The Sir William Leech Research Fellow’s Report 2013

Variety, Variability and Virtue in Christian healing ministries in North East England

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Overview of year and future dissemination of report findings

The Fellowship was held from 1.9.12 until 31.8.13. During this time, a research project was carried out into the Christian healing ministry in North East England. This utilised the research skills of Dr Rich Bregazzi (see appendix 2).

My own contribution (beyond shaping and directing the research project) was to interview a range of senior academics and church leaders and to formulate a deeper understanding of Christian healing through academic reading and reflection. The fruit of this approach is contained in the report that follows.

The findings of both the reflections on healing and the research project were presented in a group of seminars at the International Anglican Health Network Conference in Birmingham, UK, in April and in the Leech Hall, St John’s College, Durham, in May 2013. A further presentation is planned in early 2014 within a series of seminars on Health and Spirituality at Durham University.

The research paper at appendix 2 is in the process of being accepted for publication in the on-line journal *Theology and Ministry*.

It is intended that the work of research into, and reflection on, healing in North East England will continue and that further opportunities will be sought to share findings and understanding within local, regional and national contexts within the churches, the theological institutions, and the health care communities.

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The purpose of the year’s fellowship was to seek to discover, and then reflect upon, what local church ministers think they are doing, and why, in relation to a Christian healing ministry. Eight such ministers were selected — to reflect a breadth of church style and beliefs, as well as being from across the region — and were interviewed in an open and confidential manner by an expert qualitative researcher.

There was the awareness, for all concerned, that issues of healing, health and human flourishing remain key issues for both the church and for society at large, especially in areas of deprivation and poor health outcomes. This Report reflects on the findings of an investigation into the beliefs of that cohort of local Christian ministers with regard to their own healing ministries, and on how these beliefs impact on well being and flourishing in the North East region of England, with comments.

Key findings include an insight into the variety of types of healing ministries, and healing opportunities, offered by clergy and other Christian ministers; how there is notable variability in governance and accountability structures (where present) in relation to those healing ministries; and that, where such healing ministries are offered, they are done so for the good of the individuals concerned out of a desire for virtue — a true and selfless concern for others — and not out of a desire to grow congregational numbers, to make money for the church, or to increase its status or influence within the community.

Comparisons with recent concerns over how the NHS delivers health care are noted, not least in relation to the apparent failure to care, and to be compassionate, in certain contexts (Mid-Staffs, North Cumbria), with the associated loss of virtue — despite ever more complex governance arrangements being put in place by the NHS regulators.

The report explores how the five ‘C’s of healing and wholeness — Care, Compassion, Consent, Confidentiality and Competence — might be evident in both the church and the NHS, not least through a constructive dialogue. Through such mechanisms, human flourishing and the well-being of the people of North East England could improve, with the church playing an even more effective role as a partner with other agents of health and healing.

How individuals receive the healing ministry is also a key question which requires further study, connecting to the context of the variety, variability and virtue of healing practices within both the churches and the NHS.
At the end of the study, a concern remains about how accountable Christian ministers are – in relation to those seeking healing, their own congregations, other church leaders, bishops (where applicable), and to society at large. Governance structures often remain unclear and hard to define – references to national guidelines or manuals of best practice were inconsistent across the cohort of ministers, although some did look for such guidance and worked within a clearer episcopal or wider church structure.

It would be important to investigate further such matters of accountability and governance, not least in the light of parallel discourses on the safeguarding of children and so-called vulnerable adults. It would seem self-evident that anyone seeking Christian healing would by definition be ‘vulnerable’, and at risk of manipulation and the possibility of being damaged by a ‘healing’ process, especially when such a process did not reflect best practice in its seeking to facilitate healing and wholeness.

So three issues then remain – variety, variability, and virtue – in the Christian healing ministry. How vital, therefore, to find ways to scope out variety, mitigate against the risks of variability, and continue to celebrate and encourage the glory of virtue – not least as an exemplar of good practice and essential values at a time when the NHS seems to struggle (and risks continuing to struggle) as funding tightens and pressures on the system worsen.

Introduction

“‘Don’t pray over me,” she said…’

Christian healing is a contested and controversial subject, evoking cynicism and claims to the miraculous in equal measure. It is both mainstream and specialist in nature. It happens on the streets, in homes, and in conventional church and hospital buildings. Its enthusiastic proponents see healings as commonplace, where the less certain find them only rarely. And the notion of healing itself is open to a range of definitions and interpretations.

