The tangled relationship between healthcare and religion in the UK

Linda Woodhead, Lancaster University

This paper was written after attending a workshop on ‘Religion in Health and Healing’ in Heythrop College in 2011 which was funded by the AHRC/ESRC Religion and Society Programme and organised by myself, Julie Clague and Gillian Paterson. It offers my own reflections on the changing relationship of religion and healthcare, but draws inspiration and some content from the event. It was updated and revised in 2013.

I begin with what Frank Prochaska said that day about religion in healthcare in Victorian Britain. He reminded us that it was a time when the former was by no means the junior partner. There were more scripture readers and religious visitors in the population than doctors and nurses; life was ‘physically painful’; medical relief was (by contemporary standards) inaccessible and unsophisticated; religion provided both an explanation for calamity and a treasury of consolation; God was considered as the ‘Great Practitioner’ and Jesus as the ‘physician of the soul.’ Body and soul, health and religion, were treated together; medical practitioners often accepted a moral responsibility towards patients; the churches accepted a medical responsibility towards parishioners; healing and preaching were linked in the Gospels.

In the 19th century medicine in the hands of Christians passed naturally into ethics while ethics in religious hands took expression in ‘medical philanthropy’. The challenge of ‘missionary medicine’ was to provide the ‘double cure’: to consecrate medicine to the service of Christ and provide the everlasting remedy. The inability of medicine to restore patients’ bodies or to offer an explanation for death gave strength to religion. Overall, there was a desperate need for medical care in nineteenth-century Britain, especially in the poorest areas of the country where little relief was on offer beyond making the sick and dying more comfortable, and praying for their souls. Victorian nursing schools often required nurses to takes courses in theology. Christianity may have made it more difficult to live, but if we are to believe the many nineteenth-century witnesses to the faith, it made it easier to die.

In the 20th century, the introduction of new drugs and painkillers, changes in medical practice, falling mortality rates, the growth of institutional care, and the electrification of hospitals all contributed to the loss of religious influence. State medicine introduced a decisively materialist conception of health. In the secular medical culture of the NHS,
religion seemed out of step with enlarged expectations for healthcare, scientific medicine and egalitarian principles. In less than a century, the hospitals had been transformed in ideological, professional and administrative terms. There was certainly a price to be paid for this ‘progress’, and it was chiefly paid by Christianity, by charity, and perhaps even by the sick. Yet most patients felt it was a price worth paying, if medicine could cure their infirmities and eliminate pain. In a culture that rejoiced in earthly gratification, heaven had lost its allure.

Thus with the rise of modern science and the growth of the modern state comes a partial and patchy takeover of services once offered by Christians (many female, many unpaid) by ‘scientific’ medicine and its providers. Right up to the formation of the NHS in 1948, however, such providers were supplemented, and indeed outnumbered by, the armies of voluntary providers. Indeed, the C19 and first half of the C20 had witnessed an expansion of more rationalised forms of voluntary and paid community provision, often run and staffed by women (Digby 1996). As well as midwives and women guardians in poorhouses, there were female sanitary inspectors, health visitors, and women ‘counsellors’ whose work was focused on infant and maternal health.

The interwar period saw the consolidation of municipal health boards, maternity and child welfare clinics, and women and religious groups were active in the campaigning which led to the formation of the NHS. But the latter, when it came into existence, did not simply absorb this contribution, it erased a great deal of it. In many ways the NHS represented the triumph of scientific medicine over a wider programme of social healthcare and preventative medicine; of the national over the local; of the male medical profession over voluntaryism; and of secular medicine over religious, or mixed, provision of health and healing.

Intriguingly, however, the eclipse was short-lived. In 2000-2002 I was part of a research team which went into the town of Kendal in Cumbria (population c.27,000) with the aim of treating it as a sort of ‘spiritual laboratory’, to see exactly what forms of religion were active there. We quickly located 25 churches, but over the course of the two years we were there, we were astonished to keep finding more and more ‘holistic providers’, that’s to say women (80 per cent) and men who offered various forms of healing or therapy for ‘mind, body and spirit’. In total we identified 126 separate holistic providers (both one-to-one and groups) who, when interviewed, identified their practice as spiritual, and who mostly adhered to some variant of a teaching which holds that all life
is a manifestation of divine energy, or chi. When we profiled these people we found that most were over 40, and that a significant numbers were refugees not only from the churches, but also from the NHS – for example, ex-nurses. A common story was that a person felt called to care for and heal others, but after many years of struggle with bureaucratic structures, rationalised target cultures, and unsympathetic doctors or managers, concluded that she could better pursue her vocation by leaving the NHS and setting up stall on her own or with like-minded others.

