituality in medicine often champion the new attention to spirituality as a way of overcoming the problematic dualism of mind versus body so often encountered in medicine, a rupture often attributed to the work of Rene Descartes. As Puchalski notes: “More physicians are becoming aware of the unity of the human person—that is, body and spirit—and therefore are integrating spiritual care into their practice of medicine.”<sup>16</sup>

However, the current construct of spirituality in medicine furthers this dualism. It does so in three ways. First, spirituality is cast as a categorical orientation of the human person located in the faculty of decision. Recall Okon’s comment earlier:

Regardless of one’s particular spiritual orientation, every individual has to make a *decision* as to whether one’s life has meaning and value that extends beyond self, life and death. Even a focused and resolute answer negating such meaning places one in relation to the transcendent.<sup>17</sup>

Again, the content of one’s orientation or decision—the choice one actually makes—is irrelevant; one can even “negate such meaning.”





What matters is that a decision, a choice is made.<sup>18</sup> A “decision,” of course, is an activity of the reason and the will—in other words, spirituality is located as mental construct. Such a position is, once again, a good Kantian position.

Spirituality is further distanced from the body by the bifurcation of spirituality from religion or religiosity. O’Connor and associates helpfully articulate the standard distinction:

Spirituality is viewed as distinct from religiosity. Religiosity is an expression of faith through the practices of a particular religion or denomination. . . . [S]pirituality as meaning-making does not necessarily have to be expressed in a religious or denominational context.<sup>19</sup>

Thus, one might be spiritual but not religious (believing in a higher being without religious affiliation or practices), religious but not spiritual (participating in external religious practices without conscious commitment to meaning-making), or both spiritual and religious.<sup>20</sup> Here the term “spiritual” pertains primarily to “meaning” or sometimes is expanded to include “beliefs”—both of which are, again, mental constructs—while the term “religious” is typically applied to the external social, cultural, and/or institutional aspects of transcendent concerns, to the rituals, devotions, or practices of a tradition—in other words, to those things that people do with their bodies.

Thus in all of these configurations, spirituality remains a mental construct abstracted by definition from practices, embodiment, community, formation, and more.<sup>21</sup> Mind-body dualism has not been overcome, but is in fact reinforced.

### Spirituality as Subjective

The subjective-objective dichotomy operates in the field of spirituality and medicine in two ways. First, it structures the discourse itself. The very framing of the question—spirituality and medicine—is predicated on this polarity. It presupposes that spirituality and medicine are two different realms that somehow must be connected. Medicine, via the empirical method and biological reductionism, firmly staked



its claim to the mantle of objectivity throughout the twentieth century. As a mental construct, spirituality cannot but be firmly lodged in individual subjectivity, while medicine and science map without remainder the objective side of the Cartesian divide. Pastoral counselor Gary Shogren notes: “[Even] in an age when medical technology has taken on religious connotations of its own . . . religion and science [remain] neatly divided into Cartesian categories, with healing generally falling into the realm of science.”<sup>22</sup> Moreover, the turn to spirituality in medicine in the 1970s and 1980s was and remains part of a broader series of initiatives intentionally designed to integrate patients’ subjective experiences, feelings, and values into the clinical context. Spirituality, as illustrative questions from a variety of spiritual assessment instruments indicates, concerns subjective experiences and feelings: “How close do you feel to God?”; “A reason I pray by myself is because I enjoy praying”; “I feel thankful for my blessings”; and so forth.<sup>23</sup>

This distinction that places religion/spirituality in the space of subjectivity and science/medicine in objectivity relies on and reinforces particular epistemological assumptions ubiquitous in this literature, namely, that science and medicine make *truth* claims, while the same cannot be said about spirituality or religion. At best, advocates will affirm that spirituality provides individuals with “their own” truth, but this truth follows decidedly different epistemological rules; it is, if it exists, more “mystical” and therefore about it we must be apophatic.<sup>24</sup> Here the objective pole is—at least momentarily—privileged with regard to truth, but the subjective pole is privileged with regard to meaning.

At the same time, however, the subject-object polarity also structures the relationship between spirituality and religion. Spirituality continues to occupy the subjective pole, while religion becomes associated with the objective. Being linked to the objective, however, does not award religion with the status of truth that is conferred to medicine (although religion is often critiqued for making unwarranted truth claims). Instead, subjectively construed spirituality becomes privileged *vis a vis* meaning and truth insofar as spirituality itself represents



a truth about the human condition. Spiritual practices, feelings, and experiences chosen by patients assume a sort of noumenal unassailability. Religion, on the other hand, in its messy contingency and particularity and reliance on revelation (at least in part), becomes increasingly surd. It remains tolerated as a present yet accidental feature of many patients' lives, yet one senses in the literature an undercurrent of impatience. This predisposition makes itself clearest in allied contexts, for example, in bioethics where it is religion, especially objective teachings of religious authorities—not spirituality—that creates so many of the “dilemmas” in bioethics.<sup>25</sup> As Daniel Hall, Harold Koenig, and Keith Meador note in their article “Conceptualizing ‘Religion’: How Language Shapes and Constrains Knowledge in the Study of Religion and Health”:

In oversimplified terms, the Enlightenment paradigm approaches religion as a sort of “frosting” that may or may not be applied to the “vanilla cake” of generic human experience (Wolterstorff 2001a, 7). The frosting may come in several different flavors (Christian, Buddhist, Muslim), but the vanilla cake remains the same from person to person. In fact, the frosting is even optional to the extent that an atheist may choose to enjoy the cake without any frosting at all. Religion is thus perceived as a type of knowledge that may be added to the foundation built by reason and empiricism—but because it is not universal, religion is considered both optional and less trustworthy than the foundational knowledge shared by all humans and verified by our common sensory experience.<sup>26</sup>

Hall and associates testify to the ongoing struggle regarding the truth-claims religion seeks to make as a source of knowledge. Thus, while placed on the scientific side of the subjective-objective divide, religious epistemology is insufficiently empirical to prove a trustworthy source of knowledge. Equally, spirituality's nature as a foundational human intuition shared by all humans renders it more trustworthy than religion. Too savvy, however, to pretend to compete head-to-head with an empirical scientific epistemology, those who promote spirituality in medicine direct its purview away from knowledge toward the domains of “meaning” and “coping.”<sup>27</sup> As we will see,



the field of spirituality and medicine attempts to compensate for this self-avowed subjectivity by adopting the quasi-empirical tool of spiritual assessment or the more rigorous double-blind clinical trials. Not surprisingly, the methodologies and validity of many such studies are being called into question.

### Spirituality as Radically, Individually Private

A category that is both mentalist and subjective cannot be other than private and radically individual. As O'Connor and colleagues hold:

Each person makes sense of his or her life. . . . [S]pirituality [thus] is private and involves judgment. The meaning of one's life, the meaning of one's relationship with self, others and God, and the meaning one attaches to experience and events are personal and often private.<sup>28</sup>

Intriguingly, while O'Connor's ethnographic research found support for this perspective among patients, an agnostic amongst their cohort challenged this presupposition: "One patient, who is an agnostic, enjoyed talking about issues concerning life's meaning. He invited the researcher to debate with him the existence of God. Spirituality for him was a public matter, not a private one."<sup>29</sup> Again, as with the assertion that all persons are spiritual, the data confound the assumptions.

The claim that spirituality is private and individual makes possible the position that assessing and addressing patient spirituality is essential for enhancing patient autonomy. Yet here again we meet another irony, insofar as spiritual claims are inherently heteronomous. In "relating themselves to the transcendent" (whatever it is) individuals by definition cede or at least acknowledge the power that transcendent holds over their lives.