For many, the idea of health – and healing – is the return of those who are unhealthy to their better, or best, former state of being, what Hans-Georg Gadamer refers to as returning to a state of ‘equilibrium’ (1). Here, health is seen as a steady state, and healing becomes the experience of returning, of regaining a healthy equilibrium: a form of restoration to a previous state, but without necessarily moving beyond, or having learned from, the process of healing itself. For some, this speaks of a transactional healing.

For others, health is all about completeness, a type of idealised perfection – most notably described in the 1948 World Health Organisation (WHO) definition of health as a basic human right embodying complete physical, psychological and social wellbeing:

‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. (WHO 1946/8) (2)
Such a utopian view of health (and healing) may provide encouragement and vision, but is it realistic, even Christian? Christian theologians, as well as those of no faith, have grappled with such an ideal of health within the realities of what some would describe as a ‘fallen world’. In such a context, the possibility of a perfect life seems remote and foolish, with the prospect of suffering and death a constant reality, ever present, just round the corner.

In the light of this, recent Protestant theologians have sought to make sense of what health might look like in a contemporary setting. For Karl Barth, ‘health is the strength to be as man’ (sic) (3). This theme is developed by Jurgen Moltmann in his 1985 Bampton Lectures ‘God in Creation’:

‘Health is the strength to be human, displayed in the person’s capacity for happiness, and suffering, in the acceptance of life’s joy and the grief of death.’ (4)

In this realistic and hopeful assessment of what might be possible in this life, not least within the grace and comfort of God, Moltmann takes us beyond the idea of mere transaction, or an idealised utopia, into the possibility of transformation. To be healthy is to be fully human, a theme which resonates with an earlier statement by Irenaeus:

‘The glory of God is a human being fully alive; and to be alive consists in beholding God.’ (5)

This sense, of what is possible in transformational, even redemptive healing, was picked up in the research project, not least for those able to see beyond the requirement to be merely ‘cured’ as opposed to fully ‘healed’ – as one minister commented:

‘she died...almost as whole a person as I could imagine even though her body was ravaged...she knew God; she accepted what was happening’ (6)

[Please note that all speech quotations in italics are taken directly from taped interviews with ministers in the study.]

‘I feel as though my insides are falling apart but [with a smile] I myself am alright.’ (7)

In both examples we find joy as well as suffering, in the face of life and death, in the context of profound faith and a sense that ‘all will be well’. These intermingling dialogues, between life and death, healing and wholeness, suffering and cure, and transaction and transformation, will become the focus of the next section of the report – ‘what most people really want is to be healed internally’ (6).

**An Old Testament perspective**

‘Texts say less than we would like to know... Blessing is a lead category... Life being as it should be.’ (8)

Walter Moberly reminds us of the importance of blessing in Hebrew Bible thinking, that texts cannot be pushed too far, and are certainly not to be coloured by our own suppositions and expectations. Inevitably the theme of ‘shalom’ is drawn into the hermeneutical discourse – with its etymology, in
the world of ‘balance’, reminding us of Gadamer’s ‘equilibrium’. We might want to look to ideas of
goodness and holism, but there is a warning not to make too much of the idea of ‘shalom’ – no
catch-all term for reading back individualised modern concepts of well being, wholeness and peace
into the agrarian world of the Hebrews. That world sought wellbeing (‘life as it should be’) in the
interdependent relationships of the community, a corporate engagement in living life together
under the blessing of God, in the fig trees and vines of Amos as much as the restored worship of the
new temple of Ezekiel. Society matters.

Examples of individual healing miracles seem rare in the Old Testament – Naaman being one, but
not many more. And even the account of Elisha and Naaman (9) is not without controversy in its
meaning and purpose, certainly from our exploration of seeing people healed – for we start with one
leper (Naaman) and end with another (Gehazi), so the leper count ‘is not decreased’ (8).

Bruegge mann sees Elisha in this setting as one who is a ‘carrier of Yahweh’s transformative power’
(10). Yet Elisha remains a misfit in his own society, an alien who is ‘other, totally other, a most
significant other around whom the story resolves’, within a context that glorifies the power of the
king and the military. Hence when General Naaman seeks to buy his healing with silver and gold,
within a ‘commercial’ transactional model, Elisha’s call to personal transformational healing is stark
and surprising – healing becomes a gift and a gift from God – the General does nothing to bring
about the healing other than to be obedient to the command to bathe in the river and be cleansed
of his skin disease.