By the turn of the millennium, the yearly use of the most established forms of alternative and complementary health practices (CAM) in Britain as a whole was being estimated to involve around a third of the adult population of the UK (Thomas et al 2001). Many of these have an explicitly religious or, more precisely ‘spiritual’, dimension (Heelas and Woodhead 2005; Sointu and Woodhead 2008). Their philosophy is explicitly ‘holistic’. Against a bio-medical view of the human person as an organism subject to disease, they treat the ‘whole person’ understood as a unity of ‘body, mind and spirit’. This ties to an underlying metaphysic which views all forms of life as manifestations of an underlying energy, spirit, or ‘chi’. Disease is a symptom of a blockage of energy, and the multifarious techniques of alternative healing seek to uncover the physical, spiritual or mental causes of this, and to free ‘the spirit’.

So, the extension of a secular, scientific system leads not only to the decline of some established forms of religion, but to the growth of new forms of provision offered by actors who are in a position to take advantage of new demands and opportunities. Spiritual healthcare is reborn. But it is not a case of taking up where it left off, because it is significantly changed under the new conditions in which arises. It arises, in part, as a reaction to a form of scientific medicine which neglects to treat the whole person and dwells only on physical symptoms; but it is also essentially a part of consumer capitalism. Holistic spirituality flourishes because the market provides an environment in which spiritual entrepreneurs can set up small businesses for a clientele who are willing to pay for their services, and because a deregulated media provide the means of advertising and promoting their activities, first through simple adverts in newspapers, and more recently and much more effectively through the internet. Add to this the way in which key symbols and concepts of such spirituality are taken up by marketers and advertisers, and the way both fiction and non-fiction popular books burgeon to such an extent that ‘mind, body, spirit’ becomes a major section of bookstores, and you start to
appreciate the conditions of its existence. Even though such spirituality may preserve, or recapitulate, traditional elements of healing and the preservation of health, including charms, amulets, laying on of hands, herbalism, and various forms of magical practice, this is no ‘folk religion’. Rather, this is a form of religion which is as inseparable from turn-of-the-millennium consumer capitalism as the Church of England is from the nation state.

There’s an interesting twist to this tale. Although holistic healing has arisen in the context of market not state or state health service, the latter has lately become very interested in holistic healing. From the 1990s onwards, some doctors started referring patients to alternative practitioners; some practices and hospitals employed holistic practitioners on their staff; nursing training started to incorporate spiritual care; and the NHS set up an official directory of CAM providers. This is not simply because some of these treatments are effective, but because ‘customers’ demand them, and because the NHS has itself been reformed according to market logics and in a way which takes patient choice increasingly seriously. Not surprisingly, there is controversy over these changes, particularly from the scientific professionals who want to defend the integrity of ‘scientific medicine’. One result is a clinical testing and ranking of holistic healthcare practices, in which some are endorsed and others rejected. Another is an ongoing controversy over the value of CAM, which intensified in the twenty-first century, and in which homeopathy has become a particular focus of debate (because the dilution of its ‘medicines’ makes it seem an obvious placebo-based practice or, in the words of its critics, ‘mumbo-jumbo’ and ‘quackery’). In many ways this has become Britain’s version of the battles between evolution and creationism in the USA: a rallying point for mutual excoriations between defenders of secularism and of spirituality. But the more important point is that this illustrates not just the religious coming back to challenge the secular, but coming back in a market-inflected form to challenge ‘older’ welfare-inflected scientific and secular formations. So the stone which the NHS builders rejected has become, not the capstone, but at least a building block in contemporary healthcare.

Of course, there are many poorer countries in the world in which the context remains that of a dominant religious system and a restricted biomedical system. The religious system has never become as functionally delimited as in the West, and studies suggest that in many parts of Asia and Africa a 'sacred canopy' still reaches over many members and provides guidance, remedies and support for the ill and unfortunate. Religion is still
a prime supplier of explanatory narratives for sickness and death, much as in Victorian Britain. The dominance of religion is also seen amongst members of poorer societies who have migrated to richer societies like Britain, and whose culture is being reshaped in dialectic with that of the host society, including its healthcare system. In this dual context, 'explanation' of health and illness can become contested and politicised, right down to the micro-politics of the family, as with Pentecostal Nigerian Christians neglecting their medical treatment out of witness to their faith, or some Muslim youth pushed into risky sexual practice by the taboo on discussion in their families.