It is this heteronomy that is captured in the root of the term "religion"—*re-ligio*—re-ligate, to tie together. Religion claims to be that which again connects human persons with the transcendent.<sup>30</sup> Unlike the heteronomy of spirituality, this heteronomy is not personal or private but public. From the earliest uses of the term (eighth to twelfth centuries), the term "religion" meant a "state of life bound by religious



vows; the condition of belonging to a religious order.”<sup>31</sup> Religion was a public way of life embarked upon by public professions. Over time, the term broadened to encompass human “action or conduct” based on this connection to the transcendent, be they the public action of religious rituals or public adherence to a code of living in everyday life.

Thus, in the field of spirituality and medicine, where spirituality is fashioned as formal, mental, subjective, and radically individualistic and private, religion constructed is substantive, embodied, objective, and inescapably communal and public. Religion makes truth-claims and engages ensouled bodies through visible, external, communal public practices—just like its counterpart medicine. Although once inextricably intertwined and necessarily subordinated to significant and enduring religious practices, the kernel of spirituality has now been freed from the prison-house husk of religion. As such, it poses no threat to the hegemony of medicine within the clinical setting. What is more, by tranquilizing religion, spirituality and medicine allows medicine to expand its jurisdiction unimpeded. For that account, let us turn to the next section.

#### BEHIND BINARIES AND BIFURCATIONS: SPIRITUALITY AND MEDICINE AS BIOPOLITICS

Constructed, confined, circumscribed . . . *packaged* by these philosophical dualisms, religion is bifurcated from spirituality and marginalized or at least very carefully positioned *vis a vis* the clinical setting. One could ascribe this positioning of religion as simply the outcome of the unsophisticated adoption of modernist philosophical habits. Yet those acquainted with a hermeneutics of suspicion must always ask: whose interest does such a positioning serve? Is there more to this history? How did such a bifurcation come to be created? Moreover, as noted in this book’s prologue, the field of spirituality and medicine has grown exponentially over the past three decades, in part fueled by funding from the National Institutes of Health. One can think about the history of the field and ask why did it appear when it did? How did the field of medicine—having narrated its identity over against religion



for the better part of two centuries—come to so blithely accept the incorporation of spirituality-as-a-science into its domain? How did a government putatively committed to a separation between religion and state come to fund research on spirituality and health?

In this section, I will sketch initial answers to these questions by turning to Max Weber and Michel Foucault. Informed by a more sociocritical perspective on this new field of spirituality and medicine, one might argue that spirituality has been allowed to enter the realm of contemporary medicine in this new way for one simple reason: packaged in this particular philosophical configuration, it enhances the scope and power of medicine and solidifies medicine's ability to further the ends of the social order. The field of spirituality and medicine functions, in other words, as a disciplinary mode of modern, scientific "biopolitics," serving to reproduce, in and through individual bodies, the ideological commitments of contemporary culture.<sup>32</sup> Moreover, this new field of spirituality and medicine parallels the trajectory of another discipline that explosively came-to-be during the same time period: bioethics. Elsewhere, I have argued that bioethics has become a mode of biopolitics.<sup>33</sup> Not surprisingly, we find striking parallels in the fortunes of religion within both fields.

Allow me to begin with a brief overview of the notion of biopolitics, indicating as we go the various ways in which the field of spirituality and medicine interfaces with a biopolitical framework. Biopolitics, for Foucault, names an integrated set of strategies for policing and controlling populations, for "increasingly ordering all realms under the guise of improving the welfare of the individual and the population" but whose real and masked purpose is to reproduce and further the dominant social order.<sup>34</sup> For Foucault, a vital constituent of biopolitics from the end of the eighteenth century forward was biomedicine.<sup>35</sup>

To see the contemporary conversation on spirituality and medicine as a mode of biopolitics is to suggest that behind the rhetoric of freedom, empowerment, meaning, and improving the welfare of individual patients and the health of the population overall, the contemporary turn to spirituality in medicine may not actually advance



patients' interests as much as it functions to shape, direct, and manage the bodies of real, human persons toward larger and perhaps hidden institutional ends.<sup>36</sup> How might this work?<sup>37</sup>

Foucault and others identify three necessary elements in biopolitical governmentality: discourses, practices, and institutions—elements we can clearly trace in the conversation on spirituality and medicine. Discourses are bodies of concepts, literatures, that define and produce objects of knowledge, that govern the ways a topic can be meaningfully talked about, reasoned about, studied. They are, in other words, academic, scholarly, professional fields. The formation of new discourses generally entails a discontinuous trajectory—careful historical work will plot the emergence of a new discourse out of the decline of an old one. Such histories will be those of ruptures, radical breaks, and useful contingencies. However, those who tell the story of the new discipline—history is generally written by the winners—will recount its emergence as a seamless, natural, logical, necessary next step in progress toward truth.

The discourse on spirituality and medicine was catalyzed in the late 1970s with George Engel's development of the biopsychosocial model for medicine.<sup>38</sup> For Engel and others, the biopsychosocial model of medicine arose in response to deficiencies in the functional biological/physiological approach of an increasingly technologized medicine that reached a particular apex (or nadir, depending on one's viewpoint) in the late 1960s and early 1970s. The dogmatic biological reductionism of this "biomedical model" fails to account, Engel argues, for nonphysical dimensions of human illness, healing, and patient experiences, excludes nonphysical disorders from medicine, and fails to recognize its own cultural constructedness.<sup>39</sup> The newly proposed biopsychosocial model (later expanded to the biopsychosocialspiritual model) provides a way to address all these dimensions of the crisis, naturally emerging as a necessary and logical development in the progress of modern medicine. Engel's seminal article launched a movement that followed the typical discursive path—the exponential development of journals, conferences, a professional literature, college classes, centers,



and various graduate degrees over the course of the next two decades. As with all processes of discursive formation, the knowledge produced within this field becomes increasingly technical, formal, and esoteric, necessarily the purview of specialists and elite professionals. Consequently, as in all discursive formation, we find the creation of new health care professionals—in this case, chaplains, spiritual care, or pastoral care providers—those who have the necessary expertise to research and deploy the esoteric findings of this new field. Spirituality as a scientific discipline is no longer accessible by mere mortals, or even physicians, no matter how personal, subjective, universal, and private spirituality is claimed to be.

Discourses, of course, do not simply float free. In order to organize and discipline bodies, they must be incarnated in social *practices*, in what Foucault refers to as “techniques of discipline.” Discourses and practices stand in reciprocal relationship: discourses define the rules for practices, which in turn enact those discourses *vis a vis* individual bodies.<sup>40</sup> Through the creation of such bodies that then go on to act in the world in self-motivated ways, practices further realize (make real) and reproduce the vision and commitments of the discourses in the world.<sup>41</sup>

In addition to the “dividing practice” that we have already seen—the dichotomization of religiosity and spirituality—two central practices or techniques of discipline for the field of spirituality and medicine are the now manifold instruments for spiritual assessment and the practice of taking a spiritual history.<sup>42</sup> Three dimensions of these practices are key to this account. First, the practice of spiritual assessment—at least as it very quickly became to be practiced within the biopsychosocial-spiritual model—is the heir of one of two contributors to medicine-as-biopolitics identified by Foucault, namely, statistical medicine or the numerical method. Physician-philosopher Jeffrey Bishop, in his important book *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying*, provides a helpful account of the role of statistical medicine in the consolidation of medicine’s power in the nineteenth and early twentieth centuries, particularly in areas of public health, eugenics/genetics, psychology, and sociology.<sup>43</sup> More importantly, he carefully demon-





strates how the putatively numerical and statistical practice of spirituality scales and instruments becomes the “scientific” method of choice within this new model. As he notes, in the late 1970s “we find an explosion of new techniques to assess scientifically everything from grief to spirituality.”<sup>44</sup> He cites a company called Psychological Assessment Resources that offers 428 different assessment tools, forty-nine of which are located under the heading “Behavior/Health.” And this is but one of a myriad of such companies. The number of spiritual assessment instruments are now legion.