‘The General moves from leprosy, through humiliating submission to wholeness. He moves from
leprosy to wholeness, a standard miracle ... unless we have had leprosy lately’. (10)

Yet the wisdom literature of the Hebrew Bible also takes seriously the failure to find healing and find
wholeness in this life. The theme of lament is a constant one, not least in the Psalms. It is a regular
subject for the Iona Community’s John Bell, who challenges his hearers to reflect on lament and the
ways in which God and the Psalmist speak to one another about difficulty and despair, where
healing and God seem absent. He reflects on the nature of creation and of the human condition:

‘God made us good but not perfect ... to live in a planet with fault lines, where human beings have
fault lines ... we believe we should be perfect, but this is a denial of humanity. Maturity is owning up
to the fact that we live in a creation with fault lines, and we have the same’. (11)

Walter Brueggemann has inspired others to continue the observation of this dialogue between the
wisdom writers and God (12), as seen in a recent article by Suderma entitled ‘The Cost of Losing
Lament for the Community of Faith: on Brueggemann, Ecclesiology, and the Social Audience of
Prayer’ (13). Suderma argues that we, as third party observers to the conversation, are enabled to
develop a vocabulary and context for understanding and expressing what it means for God not to
heal as we had hoped and prayed, even to appear absent amidst the suffering of God’s people. In
this way, how to cope when a cure is not received – but other blessings might be – can be articulated
and, to some degree, celebrated.

‘Christ-likeness is sometimes seen through suffering and difficulty.’ (6)
In a contemporary culture that looks only to the surface (the perfect body) this type of narrative seems perverse and incomprehensible. Yet it may be the only narrative to offer true hope to a population that in many ways is broken, dislocated and hope-less – bringing God’s transformative healing power into the disorientation of our own world, as it really is.

Lament and Praise

Yet it would be unhelpful to focus too strongly on discourses about the failure to heal – or at least in the late-modern understanding, which is the requirement to ‘cure’. Intolerance of pain, suffering and death in our societies makes addressing issues of health, healing and wholeness difficult. Yet where there is joy in church worship and a deep sense of the presence of Christ in the sacraments, much can be made new. Our ministers saw God at work in different ways and via different expressions of church worship – as a part of the more formal eucharist – healing enabled by ‘Two sacraments...forgiveness and...anointing’ and during a time of free-flowing charismatic worship ‘people can get healed in worship...without having to come forward’ (6).

Some contexts can risk manipulation and hype of the atmosphere, without there being an appropriate sense of control and emotional security – two comments seemed double-edged in this regard, unsure perhaps of whether to celebrate or be chastened: ‘people fell off the chairs...we had bodies in front of the platform...it was amazing’; it was ‘Pandemonium...the Dean didn’t let us have it any more’ – the latter raising the question of willingness and capability to manage an emotionally charged event.

The Importance of Community

‘The gifts become the gift of the community’

‘It’s not just the priest that can heal ... people are called into healing ministry...the laity’ (6)

In interviews with both Justin Welby (14) and Sam Wells (15) the importance of community, both as a context for and a mediator of healing, became evident. Whether in a cathedral or a parish church setting, the living community of the church becomes, for Welby, a place ‘helping bring somebody to God’ where the most hateful thing is ‘telling people what should and should not happen.’ The prayer, shared together, is ‘O help’ with the heart of the process ‘wanting to meet with God’. The priority remains the person being prayed for, held within the life of the community, not a counselling process. Neither is healing a tool for evangelism, a theme to be discussed later. Rather it is ‘a “gift” to the whole Body, not to the individual.’

For Wells, one key issue within society is that of isolation, of people being alone and a healing ministry seeks to reduce such isolation, bringing forgiveness and reconciliation, rather than a ‘removal of obstacles’ to being healed. We find a poverty and fragility of relationships, and forgiveness and healing become possible in the context of community (so the four friends lower the
man through the roof in Mark chapter 2, whereas the man by the pool in John chapter 5 has no one to help him).

And community can be both a welcome in from the street, being accepted and loved, and being invited into a more formal healing service in the side chapel, where the clergy lead ‘on behalf of the whole community’.

‘There are people who make grand appeals and claims and wonderful things happen...but wonderful things can happen through the caring person who says let’s...meet for a coffee.’