In the UK in the 21st century we are increasingly witnessing the emergence of a highly developed notion of the 'whole person' (not just a sick body) which brings in its train a powerful surge of demand for new approaches in health and social care. The science-based providers have been slow in adapting to this new environment. Agencies are always defending territory, professions have material interests as well as scientific ones and fight to hold onto privileges over legislation and certification, whilst business corporations (e.g. pharmaceutical companies) throw their huge weight into the scales in asserting their interests. The very explanation of health and illness is now a site of intense conflict and competition, whether at the micro-level of the individual patient assessing a course of action through an illness episode, or at the macro-level of theology, epidemiology, scientific publishing, national legislation and international policy. Ideas, discourses, technologies of cure and care, specific remedies - all are competing for buyers in an expanding marketplace.

'Spirituality' figures increasingly highly in these debates. The fact it has many meanings helps its progress. Chaplains use the term in reporting how their practice has moved from being primarily religious to being primarily humanistic, in the sense of providing person-centred support for whoever needs it in the healthcare system – staff and families as well as patients: this is 'spiritual care' as a clinical practice. 'Feelings' are also an important factor which spirituality is able to include as integral to its 'definition of situations', but with which both scientific medicine and credal religion have had less concern. And this is important: patients facing suffering and loss of control need to be able to find hope; health workers facing depersonalisation and exploitation in outcomes-driven delivery systems need to recover motivation; CAM practitioners seek to mobilize the patient's emotion and faith in their commitment to self-healing; leaders of communities caught in major transformation find themselves challenged to engage
their communities in decisions about matters of life and death which are simultaneously religious, cultural, educational, and scientific. At the sociological/epidemiological level, a new awareness of spiritual issues as impacting on etiology and outcome of health disorders is pushing research into new and wider questions, and hence towards broader and more cultural methods, whether for AIDS in South London ethnic minorities or for an ‘epidemic’ of obesity.

The irony here is that structurally, an ‘advanced’ society like Britain seems to be in the process of moving towards the traditional. Confronted by the assertion of ‘the person AND their meaning’, the functionally delimited, autonomous spheres of church religion and biomedical health are breaking down. Taking the long view, and adding a global perspective, we can perhaps propose a kind of natural history of religion and healthcare of a three-stage kind:

First, almost universally, societies whose social practices were wholly blended with their metaphysical beliefs so that it was not really possible to discern either a 'religious' or a 'medical' sector: here it was the religious/metaphysical realms which were looked to for explanations and meanings for illness, suffering and death. A life-meaning harmoniously integrated into the divine will was the norm.

Secondly, initially in the West, pari-passu with the emergence of specialised functional spheres in the economy, education, technology and the law, healthcare, led by scientific medicine, became an autonomous system, with a socially recognised, legally guaranteed monopoly over both metaphysical and physical realms of bodily health. Effectiveness in medical outcome was the transcendent norm.

Thirdly, the era we are now living through, in which both metaphysics and the material sciences (e.g. quantum physics) grow beyond the limits of the 'mechanistic world view' and co-create a culture of holism and body-spirit integration. This emergent culture seeks, not to repudiate the religious meanings and effective physical medicine of the two earlier eras, but to include them in a more complex culture oriented to the achievement of personal development and human fulfilment through a new self-awareness and reclaimed agency. Once again harmony is the transcendent value, but now it is harmony of a healthcare system with a presumed ideal self, relationally embedded, to be forged and reforged through the vicissitudes of life, always growing, including in illness, even in dying and death.
Could this be described as ‘progress’?  

References


---

1 Some were incorporated in the book I edited with Rebecca Catto *Religion and Change in Modern Britain*. London: Routledge 2012.


4 The closing paragraphs and the final observations and question are shamelessly borrowed from Desmond Ryan’s wonderful summing up of the Heythrop workshop. The full proceedings of that day are available at
http://www.religionandsociety.org.uk/research_findings/featured_findings/religion_in_health_and_healing_how_significant (accessed 10th December 2013)