Second, often structured according to Likert Scales, such assessment vehicles are shaped according to the assumptions contained in the discourse on spirituality and medicine. The four-question FICA tool, for example, speaks of spirituality, faith, and beliefs rather than religion (“Do you consider yourself spiritual?”) and defines the role of spirituality as meaning or comfort (“What things do you believe in that give meaning to life?”; “Does [your faith center] provide support/comfort for you during times of stress?”).<sup>45</sup> Other approaches conceive spirituality in terms of developmental psychological functioning, *a la* Fowler’s Stages of Faith<sup>46</sup> or as a method of psychological coping, an assumption captured in the telling acronym of one of the most commonly cited assessments developed by two of the leading figures in the spirituality and medicine field, Ken Pargament and Harold Koenig, the RCOPE.<sup>47</sup>

This limited psychosocial account of religion and spirituality would be less troublesome but for one key biopolitical dimension of these assessment instruments: they not only are shaped by certain assumptions about religion and spirituality, but also seek to reproduce these assumptions through the participative shaping of patients. For example, insofar as spiritual assessment instruments frame questions in terms of feelings, social support, or coping rather than terms of facts or truth, they subtly yet effectively may shape the way patients subsequently understand the nature and relevance of their own religiosity. Equally, patients who do not fit the mold may be subtly (or perhaps not so subtly) prodded in a particular direction. For example, nurse Carrie Dameron, in providing a succinct account of the very succinct



FICA assessment tool, recounts the story of one Mrs. Garcia. When asked about her spiritual beliefs, Mrs. Garcia responds: "I don't really have any spiritual beliefs or religion, but I like to go to the woods and sit quietly, listening to nature. Sometimes I take a meditation book and think about the words and sayings." Dameron interprets this finding in, *prima facie*, a peculiar manner:

Using the FICA spiritual assessment, we discovered that Ms. Garcia says she is not spiritual, yet she practices spirituality in her life. We see that she has spiritual support through her friend and through meditation books. Ms. Garcia's assessment reveals her spiritual needs, but also communicates that the nurse is caring and open to discussing her issues. This begins a rapport between the nurse and the patient, laying the foundation for further spiritual discussions and caring nursing interventions. Later the nurse can check with Ms. Garcia and see how she is doing, continuing to assess and develop a relationship with her. Eventually the nurse might ask permission to talk further about spiritual beliefs and offer to pray with Ms. Garcia.<sup>48</sup>

Earlier Dameron observed that "many words Christians equate with spirituality have a Christian connotation. Examples include: church, prayer, worship, Bible, sacraments and God. Alternate words to use are faith/spiritual community, spiritual practices, meditation or quiet time, music, spiritual literature and higher/influential power or force."<sup>49</sup> In both cases, spiritual assessment embodies an attempt to shape patient understandings of their own spirituality/religiosity—either by shifting their words away from substantive, particular Christian language toward a spiritualized Esperanto or by imposing upon them a spirituality of which they are in possession unawares, eventually leading to religious practice! Similarly, Pargament and colleagues understand religious coping to be positive or negative. As they note: "Although the concept of coping has a positive connotation, coping can be ineffective as well as effective. Religion also has its darker side."<sup>50</sup> Such a perspective on religion is not simply objective and scientific. Kyle Brothers observes astutely:

For the purposes of RCOPE, its designers narrowed the meaning of religion to religious coping. As psychology researchers, they view humans as discrete



individuals who function either successfully or unsuccessfully within society; it is because of this perspective that Pargament et al. are able to make normative claims that some religious coping is positive and some is negative. For these authors, then, the question is not only how religious coping functions in the lives of people undergoing life stressors, but also how religious coping helps or hinders functioning in society.<sup>51</sup>

In this way, discursive practices seek to take “unruly” bodies—bodies like those of Mrs. Garcia, of the agnostic cited earlier who believed spirituality to be public, or the 25 percent of respondents who classified themselves as neither spiritual nor religious, or those with negative religious coping—and change them, to fit them into the conceptual commitments of the new orthodoxy, thereby rendering them “docile”—amenable to the norms of medicine and the state.<sup>52</sup>

Finally, discursive practices are assisted in this process largely by being embedded in *institutions*, centralized social spaces that provide a visible social sanction for the claims put forward in a particular discourse. Such institutionalization is necessary for two reasons. On the one hand, it provides a place with authoritative sanction for the surveillance that is crucial for the mapping and normalizing of the bodies within a given population. On the other, as noted above, institutionally sanctioned discourses define the “normal,” and through techniques and practices, they encourage individuals to regulate and achieve their own conformity with these established norms.<sup>53</sup> Over time, institutionalized discursive practices subtly move individuals to adopt certain attitudes and practices (e.g., that spirituality and religion are two different things) and in this way, they come to be embodied and enacted within the larger culture, prevailing as normal and acceptable. In other words, institutionalization has the effect of rendering particular discourses “true.” This “truth” is reinforced via the ability of institutionalized discursive practices to “predict” normalizing outcomes and to produce “normal” bodies (to shift persons from one set of norms to another), a dance that reinforces the “scientific” character of the discourse’s growing body of knowledge.

All these dimensions are captured within the field of spirituality and



medicine. While resistance from clinicians continues, spirituality-as-assessable has clearly become embedded to a significant degree within the institutions of medicine and the hospital. Spiritual care professionals visit patients, they administer spiritual assessments—both now a standard part of the surveillance mechanism of modern medicine as well as a method for teaching patients certain normative concepts. Not surprisingly, the outcomes of assessment after assessment demonstrate the validity of the assessments' presuppositions (e.g., that spirituality is a universal component of the human psyche), particularly if administered to radically different demographic populations. The results of these assessments enable practitioners to intervene with patients, to normalize those unruly who might prove disruptive to the smooth flow of the medical regime. With the institutional backing of statistical science and clinical medicine, the findings from spiritual assessments are trumpeted as true, a truth reinforced by NIH funding and now thousands of studies published in prestigious sounding academic journals, backed by a plethora of "data."

As such, as Bishop rightly notes, it is not only the case that the biopsychosocialspiritual model proposed by Engel provided a solution to a crisis of biological reductionism. More significantly, Engel laid the groundwork for medicine to become totalizing. With the development of the biopsychosocialspiritual model:

We see the deployment of the statistical sciences—particularly in psychology and social work—and the expansion of techniques of assessment to capture every dimension of human thriving. A biopsychosocialspiritual medicine is born—a medicine that addresses all features of human thriving. It sets out to nominally define, to operationally assess, and to statistically measure the wholeness of human living; it is a medicine devoted to holistic care, or perhaps better a medicine devoted to total care. Biopsychosocialspiritual medicine measures all things and is the measure of all things.<sup>54</sup>

From the perspective of biopower, it becomes easier to see how the discourse on spirituality and medicine was permitted to enter into and remain within the sacred space of the clinic. Rather than providing a necessary corrective to an overly reductionistic biomedicine, spiritual-



ity allied to practices of surveillance surreptitiously served to provide a way for medicine to exponentially expand the jurisdiction of its gaze and to finally marginalize the only other long-standing claimant to authority over the bodies of citizens: religion.