‘I think it’s really just talking to people...just being with people and talking to them’ (6)

 Miracle

‘I’m absolutely against the idea that it’s always God’s will to heal’

‘I believe totally and completely in divine healing’

‘Most people experience healing through...medicine and drugs’

‘I don’t know how it works’ (6)

Perhaps the most contested area in the church’s healing ministry is the place of miracle. As the quotes above demonstrate, the cohort of ministers was divided on the subject. Bishop Colin Buchanan, in his Grove Monograph on Healing Services (16), seems cautious about seeing miracles today, at least in the Church of England. Another retired Anglican bishop would take a different view on the matter. For Bishop Graham Dow (17) healing is multi-faceted – physical, mental, spiritual, inner, social – and may involve deliverance. ‘Words of knowledge’ may open up ways into healing and release. There is integration and holism, and ‘science is good’ too. Healing involves ‘progress towards “well-being”’ and is multidimensional. There is the power of blessing (‘I bless you in the name of Jesus Christ.’) and the Holy Spirit remains poised to enable God’s blessing to become a transformative reality on the ground.

Jurgen Moltmann recognises the on-going power of Pentecost, healing happening ‘when and where God wills’ (18). Anthony Thiselton (19) questions whether the terminology of the ‘miraculous’ is the most accurate way of conveying God’s almighty sovereignty ‘to act in or through causal processes or otherwise , as God chooses.’ Reflecting on 1Corinthians 12v10, Thiselton ponders whether to translate energemata dunameon as ‘the working of miracles’ or ‘actively effective deeds of power’. For him, ‘“deeds of power”’ does not exclude miracles, but neither does it specify them’.

Thiselton also makes reference to the ministry of John Wimber (20), with his emphasis, at least initially, on ‘power evangelism’ and ‘power healing’. Justin and Caroline Welby found Wimber and his Vineyard church leaders immensely supportive and wise during a dark time in the experience of their own family, after the death of their daughter Johanna. After speaking with American Vineyard leaders Bob and Penny Fulton in October 1983, Welby comments that ‘they enabled us to see that God was walking with us in this very painful period.’ (21) For some, Wimber seemed to soften his
position and understanding of the place of power in the healing ministry. John Stott (22) met him in Edinburgh in October 1988 (a few years after the publication of Power Healing) and they spent two hours together. Timothy Dudley-Smith (23) remembers Stott’s awareness of a change in Wimber’s position, not least that Wimber himself was unwell and on medication (he died in November 1997 aged 63), and that an increasing number of his congregation ‘are not healed’. Before they parted, Stott suggested (and Wimber agreed) that part of their difference in viewpoint could be accounted for by the tension between the ‘already’ and the ‘not yet’ – an eschatological concern of realisation (now, in process, futuristic): between ‘Kingdom come and Kingdom coming’ (24).

However one chooses to place miracle in the spectrum of the church’s healing ministry, powerful negative forces remain – to contest the space where healing and holism can flourish. There is blessing, but also darkness. There is ‘no formula for healing’ but where the Kingdom of God is proclaimed, the church’s healing ministry continues – in continuity with New Testament times (St Paul’s ‘signs and wonders’) as much as 4th century exponents such as Hilary of Poitier (25).

Five ‘C’s - Care, Compassion, Consent, Confidentiality and Competence

‘Someone prayed, at the end I just felt God say go and lay hands on him’

‘Check with your doctor...you don’t want people to say they received healing whereas nothing has taken place, there is nothing to hide...’

‘Any kind of healing ministry that isn’t surrounded by love and grace is bad practice’

‘I’ve seen people humiliated’

‘People are harangued and told that they must have faith and God will heal them’ (6)

The parallels with the NHS are marked. The public attention given to care and compassion in healthcare is acute. Recent reports from NHS Trusts in Mid-Staffordshire (26) and North Cumbria (27) highlight the particular problems of individual NHS hospital trusts in delivering the five foundational ‘C’s of healthcare and healing. A wider concern has more recently been expressed over the variable implementation of the Liverpool Care Pathway (LCP) for end-of-life care (28).