In this way, the story of spirituality and medicine parallels in an uncanny way the story of bioethics. Likewise launched in the mid-to-late 1970s and experiencing exponential growth as a field, the trajectory of bioethics can also be narrated as one of disciplinary formation via the development of esoteric discourses, overseen by a new profession of specialists, embodied in techniques of discipline such as informed consent, living wills, and research regulations, embedded in institutions such as laboratories, hospitals, and clinics, thereby reproducing new norms that serve not primarily the interests of the patients or physicians but rather the interests of the medical-industrial-government complex.<sup>55</sup>

Equally, for our purposes, this new field of bioethics—although born out of the field of theology—quickly moved to marginalize religion. By 1990, the “secularization of bioethics” was a recognized issue.<sup>56</sup> Kevin Wildes narrates the canonical story of the development of bioethics, maintaining that like the biopsychosocialspiritual model of medicine, bioethics emerged because of the increased technologization and biological reductionism of medicine in the 1960s. For Wildes, bioethics’ initial theological character was pushed aside as a necessary, logical advance:

[B]ioethics has emerged as a field that is distinct from theological ethics and traditional physician ethics even though both disciplines were important to the development of the field. . . . [O]ne needs to understand why theological voices receded from the field. . . . The turn toward a secular bioethics became a search for a secular or civil religion that might bind the sentiment of citizens who were at least nominally divided by religions, cultures, or other differences.<sup>57</sup>

Religion, in other words, is particular and divisive, unlike the universal category of spirituality, or, as those familiar with bioethics know, the main, canonical bioethics principle: autonomy.<sup>58</sup> The resemblances



between spirituality and autonomy in these two discourses should not go unremarked. Both, of course, are formal, universal, *a priori* categories of human nature, mentalist constructions located in the rational will, contentless by definition (the content to be specified by each individual), completely subjective, and radically individual and private.<sup>59</sup>

Key to the marginalization of theology and religion within bioethics was a shift in modes of rationality—from substantive rationality to formal, instrumental rationality. Sociologist John H. Evans, in his book *Playing God?: Human Genetic Engineering and the Rationalization of Public Bioethical Debate*, carefully documents how the substantively rational arguments and religious language that characterized the early stages of bioethics became, by the late 1980s, systematically excluded or at least carefully positioned so as to be mostly irrelevant within public bioethics, usurped by the formal, instrumental rationality of the four principles and an emphasis on bureaucratic procedure.<sup>60</sup> A similar shift can be traced within the field of spirituality and medicine. As Levin suggests, early voices in this field were more interested in metaphilosophical questions (e.g., “What does this really mean?”), but these sorts of substantive questions were quickly left behind in the turn to formal modes of statistical analysis. The early pioneers in this field, as they note, were animated by “more fundamental (and one could say existential) questions about the relation of spirit and body. . . . Before the empirical research enterprise that is the contemporary religion and health field got started in earnest, about 20 years ago, theoretical discussions, especially theological discussions could be found on occasion throughout this literature.”<sup>61</sup>

Yet Ken Vaux, Harold Vanderpool, and Paul Tillich in spirituality and medicine met the same fate as those like Paul Ramsey, Richard McCormick, and even secular geneticists like Hermann Muller in the field of bioethics. Substantive, contentful, theologically informed accounts of religion (and even spirituality) were quickly replaced with instrumentalist accounts focusing on the potential positive effects of religion or spirituality on health outcomes or the use of spirituality to instrumentally manage patient care. This becomes clearest when



spirituality itself is deemed “unhealthy.” As with Pargament earlier, Christina Puchalski also maintains that one can differentiate between “‘positive’ versus ‘negative’ spirituality”:

[If] spiritual issues don't really seem to be important, then I may not do anything with that content. But if someone comes in and says something that I hear as a warning sign, I might want to refer to a trained chaplain to help sort that out. For example, a person may see God as punitive and spiritual assessment may allow me to make a link between this attitude and the patient's not wanting to take medicines, or not taking care of him or herself.<sup>62</sup>

Spirituality becomes an occasion for intervention—in other words, its content becomes important—when it subverts the goals of medicine.<sup>63</sup>

The endpoint of this logic of instrumentality is a consumerist or commodified approach to spirituality and religious practice. Health care itself is located in an ever increasingly consumerist culture. Not surprisingly, the increase in interest in spirituality over the past decade or so has paralleled the trend toward commodification of medicine itself. As Joel Shuman and Keith Meador have incisively noted:

The movement in contemporary North American culture for a more religious medicine has more to do with the fact that both religion and medicine have become phenomena shaped by the consumerist ethos of late modernity. . . . Religion and medicine are, in contemporary North American culture, means of achieving desirable goods external to their practice; both are increasingly viewed as means for self-interested individuals to attain the nearly universally desirable commodity that is individual health. Health is thus . . . to borrow the language of Marxist critique, fetishized, meaning it is valued, pursued, and exchanged without reference to the persons or communities who produce it or to its proper place in a hierarchy of goods of a society committed of pursuing a substantive account of human flourishing.<sup>64</sup>

We find in the literature under consideration here a similar fetishization of spirituality and religious practices. Unmoored from their traditional or communal sources, spiritual or religious practices became services and coping options among which patients might choose—pastoral



counseling, meditation, energy work, chapel service, Reiki, Therapeutic Touch, yoga, anointing. Even anointing has not been immune; to some it has seemed offensive to limit anointing to Christians, when it ought rather be available to anyone who wants to experience the comforting touch of oil in the company of significant others to make the “feel bad” places in their bodies “feel good.”<sup>65</sup> Patients may choose some, all, or most importantly, *none* of the above.<sup>66</sup>

George Engel was, of course, a psychiatrist. Bishop notes that, in the 1970s, psychiatry (like medicine) was in crisis. Psychiatrists, apparently, were not sure “whether the ‘categories of human distress’ that they treat are properly considered ‘disease,’”<sup>67</sup> lacking as they did at the time an identifiable biological basis. Somewhat surprisingly, Engel targets Christianity as the course of the problems with reductionistic, technological medicine. As Bishop notes:

Engel does not repudiate Western science; he merely opposes the reductive nature of Western medicine. Rather than arguing that science itself is reductive, Engel lays the blame at the feet of a medical science that has been infected by a Christian dualism. The purported mind/body dualism of Christianity defines the body as a mechanism separate from the mind or soul, resulting, he argues, in a science that places too much emphasis on the physical body and too little on the psyche or on society.<sup>68</sup>

The invention of the biopsychosocialspiritual model was therefore not just a proposed solution to a crisis in medicine and psychiatry, nor was it solely a masked move to totalize the jurisdiction of medicine: via the subterfuge of encompassing spirituality, the biopsychosocialspiritual model became a decisive weapon in the ongoing conflict between religion and the Masters of Suspicion who founded the field of psychiatry. Consequently, it is not accidental that most of the research and writing in the field of spirituality and medicine is conducted by persons located within the disciplines of psychiatry, psychology, and counseling, and that spirituality and religion are, ultimately, reduced to psychological modes of coping. As medical ethics saved the life of philosophy, it could be argued that spirituality—as a component of the biopsychosocialspiritual model of medicine—played a key role in





ousting religion and saving the life of psychiatry, catalyzing its promotion to a mode of biopower, finally coequal with its medical counterparts.<sup>69</sup>

#### BEYOND BIOPOLITICS: THE EMBODIED POLITICS OF RELIGIOUS PRACTICES

It is plausible, thus, to suggest that the field of spirituality and medicine has become part of the biopolitical matrix of medicine. As long as spirituality facilitates medicine's efficiency in serving the ends of the social order, it will be welcomed within the halls of the modern medical center. As long as it reproduces radically individualized consumers, who understand themselves as primarily autonomous choosers or decision makers, and stays in its private, interiorized, subjective space, it will be considered legitimate and perhaps a necessary partner. If it does not, flags immediately go up.

We find such flags in an essay by Stephen Post, Christina Puchalski, and David Larson entitled "Physicians and Patient Spirituality: Professional Boundaries, Competency, and Ethics." As the title suggests, they here grapple with the thorny issues of "professional boundaries"—a key question in the always-conflicted process of biopolitical disciplinary formation.<sup>70</sup> The issue with which they grapple is a "serious ethical question [pertaining to] the actions of physicians who also wish to act as pastoral caregivers."<sup>71</sup> In a deeply revelatory passage, they suggest:

[I]t is a general mandate of modern developed societies to keep professional roles separate. For example, one does not expect the clergy person who is also a licensed physician to wear his or her pastoral garb in the clinic when functioning as a clinician, nor the white physician's coat at religious service. (Yet the physician-minister or the physician who intends to proselytize, when serving in developing countries or in health care settings that are religious and clearly advertise themselves as such, may merge roles without controversy.) . . .

The pressure to blur the boundaries between the professions often comes from patients. For example, about half of patients indicate a desire to have physicians pray with them. If this finding is accurate, physicians might need to explain to patients why such activities usually better fall under the pur-



view of competent pastoral care. . . . Over the past three decades, biomedical ethics has focused on demystifying the authority of the paternalistic, “priestly” physician of old, thereby allowing greater patient empowerment through autonomy and self-determination.

Adding a sacred or religious mystique to the power of the physician is suspect. For example, we would not condone a Jesuit medical geneticist who maintains that it is appropriate and “nondirective” to wear his clerical collar when doing reproductive genetic counseling in a non-Roman Catholic health care setting. Nor would we want the clinician in a nonreligious health care setting to raise the question, “Have you accepted the Lord?” Many patients would be confused and rightly offended.<sup>72</sup>

Many would be “*rightly offended*.” When it comes to religious practices such as prayer—though not “spirituality”—Post and his colleagues are clearly unsettled by the prospect of fluid boundaries. Health care professionals are enjoined to be particularly vigilant in policing them. Not only might such boundary crossing be confusing; it would be *offensive*. Deeply seated—deeply embodied—sensibilities are at stake here.

Yet not for all. It could be uncontroversial, the authors admit, for a clergy-physician to merge roles in a developing country. “About half of patients” would like their physicians to pray with them. Patients, in other words, are insufficiently “normalized.” Thus, it falls to the physician (at least in the United States) to order them rightly, “to explain to [them] why such activities usually better fall under the purview of competent pastoral care.”

The passage from Post and colleagues reveals that more is going on in religious practices like anointing the sick than simply “meaning-making” or “coping.” Rather, I would suggest that religious practices are equally disciplinary, equally embodied, equally political, but seeking to reproduce not citizens for contemporary society but rather adherents of a different social order, namely, faithful disciples for the church or members of the kingdom of God. Thus, Post and colleagues are quite right to be worried about the permeability of the boundaries where medicine and religious practice meet. A priest in



the ICU ought rightly be seen as a bizarre irruption of the church—of an alternative politics—in the domain of medicine. Indeed, practices like anointing are, essentially, practices of resistance. In their concrete, embodied, communal, public materiality, they cannot but resist the philosophical dualisms that shape the space in which they are permitted to operate. Rooted in traditions and understood as ends in themselves, they resist instrumentalization and commodification. And, as oriented toward a radically different *telos*, they potentially provide a concretely embodied means to resist cultural hegemony.

Thus, it is not only the case that the field of spirituality and medicine construes both spirituality and religion in ways deeply counter to normative Christian understandings of itself, of sickness, health, healing, spirituality, religion, divorced from theological contexts of belief, practice, and community—to the point that theologians and religious practices like anointing of the sick can find little if any place in this literature. It is not only the case that the field has failed to consult with those with real theological expertise. It is not only the case that theologians have dropped the ball in seeking to participate in this field.

Rather, they were edged out, just as the theologians were edged out of bioethics. It happened to them unawares, under the most benign and deceptive of auspices—that of making space for patients' religious preferences in the clinical setting as a way of attending to their care, promoting their wholistic healing, and providing meaning in their dying. The agenda, then, is before us. Seeking to infuse the field of spirituality and medicine with more accurate and substantive theological content, with more intellectual rigor regarding the realities of spirituality and religion will not be enough. At stake is a contest of politics, of regimes of truth, waged via the bodies of patients and the populace. Those committed to questions of religion and medicine are challenged to begin to attend in a more careful historical, sociological, and theoretical way to the particular contingent historical forces that gave rise to the field of spirituality and medicine, including the political commitments of the particular context in which it arose both within society as well as within the realm of medicine. We are challenged to



unmask the arbitrary nature of the field's normative structure as well as the dubious scientific status of many of its claims. Equally, we are challenged to come to a deeper appreciation of political dimensions of religious traditions particularly as they are enacted through embodied engagement with adherents. It may well be our own failure to understand the power and complexity of our own traditions that enabled their deformed marginalization.

We find this power and complexity, I think, in the very practices of our traditions. In many ways, they speak more powerfully than any analyses, though they speak quietly and we tend not to listen. Such witness is given by John Carmody, whose experience of anointing opened these reflections. For I think in his conclusion he captures precisely this truth, that an embodied practice like anointing the sick is not simply a health technology in service of "meaning," but rather is an embodied politics—a practice by which the sick are claimed or reclaimed by the church. He concludes:

Lying in my narrow hospital bed, feeling the oil of gladness and healing, I knew I had little time. More importantly, though, I felt, by a wondrous grace, that this was the first time in my effective memory that the church . . . was praying for me individually, by name, to deal with painful circumstances, suffering, and needs uniquely my own. . . .

[With anointing,] [s]omething maternal really did appear. I truly felt taken to the bosom of a holy family that cared for me. It knew about my muscle spasms and my dismal prognosis. It loved me despite my many manifest failings and my worst secret sins. . . . [I]t was a community of prayer, offering the praise and petition that have always been its primary reason to be. And, for what seemed to me to be the first time, I, little John, weak John, competent John, mixed-up John, strong John, very sick John had a name in this community. My pain grieved it. My dying would sadden and diminish it. I mattered. . . . [T]he church at prayer in my anointing said, . . . "Come close, into our embrace. Become part of the communion of saints as we intercede for you to God."<sup>75</sup>

In anointing, John Carmody found himself reconciled to his mother, the church.



The practice of anointing, then, ought well be seen as deeply subversive of the contemporary configuration of spirituality and medicine, and maybe even of medicine itself. The sacrament of anointing is, indeed, a practice through which patients, families, and sometimes even health professionals find comfort, meaning, and strength to cope with their situation. But more importantly, in the sacrament of anointing of the sick, the church walks into the clinic and claims its own. As the church, as an institutional political body, it cannot help but to challenge the biopolitics of medicine—to break through the well-policed boundaries that not only keep spirituality in the service of medicine but that discipline patients in service of ends not their own. As such, anointing might prove not only to be subversive of spirituality and medicine; it might indeed be its salvation.

#### NOTES

1. This chapter is a revised and expanded version of papers entitled “*Anointing the Sick?: Practicing Religion in the Clinical Context*,” presented at the annual meeting of the American Society of Bioethics and Humanities, October 2004, and at the Duke University Center for Spirituality and Health, May 6, 2010.
2. John Carmody, “Meeting My Mother Again,” *Commonweal* 121, no. 5 (1994): 30.
3. For a more nuanced account of these histories that challenge conventional wisdom about the conflict between science/medicine and religion, see Gunter Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York: Oxford University Press, 1999); Gary B. Ferngren, *Medicine and Health Care in Early Christianity* (Baltimore: Johns Hopkins University Press, 2009); Christopher J. Kaufman, *Ministry and Meaning: A Religious History of Catholic Healthcare in the United States* (New York: Crossroad Publishing Company, 1995); and Amos Funkenstein, *Theology and the Scientific Imagination From the Middle Ages to the Seventeenth Century* (Princeton, NJ: Princeton University Press, 1989). It is important to note that the relationship between medicine and religion remains quite vibrant and far less conflictual beyond the borders of the United States as well as within poor communities within our own society.
4. In this chapter, for simplicity and consistency, I will use the phrase “spirituality and medicine” to refer to the broader field that includes attention to spirituality, medicine, health, and sometimes religion.
5. Even within the Christian tradition, the status of the anointing of the sick is a bit ambiguous. It certainly is an ancient practice, witnessed in the New Testament and practiced continuously throughout Christian history. Traditions with formal practices associated with illness and healing admit of a wide range of diversity. At the one end



of the spectrum one finds the Orthodox and Roman Catholics, with highly sacramentalized rituals practiced in various settings (sanctuary, home, hospital). Alternatively, traditions of the more Pentecostal variety have developed practices of “faith healing,” less high-church perhaps but no less ritualized. Faith healing traditions at times set themselves against modern medicine, offering prayer as an alternative modality in the medical armamentarium whose efficacy is rendered moot should a sick person avail themselves of contemporary medicine.