Care seems fundamental for so-called caring professions – medicine, nursing, church ministry. Its absence feels deplorable, a denial of all professional values. In the above quotes, examples of poor practice (‘people humiliated’), with theologies that blamed recipients for a lack of faith should they not be healed (‘harangued and told they must have faith’) were set forth and condemned. Equally, the confidence that God would heal could also be problematical, not least where there was an absence of loving support and follow up (comments have already been made earlier on the need for a language (e.g. of lament) when healing does not occur as hoped for. Themes of care and compassion then become symbiotic in allowing a different form of healing (as opposed to ‘cure’) to take place.
The themes of ‘confidentiality and consent’ are more problematical. In many, if not most, of the healings of Jesus, healing takes place in the public square, as he is journeying, beside the road – for all to hear and see. In the case of the paralysed man by the pool of Bethesda, in John chapter 5, the expectation for the recipient is that Jesus will help him into the pool for healing. Instead, Jesus commands him to get up and walk. For the man lowered through the roof in Mark chapter 2, consent, if given at all, comes from his four friends. For the demon possessed man of Matthew chapter 8, it is the demons who request their transfer into the herd of pigs, not the man. For the woman with a discharge in Luke chapter 8, touching the garment of Jesus is enough to heal – without, it would seem, the consent of Jesus (‘Who touched me?’). For today’s healing ministry, the context, and the expectation of people asking for healing, is very different, and issues of safeguarding, consent and confidentiality remain paramount. This would be the case across the range – from healing in the streets, in a church, or a home setting for such a ministry.

Finally, we come to competence. Here it is as much about competency of process and explanation, as it is about seeking to control the power of God! Guidelines exist, at least within the Church of England (see appendix 1), and can be found in publications such as John Leach’s Grove Booklets (29) – not least (from the Guidelines) that ‘Persons in this ministry should be aware of their personal limitations and ensure that they are properly prepared and fit to be involved.’ The lack of overt reference to explicit guidelines or codes of conduct in the interviews suggests a degree of unawareness of some of the risks involved in this ministry – not least where safeguarding is concerned.

It was good to find in one interviewee the mature response -

‘Check with your doctor’.

The Three Vs – Variety, Variability and Virtue

Variety

‘The whisper of the Spirit…and a cup of tea and a scone in Fenwick’s afterwards’

“We’re not really given any tools…we’re not taught how to bring wholeness to people’ (6)

Variety relates to the range of contexts and modes of healing practice encountered during the interviews. Such healing ministries take place in hospitals, in church buildings, in homes and on the streets; they may be in the context of a Eucharistic service or where there is no accompanying act of worship; there may, or may not be, the use of oil and/or the laying on of hands; there may be a ‘word of knowledge’ to inform events, happening in private or firmly in the public square; involving individuals or a large group; appearing low key or high profile. And there is the issue of whether there is the belief that God calls an individual minister to be His agent in healing, or whether it is through engagement with the minister’s congregation, or church fellowship, that healing is made
possible – where the people of God or their representative are God’s agency, or equally there is a combination of the two.

Within this variety, there was no clear impression that other forms of healing ministry were somehow unacceptable, unless, of course, they put people under undue pressure or appeared exploitative – the poor forms of practice noted above. Rather, there seemed to be an openness amongst practitioners to a range of possibilities in healing contexts – a generosity towards others – where personal preferences, theological understandings, and liturgical practices (or the lack of them) informed the practitioner, but did not necessarily exclude the possibility that other approaches and methods might also be valid.

Variability

‘If the Bishop says it’s ok, it’s ok’

‘...things could be better I think we could have more diocesan support...’

‘In so far as you can be trained in this kind of thing’ (6)

The concept of variability can refer to at least two understandings: variability in outcome (‘Did the patient get better?’ in medical terminology) and variability in methodology and governance. The former theme will not be followed, not least as no independent way of judging outcomes of the healing ministries was explored, other than anecdotal comments from those ministers interviewed.

Governance, or the lack of it, has been an issue in the NHS ever since its inception in 1948, not least with the introduction of ‘Clinical Governance for the NHS’ in 1998 by Sir Liam Donaldson, the then Chief Medical Officer for England (30). With the introduction of clinical governance came greater regulation, especially for doctors, and challenge to the NHS culture – with the introduction of clinical guidelines (NICE), monitoring by the Care Quality Commission (CQC), the revalidation and stricter appraisal of doctors by the GMC, and tighter controls on training in areas of consent, confidentiality, equality and diversity and safeguarding.