6. Andrew Lustig, “Prescribing Prayer?: Say the Rosary & Call Me in the Morning,” *Commonweal* 131, no. 8 (April 23, 2004): 7.
7. Elsewhere I have argued that if one studies the Christian tradition carefully, one actually finds an inverse relationship between liturgical involvement, spiritual accomplishment, and health. Sanctity, in fact, can be hazardous to one’s health. See “Suffering in Communion with Christ: Sacraments, Dying Faithfully, and End-of-Life Care,” in *Living Well and Dying Faithfully: Christian Practices for End-of-Life Care*, ed. John Swinton and Richard Payne (Grand Rapids, MI: Wm. B. Eerdmans Publishers, 2009), 59–85. I would now add to the argument there a reference to one of the fundamental practices of the Christian faith: the preferential option for the poor. As many witness, to live in solidarity with the poor may well mean to find oneself the victim of the structured risks that for the poor are everyday realities—death or morbidity from violence or “accidents,” from easily treatable communicable diseases, from malnutrition, parasites, and more.
8. This section will primarily draw from the growing literature on “spirituality and medicine.” It will focus on those who advocate for spirituality as a means of enhancing the patient-physician relationship (Christina Puchalski and Anna L. Romer, “Taking a Spiritual History Allows Clinicians to Understand Patients More Fully,” *Journal of Palliative Medicine* 3 [2000]: 129–37) or honoring patient autonomy (Stephen G. Post, Christina M. Puchalski, and David B. Larson, “Physicians and Patient Spirituality: Professional Boundaries, Competency, and Ethics,” *Annals of Internal Medicine* 132 [2000]: 578–83). As mentioned above, an allied literature advocates attending to spirituality within the domain of medicine because of its effects on health outcomes. For an account of the “religion and health” literature parallel to that offered here, see the lucid and compelling analysis in Joel James Shuman and Keith G. Meador, *Heal Thyself: Spirituality, Medicine, and the Distortion of Christianity* (New York: Oxford University Press, 2003). The parallelism between these two conversations is not accidental, as the latter derives from the former.
9. See Jeffrey P. Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame, IN: University of Notre Dame Press, 2011), 229.
10. Other binaries could also be discussed, e.g., universal vs. particular. It is worth noting an inversion of these binaries relative to their usual positions of normativity. Within much of the Western tradition, formal and mental/rational constructs were allied with objective, public constructs, and often equally correlated with gender (see Jean Bethke Elshtain’s classic work, *Public Man, Private Woman: Women in Social and Political Thought* [Princeton, NJ: Princeton University Press, 1981]). Within the spirituality and medicine literature, however, the formal and mental are paired with subjec-



tive and private. Moreover, without saying as such, this normative pole of the binary wherein lies spirituality also seems overwhelmingly feminine, over against the more "masculine" poles of either religion (concrete, particular, embodied, objective, public) which is disvalued or of medicine (also concrete, particular, embodied, objective, public, true) which is valued. This aspect of the discourse on spirituality and medicine warrants further reflection.

11. Puchalski and Romer, "Taking a Spiritual History," 129. They continue further on: "I have a patient who feels that nature is very important, and she said something like, 'I'm a naturalist, and looking at trees makes me feel really centered and with purpose.' In fact, one of the things she said was that if she were dying, she would want me to refer her to a hospice with a window next to some trees, because that's what gives her meaning and purpose in life. Now, I don't think I would have gotten this information out of a strict psychosocial type of interview" (131). Further examples include: "Spirituality . . . pertains to ultimate meaning and purpose in life" (Post et al., "Physicians and Patient Spirituality," 578); "Religiosity is an expression of faith through the practices of a particular religion or denomination, while the predominant understanding of spirituality is meaning-making" (Thomas St. James O'Connor, Elizabeth Meakes, Pam McCarroll-Butler, Shannon Gadowsky, and Kathleen O'Neill, "Making the Most and Making Sense: Ethnographic Research on Spirituality in Palliative Care," *Journal of Pastoral Care* 51 [1997]: 25-36, quotation on 27); or "The understanding of spirituality has also evolved. For example, hospice's original religious definition of spirituality as a relationship with God or a Divine Other has been replaced by a definition of spirituality as the personal and psychological search for meaning" (Timothy P. Daaleman and Larry VandeCreek, "Placing Religion and Spirituality in End-of-Life Care," *JAMA* 284 [2000]: 2514-17, quotation on 2516; emphasis added).

With regard to the religion and health literature, Shuman and Meador note: "Religiosity is . . . an a priori capacity possessed by every human individual" (*Heal Thyself*, 33). They cite Herbert Benson in this regard: "Apparently, just *having* a strong belief is enough to cause things to happen in our physiology, but this is a very ticklish point. It does seem that just the state of belief, which can emanate from a variety of personal, philosophical, or religious orientations, is itself a powerful force. Does it matter what you believe in? Belief in *something* is crucial. The very force and effectiveness of your personal belief stems from your basic assumptions that your belief matters. If you want to experience the physiological benefits of the Faith Factor and you find you have nothing to believe in, it may be helpful to believe generally in the power of life or perhaps even just in the power of belief itself" (*Beyond the Relaxation Response* [Berkeley, CA: Berkeley University Press, 1985], 81-82).

12. O'Connor et al., "Making the Most and Making Sense," 29; emphasis added.
13. Tomasz R. Okon, "Palliative Care Review: Spiritual, Religious, and Existential Aspects of Palliative Care," *Journal of Palliative Medicine* 8 (2005): 392-414, quotation on 392.
14. Yet see also Shuman and Meador: "So the modern account of religion proffered by the advocates of the new rapprochement turns out not to be theologically neutral at



all, for religion is never religion as such but always a particular religion. The freely chosen, utilitarian religion of individual experience is the particular religion of capitalist high modernity" (*Heal Thyself*, 40).