The comparison with the cohort of church ministers is interesting, and is reminiscent of working as, say, a young GP medical partner 30 years ago. Fresh from medical school, and having done only one year as a trainee GP within a 3-year hospital-based scheme, doctors did ‘what seemed right in their own eyes’, learning (or not) as they went along, with limited accountability other than to their own professional values and judgements, and the broadest understanding of ethical frameworks. Hence, with the introduction of clinical governance came the need to begin to follow national clinical guidelines, be annually appraised, allow others to review clinical practice, and work more effectively within an accountable clinical team.

It should be noted that these initiatives risk producing ineffective systems of hyper-accountability, as described by Onora O’Neill in her Reith Lectures (31) – where the imposition of endless data collections, and impossible levels of regulatory intervention, kill any sense of personal responsibility and the ability to use judgement, wisdom or even the merest common sense.
Within the clergy sample, there was marked variation in governance systems, if they existed at all. Some looked to the Bishop for guidance, and for accountability structures. Others had groups of lay elders or the equivalent, whom they themselves had often appointed. For others, accountability was solely to God the Holy Spirit. One might also wonder about accountability to wider society, and, of course, to the people they were ministering to.

Initial and up-date training was also unpredictable – such as learning from charismatic mentors, receiving teaching within theological college or course formation, through personal study of the Bible, or learning on the job, as you went along. Although literature on methodology and praxis is available (such as Grove Booklets, and works by Francis McNutt and Bishop Morris Maddocks) – they were rarely referred to, making one wonder what on-going process of learning and reflection might be happening.

‘All ministry must be exercised with discipline and within an authority structure,’ as Welby noted.

**Virtue**

‘This is not primarily evangelistic work, this is primarily pastoral work...we don’t go out to save souls, we go out to heal the sick’

‘[I] just react to the person as a person [not as a potential] convert…’

‘I let them have their atheism’ (6)

Whatever else, there was clear evidence that the motivation to be involved in any form of healing ministry for our eight interviewees came from a sense of vocation: from a calling from God to offer help, support and care to those in need. In the general and obvious sense of the word, we consider this to be virtuous. Evidence of this came from what was offered in conversation (word) and also by what they were doing on the ground (deed) – going out on to the streets, not least as street pastors in the middle of the night in difficult contexts; being called into hospital settings at all hours; being willing to spend time with people; being open, when it occurred, to be trained and to train others, desiring to work as a team with laity.

It is difficult to clarify the presence or absence of instrumentality in our interviews – How much was the motivation to offer healing free from the desire to see conversions and new “bums on seats”? In general, this sort of instrumentality was mainly absent – motivation came from a call from God to ‘do good’, to be available to others in their need and to offer help and hope. Within that offer was a desire that individuals might find a living faith in Jesus Christ, since that, for the minister, was the ultimate healing. Yet there was no clear sense of a primary desire to see congregations growing purely as a result of healings, and, inevitably, many of those offered some form of healing ministry were already church members in the broadest sense – they were there, attending church, to receive the offer.
The clear commitment to offer a healing ministry came from a sense of vocation, from the desire to offer personal pastoral care, and the belief that this was part of what it meant to be a Christian Minister.

3 sets of questions remain

Three brief sets of questions remain.

Should variety in the Christian healing ministry be seen as positive or negative, as good or bad? In the light of the healing miracles of Jesus, and post-Pentecost, but in a more complex society, should the church’s ministry become more monochrome and predictable? Does the degree of variety indicate too much looseness and clack of clarity in an un-focussed practice of the church’s healing ministry?

Is variability in governance and regulation no longer an option, given other concerns over matters of best practice and accountability, not least in terms of safeguarding – for all who come for healing could be considered as ‘vulnerable’? But in the highly regulated and clinically governed parallel universe of the NHS there is still, for example, the Mid-Staffordshire Inquiry into all that went wrong within one NHS Hospital Trust, with all its apparent regulation and accountability. And how can work in partnership with other agencies, including the NHS, flourish?

Is virtue, like trust, a quality to be held on to almost at all costs – so hard to keep and so easy to lose? Robert Francis QC noted in the Mid-Staffs Inquiry report that ‘The evidence gathered by the Inquiry shows clearly that for many patients the most basic elements of care were neglected.’ ‘Food and drinks were left out of the reach of patients.’ ‘Staff failed to make basic observations and pain relief was provided late or in some cases not at all.’ Now whether Mid-Staffs is typical of the NHS as a whole is for others to judge – but it is a reminder of what can happen when virtue, for whatever reason, is left behind.