15. Wilfred McSherry and Keith Cash, "The Language of Spirituality: An Emerging Taxonomy," *International Journal of Nursing Studies* 41 (2004): 151–61, quotations on 152.
16. Christina Puchalski, "Spirituality and Health: The Art of Compassionate Medicine," *Hospital Physician* 37, no. 3 (March 2001): 30–36, quotation on 32.
17. Okon, "Palliative Care Review," 392; emphasis added.
18. Shuman and Meador similarly observe: "Even among those whose work has been concerned mostly with 'traditional religious faith and practice,' the decided emphasis in most of the popular literature on religion and health is on the act of believing and the effects of that act, rather than the particular object of belief. Believing is understood primarily as an act of the human will" (*Heal Thyself*, 33).
19. O'Connor et al., "Making the Most and Making Sense," 27.
20. Sometimes data confound the claims within this literature. As Tomasz Okon notes: "In a recent study respondents were asked to define themselves on a religiosity-spirituality spectrum. Ten percent of respondents described themselves as spiritual and not religious. The majority considered themselves both religious and spiritual, while a quarter described themselves as neither religious nor spiritual" (Okon, "Palliative Care Review," 393, citing Leila Shahabi, Lynda H. Powell, Marc A. Musick, Kenneth I. Pargament, Carl E. Thoresen, David Williams, Lynn Underwood, and Marcia A. Ory, "Correlates of Self-Perceptions of Spirituality in American Adults," *Annals of Behavioral Medicine* 24 [2002]: 59–68). What to make of that latter 25 percent?
21. A similar problem is found in the religion and health literature. Here the objective, external, embodied aspects of religion are largely eliminated and religion is reduced to a mental construct. Per Shuman and Meador: "[T]he central issue is the act of believing. Negative beliefs tend to produce negative outcomes, whereas positive beliefs, regardless of the precise material content of their particular object, tend to produce positive outcomes" (*Heal Thyself*, 34).
22. Gary Shogren, "Will God Heal Us?: A Re-Examination of James 5:14–16a," *Evangelical Quarterly* 61 (1989): 99–108, quotation on 99.
23. For these and similar questions from spiritual assessment instruments, see Okon, "Palliative Care Review," 398, Table 3: Constructs of Religion and Spirituality, Instruments, and Illustrative Phrases.
24. As Shuman and Meador note: Spirituality "has its origins in individual human subjectivity, [therefore] it is fundamentally private and personal. . . . In this sense it is decidedly mystical" (*Heal Thyself*, 35).
25. A stock case in bioethics is the case created by an irrational religious belief: Jehovah's Witnesses and blood transfusions; parents who rely on faith healing; the Roman Catholic position on contraception, sterilization, or abortion; family members' hopes for "miracles"; "religious" objections to organ donation; and so forth. Such cases are never characterized as conflicts over "spirituality."





26. Daniel E. Hall, Harold G. Koenig, and Keith G. Meador, "Conceptualizing 'Religion': How Language Shapes and Constrains Knowledge in the Study of Religion and Health," *Perspectives in Biology and Medicine* 47 (2004): 386–401, quotation on 388.
27. As we will see, spirituality and religion are, in this field, largely reduced to matters of feeling and coping. This is due not only to the Kantian commitments of this field (for whom religion was reduced to morality) but equally to the fact that the field of spirituality and medicine was largely birthed and colonized by those in the psychological disciplines. More on this latter point below.
28. O'Connor et al., "Making the Most and Making Sense," 27, 28.
29. *Ibid.*, 32.
30. "Religion, n." in *OED: Oxford English Dictionary* (online version, December 2011), accessed at <http://www.oed.com/view/Entry/161944?redirectedFrom=religion>.
31. *Ibid.*
32. Anne Bradshaw has observed, in the context of transformations in the practice of hospice that occurred in the 1980s and 1990s (the same time frame that saw the development of spirituality and medicine), that "the preponderance of medical and psychosocial techniques seem to support the warning . . . that hospice care may become predominantly a technique for the professional expert to exercise power" ("The Spiritual Dimension of Hospice: The Secularization of an Ideal," *Social Science and Medicine* 43 [1996]: 409–19, quotation on 415).
33. See M. Therese Lysaught, "And Power Corrupts . . . Religion and the Disciplinary Matrix of Bioethics," in *The Handbook of Religion and Bioethics*, ed. David E. Guinn (New York: Oxford University Press, 2006), 93–128; and M. Therese Lysaught, "Docile Bodies: Transnational Research Ethics as Biopolitics," *Journal of Medicine and Philosophy* 34 (2009): 384–408. See also Jeffrey P. Bishop and Fabrice Jotterand, "Bioethics as Biopolitics," *Journal of Medicine and Philosophy* 31 (2006): 205–12.
34. Herbert L. Dreyfus, *Michel Foucault: Beyond Structuralism and Hermeneutics* (Chicago: University of Chicago Press, 1982), xxvi; and Joanne L. Finkelstein, "Biomedicine and Technocratic Power," *The Hastings Center Report* 20, no. 4 (1990): 13–16, quotation on 15.
35. Key works by Foucault here include *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan (New York: Pantheon Books, 1977); *The Birth of the Clinic: An Archeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Pantheon, 1973); *The Order of Things: An Archeology of the Human Sciences* [1970] (New York: Vintage, 1990); and *The Birth of Biopolitics: Lectures at the Collège de France, 1978–1979* (New York: Picador Press, 2010).
36. Foucault refers to this dynamic as "governmentality." Governmentality does not ascribe agency to a class or any specific individuals, although some individuals and groups clearly benefit from a given system of institutionalized discursive practices. These practices are not, *per se*, intentional, nor directly under control of particular individuals or groups. Rather, their power lies in that they are, in Dorothy Smith's words, "pervasive and pervasively interconnected" connecting "extralocal" ruling rela-



tions to local contexts (*Reading the Social: Critique, Theory, and Investigations* [Toronto: University of Toronto Press, 1999], 49).

37. The focal point of Foucault's analyses—be it of the clinic, the asylum, or the prison—is the material reality of *bodies*. Foucault is particularly interested in mapping the ways in which bodies within a particular social space are organized and “produced”—shaped, that is, to perceive and behave in particular ways. Within a biopolitical regime, power will not most often be wielded in an overt, coercive manner. Ideally, individuals come to wield it over themselves. Within a regime of disciplinary power, each person—by internalizing the norms and surveillance of the social order—effectively disciplines herself or himself. As such, this exercise of power can direct individuals to engage in actions that are not necessarily to their advantage. In short, the basic goal of disciplinary power is to take wild, unruly persons and produce persons who are “docile”—persons, in other words, who do not have to be externally policed.
38. George L. Engel, “The Need for a New Medical Model: A Challenge for Biomedicine,” *Science* 196 (1977): 129–36.
39. Ironically, Shuman and Meador note: “Modern thought, political and scientific, is notoriously reductive” (10), and “radical individualism” (*Heal Thyself*, 10) is but the outworking of that reductiveness in the realm of anthropology. Might one argue that Engel's heirs and the champions of the radically individualistically private biopsychosocialspiritual model corrected the biological reductionism of medicine with an anthropological reductionism—thereby not solving the problem of reductionism at all?
40. As Arthur W. Frank notes: “Theory needs to apprehend the body as both medium and outcome of social ‘body techniques,’ and society as both medium and outcome of the sum of these techniques. Body techniques are socially given—individuals may improvise on them but rarely make up any for themselves—but these techniques are only instantiated in their practical use by bodies, *on* bodies. Moreover, these techniques are as much resources *for* bodies as they are constraints *on* them; constraints enable as much as they restrict. . . . People construct and use their bodies, though they do not use them in conditions of their own choosing, and their constructions are overlaid with ideologies” (“For a Sociology of the Body: An Analytical Review,” in *The Body: Social Process and Cultural Theory*, ed. Mike Featherstone, Mike Hepworth, and Bryan S. Turner [Newbury Park, CA: Sage Publications, 1991], 36–102, quotation on 47, 48).
41. Bodies, of course, can equally resist, recreate, and transform discourses.
42. An additional dividing practice is the distinction between physical pain and nonphysical (existential/spiritual) pain asserted within this field, with both sorts of pain now being subject to medicalization, either through the form of pharmaceutical or personnel intervention. I thank Tomasz Okon for this observation.
43. Bishop, *Anticipatory Corpse*.
44. *Ibid.*, 238.



45. See Carrie M. Dameron, "Spiritual Assessment Made Easy . . . With Acronyms!," *Journal of Christian Nursing* 22, no. 1 (2005): 14–16. This article is a classic example of this literature in many ways. Dameron begins by noting: "Meeting the patient's spiritual needs is part of daily nursing care, yet many nurses feel uncomfortable performing a spiritual assessment. This is especially difficult when the patient presents no clues to their spiritual/religious preference or has a spiritual belief unfamiliar to the nurse. However, there are simple, easy-to-use assessment tools that can help us quickly assess and plan for spiritual needs. . . . None of the questions impart a religion or belief system onto the patient. These are open-ended questions that ask the patients about their personal spiritual beliefs. It is important for Christians and adherents of other religions to phrase questions in a spiritual assessment in a way that is open and non-judgmental" (14).
46. See Bishop, *Anticipatory Corpse*, 241.
47. Kenneth I. Pargament, Harold G. Koenig, and Lisa M. Perez, "The Many Methods of Religious Coping: Development and Initial Validation of the RCOPE," *Journal of Clinical Psychology* 56 (2000): 519–43. As with a significant number of psychosocial and spiritual assessment instruments, the RCOPE was initially validated in part with college students, a group of predominantly white, single, freshman women. The college student cohort is generally known to lack significant knowledge of their own religious traditions and, at the same time, to often be distancing themselves from the religious traditions of their parents. One might speculate that these general characteristics of college students would be more pronounced at public or largely secular institutions (e.g., Bowling Green State University, Duke University) than they would be at religiously affiliated universities. Intriguingly, Pargament and associates find that the RCOPE "proved to be applicable to populations with different levels of religiousness, with different problems, and at different ends of the adult life span" (538)—namely, equally applicable to college students and hospitalized elderly persons, many with quite severe, likely terminal illnesses. Given the necessarily different relationships with their religious traditions necessitated by (roughly) fifty years of lived religion and life events, this finding is quite astounding. This finding likely speaks more to the assumptions built into the instrument than to the differential realities of lived religiosity.
48. Dameron, *Spiritual Assessment Made Easy*, 15.
49. *Ibid.*, 14.
50. Pargament et al., "The Many Methods of Religious Coping," 524.
51. Kyle B. Brothers, "Coping with Religious Coping," *Virtual Mentor* 11 (2009): 767–71, quotation 768.
52. "As one might expect in a culture where religiosity is at once ubiquitous, malleable, and radically individualized, the deity—or more frequently 'faith' or simply 'spirituality'—is often invoked as a means to achieve a variety of ends that are determined by forces of the broader culture" (Shuman and Meador, *Heal Thyself*, 9).
53. As Joanne Finkelstein notes: "It is principally through discourse, that is, through the ways in which systems of knowledge are established, expectations of human abilities



- discussed, and subjects and practices described in the working literature of a professional group, that the 'normal' is defined" ("Biomedicine and Technocratic Power," 15).
54. Bishop, *Anticipatory Corpse*, 228.
  55. My account of bioethics as biopolitics in "And Power Corrupts . . ." did not attend sufficiently to the role of political economy in biopolitics, a point elucidated for me in Foucault's *The Birth of Biopolitics*. Any account of the biopolitical nature of bioethics, and of spirituality and medicine, must necessarily attend to the political economy of the field as well.
  56. See Daniel Callahan, "Religion and the Secularization of Bioethics," *The Hastings Center Report* 20 (1990): S2-4, and the rest of the special supplement on religion and bioethics in that same issue; Janine Marie Idziak, "Theology and the Discipline of Bioethics," *Bioethics Forum* 8, no. 3 (1992): 13-17; and Allen Verhey, *Religion and Medical Ethics: Looking Back, Looking Forward* (Grand Rapids, MI: Wm. B. Eerdmans Publishers, 1996), particularly the essay by Stephen E. Lammers, "The Marginalization of Religious Voices in Bioethics," 19-43.
  57. Kevin W. Wildes, "Religion in Bioethics: A Rebirth," *Christian Bioethics* 8 (2002): 163-74, quotation on 163, 168.
  58. A longer argument would, of course, plot the contingent historical forces and political commitments that created the radical separation between the religious and the public/political, which created religious belief as a radically private, subjective, individual thing. William T. Cavanaugh's work on the sixteenth-century wars of religion (first outlined in his essay "A Fire Strong Enough to Consume the House: The Wars of Religion and the Rise of the State," *Modern Theology* 11 [1995]: 397-420; and then developed more fully in his recent book *Theopolitical Imagination: Christian Practices of Space and Time* [London: T&T Clark, 2002]) provides this account. Here he demonstrates how the wars of "religion" were not so much about "religion"—they were about the reconfiguration and consolidation of new forms of political power—but that this political process was masked by the use of rhetoric about "religion" which cast "religion" as this terribly divisive and violence-inciting thing that must therefore, for peace and the public good, be relegated to the realm of the private. Once religion is banished to the private realm—interiorized, disembodied, disincorporated—Freud (the negative reading of religion) or James (the experiential expressivist) follows, giving rise on the one hand to a contentless "universal spirituality" in the public realm or to "psychologism" in the realm of medicine.
  59. Unlike spirituality, certain human persons can be deemed to lack autonomy, but autonomous persons, per the above account, cannot be without spirituality within this construct, even if they autonomously deny or reject it!
  60. John H. Evans, *Playing God?: Human Genetic Engineering and the Rationalization of Public Bioethical Debate* (Chicago: University of Chicago Press, 2002).
  61. Quoted from the prologue to the present book (Jeff Levin, "The Intersection of Spirituality, Theology, and Health," in *Healing to All Their Flesh: Jewish and Christian Perspectives on Spirituality, Theology, and Health*, ed. Jeff Levin and Keith G. Meador (West Conshohocken, PA: Templeton Press, 2012), 000.



62. Quotation from Anna L. Romer, "Taking a Spiritual History Allows Clinicians to Understand Patients More Fully: An Interview with Dr. Christina Puchalski," *Innovations in End-of-Life Care* 1, no. 6 (1999); accessed at <http://www2.edc.org/lastacts/archives/archivesNov99/featureinn.asp>.
63. Cf. Daaleman and VandeCreek, "Placing Religion and Spirituality in End-of-Life Care": "Religion-based ethics can both facilitate and impede clinical decision-making" (2514). It seems, however, that if creating a space for spirituality in the clinical setting is about fostering patient autonomy, judgments about "positive" and "negative" spirituality would be unwarranted. This slip on Puchalski's part betrays the deeper biopolitical motive of spirituality and medicine. Shuman and Meador aptly identify this as a utilitarian approach to spirituality: if it is useful, it should be pursued; if it would lead to negative health or well-being outcomes, it should be avoided (*Heal Thyself*, 37). As in bioethics, utilitarianism is hard to overcome, even with regard to spirituality.
64. Shuman and Meador, *Heal Thyself*, 6.
65. Jerome W. Berryman, "The Rite of Anointing and the Pastoral Care of Sick Children," in *The Sacred Play of Children*, ed. Diane Apostolos-Cappadona (New York: Seabury Press, 1983): 63–77.
66. The chaplain members of the interdisciplinary care team are the only members that generally are optional; those patients who are not interested in addressing the spiritual dimensions of their illness or dying process are not required to do so. Foregoing interaction with the physician, nurse, or social worker is far more difficult.
67. Bishop, *Anticipatory Corpse*, 229.
68. *Ibid.*, 234.
69. See Stephen Toulmin's now classic article, "How Medicine Saved the Life of Ethics," in *New Directions in Ethics: The Challenge of Applied Ethics*, ed. Joseph P. DeMarco and Richard M. Fox (New York: Routledge and Kegan Paul, 1986), 265–81. By "ethics," here, Toulmin is referring to secular analytic philosophy.
70. The disjunct between spirituality and religiosity is reinforced professionally. O'Connor and associates note: "Religious needs are best handled by a competent person from the patient's religious faith group. . . . Spiritual needs [on the other hand] can be handled by competent health-care professionals from a variety of disciplines" ("Making the Most and Making Sense," 28). Puchalski's work, of course, is designed precisely to encourage health care professionals to develop this competency.
71. Post et al., "Physicians and Patient Spirituality," 581.
72. *Ibid.*
73. Carmody, "Meeting My Mother Again," 30.