In a recent book (32), the question was asked, ‘Why is it that good people can offer bad care in the NHS?’ There were issues of over-regulation and the loss of autonomy and personal responsibility for practitioners, and a loss of the ability to use judgment and wisdom.

One challenge for the churches may be how to remain virtuous in their healing ministries whilst also assuring everyone, not least those to whom the church seeks to minister, that practices are safe and sensitive, full of compassion and abounding in love, as well as the power of God.
References


(2) *WHO 1948 constitution* (Geneva: World Health Organisation, 1948)


(5) Saint Irenaeus, *Against Heresies*, 4.34.5-7


(7) Ruth Etchells, overheard by JH just before she died of ovarian cancer (Durham: July 2012)


(9) See 2 Kings 5 v1-27

(10) Walter Brueggemann, *Testimony to Otherwise: the testimony of Elijah and Elisha* (St Louis, Missouri: Chalice Press, 2001)

(11) John Bell, *Interview with JH* (Durham: 24.11.12)


(14) Justin Welby, *Interview with JH* (Bishop Auckland: 17.12.12)

(15) Sam Wells, *Interview with JH* (London: 21.11.12)


(17) Graham Dow, *Interview with JH* (Durham: 8.10.12)


Justin Welby, interview given on 24.1.13 at Trent Vineyard Church, Nottingham


Saint Hilary of Poitiers, *Treatise on the Trinity* (France: 4th century)

Robert Francis QC, *Final Report Of The Independent Inquiry Into Care Provided By Mid-Staffordshire NHS Foundation Trust*


Tim van Zwanenberg and Jamie Harrison, *Clinical Governance in Primary Care.* (Abingdon: Radcliffe Publishing, 2002)


Valerie Iles, *Why reforming the NHS doesn’t work: The importance of understanding how good people offer bad care* (London: 2011)
Appendix 1

House of Bishops’ Guidelines for Good Practice in the Healing Ministry

The healing ministry is Jesus’ ministry entrusted to us, always to be exercised with reverence, love and compassion. The guiding principle is to recognise the presence of God in those receiving this ministry and honour his presence in them.

1 Prayer and preparation

The healing ministry is based on prayer in the name of Jesus Christ; those involved in this ministry should be prayerful, regularly practicing Christians who acknowledge his healing love and are willing to pray and listen for guidance in order to minister appropriately to others.

2 Safety

All reasonable steps should be taken to ensure the safety of the person receiving this ministry. People have a right to know what is being provided and how they will be ministered to.

3 Accountability and diocesan regulations

Everyone involved in the healing ministry needs clear lines of accountability to recognise who holds relevant authority within their parish church. All reasonable steps should be taken by those involved to ensure their awareness of current law as it applies to this ministry, e.g. data protection, informed consent. Legal liability issues must be considered from an insurance viewpoint. Existing diocesan regulations should be also followed.

4 Training

Individuals should receive appropriate training in this ministry and be kept up to date with developments and its ecumenical expression. Healing team leaders must ensure that members have opportunities for training and a common understanding of good practice.

5 Competence and boundaries

Persons in this ministry should be aware of their personal limitations and ensure that they are properly prepared and fit to be involved. If fitness is doubtful or compromised or there is a conflict of interest, they should withdraw from ministering to others. Professional boundaries with health care professionals and chaplaincies should be observed.

6 Personal conduct
The healing ministry is part of the message of the gospel; the personal conduct of everyone involved should encourage confidence in this ministry and not undermine it. Language, personal hygiene, general appearance, body language and touch used by those ministering should be appropriate, considerate and courteous towards those receiving it. No one should be ministered to against their will.

7 Confidentiality and public statements

People’s privacy and dignity should be respected and protected. Any limitations to confidentiality should be explained in advance and any disclosure should be restricted to relevant information. It should be conveyed only to appropriate people, normally with the parishioner’s consent, and not misused in any way.

8 Counselling and psychotherapy

These specific treatments, as distinct from pastoral care and listening, should only be provided by accredited counsellors and therapists who adhere to the codes of ethics and practice of their regulatory organisations and who have professional insurance cover.

9 Deliverance

The House of Bishops’ guidelines (1975) should be followed and diocesan Advisors consulted when necessary.

10 Partnership

The healing ministry should be carried out in co-operation, where appropriate, with chaplains and representatives of our ecumenical partners, and those involved in professional and voluntary healthcare, whilst recognising that they may be bound by other codes of conduct.

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Appendix 2


Attached as a PDF document