Medicine, Wellness, and Post-Institutional Spiritualities: A Critical Engagement

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Some of the most interesting experiments in co-vivencia occur in healthcare settings. There is now an established literature on the challenges and opportunities created for public health institutions by changes in the ethno-religious landscapes of liberal democracies (Reimer-Kirkham et al. 2020; cf. Coward and Ratanakul 1999). We certainly have not exhausted the need for ongoing conversations about how to make contemporary healthcare more inclusive and effective for the growing numbers of Muslims, Sikhs, Hindus, and Buddhists in immigrant-receiving societies such as Australia, Canada, Spain, and the United Kingdom (Coward and Stajduhar 2012). Scholars often expect to find that (and are not surprised when) conventional biomedical institutions tend to resist the accommodation of medical norms and practices (Stephenson 2005) that are neither "evidence-based" nor straightforwardly "western." But it is also the case that we observe perhaps counter-intuitive phenomena, such as the fact that healthcare institutions (at least in Canada) seem to be very responsive when it comes to integrating Indigenous practices and activities (Bramadat and Seljak forthcoming).

Interactions between putatively secular institutions and capital-R religious communities remain quite interesting. However, there is also much to learn from studies of individuals and groups with mixed or unconventional approaches to religion and spirituality who try to navigate the institutions and norms of our health system.

The project that generated the nine essays in this special issue began in the middle of the COVID-19 pandemic, which allowed us to see, and in many cases experience, the ways health spaces respond to a global crisis and the existential quandaries this generated. In the process, many of us noticed that far from being sterile bastions of positivism (an enduring if inaccurate caricature of hospital settings and personnel), in truth, personal, post-institutional, creative, embodied, and often political forms of spirituality are present in healthcare and wellness settings, debates, and discourses. While it is true that many individuals in our societies are distancing themselves from conventional religious institutions and life-ways (Thiessen and Wilkins-Laflamme 2020), the relationship between medical science and religion (or spirituality) is not a zero-sum game. Novel forms of religiosity, spirituality, or non-religiosity do not simply supplant conventional varieties of religion; they change the dynamics that scholars, practitioners, and clinicians need to bear in mind.

The COVID-19 pandemic underlined just how complicated the relationship is between public health and both religious and spiritual ways of being. We know that the vast majority of religious institutions in liberal democratic societies supported the public health orders of their governments. Nonetheless, the pandemic underlined the need for scholars and others to think together about not just "conventional" religious imaginations of the body, but also approaches to the body that emerge out of practices and perspectives such as Traditional Chinese Medicine, Indigenous medicines, Ayurveda, homeopathy, reiki, intuition, acupuncture, and yoga. As well, in the last four years we witnessed the power of "conspirituality," the fusion of "new age" and "conspiracy theory" orientations (Ward and Voas 2011). These alternative, complementary, and often thoroughly spiritualized approaches to individual and public health are certainly not new, but conspirituality played a very powerful role in the acutely politicized forms of vaccine hesitancy (especially but not exclusively in the United States); it seems clear that these movements, emotions, and discourses are likely to inflect conversations about health and wellness for many years to come.

I initiated this conversation among clinicians and

scholars of health, spirituality, and the sociology of religion because open engagements are needed to come to terms with the relevance of these relatively unconventional forms of spirituality for our collective understanding (and pursuit) of public and personal health.

These nine short essays began their lives as "think-pieces" prepared in advance of a workshop I hosted at the University of Victoria in 2021[1], and were revised over the next few years in light of peer evaluation and the lessons we all learned in the intervening pandemic years about health and wellness. These pieces contribute not just to emerging conversations in religious studies and the sociology of religion and health, but to the overlapping and growing fields of health humanities and medical humanities.[2] The latter two fields foster critical conversations about what it means to imagine and promote health in complex multicultural and multireligious societies.

Isabelle Kostecki takes readers into Quebec hospitals to explain the emergence of new death rituals that demonstrate some of the creativity that often characterizes post-institutional spiritual activities overseen by spiritual care providers. We stay in Quebec for Géraldine Mossière's essay on "spiritual coaches." These practitioners offer a wide variety of services in the province's health settings, and yet they are subject to legal, professional, and institutional regulations that limit—with mixed consequences—the kinds of interactions they might have with clients and their families. Justin Stein examines reiki, a popular mode of healing often found in North American biomedical spaces. The debates over whether, or how, to include reiki in hospital settings reveal a great deal about the fuzzy boundaries between conventional and complementary modes of imagining health and wellness.

Andrea Jain explores the ways spiritual practices such as yoga are often used as self-management interventions in health settings. She also turns her attention to Black veganism as an embodied assertion of Black health and food justice in social and health systems that do not seem to be designed to support minority communities (and everyone else, for that matter). Mar Griera explores the ways different spiritual and religious practices and practitioners are treated in the Spanish prison system. She helps us understand the ways privilege and history explain why relatively new wholistic wellness practices (such as yoga) are imagined quite differently than conventional Christian practices.

In an effort to demonstrate the value of a broad health humanities orientation to complex global health issues, Sheryl Reimer-Kirkham introduces us to the fascinating case of albinism in South Africa. Her reflections also include insights into the challenges and benefits of Canadians carrying out research on societies far removed from themselves. In their essays, Paul Bramadat and Anna Halafoff write about the phenomenon of "conspirituality" in Canada and Australia, respectively. Each of them links these phenomena to broader crises gripping their two societies and explores ways of understanding and remaining in dialogue with those critical of conventional approaches to wellness and risk. In Linda Woodhead's essay we consider "carers" in the United Kingdom (e.g., family members, volunteers, and others engaged in vital but non-specialist efforts such as bathing, dressing, and feeding others). By drawing attention to these often poorly compensated and marginalized service providers, she can pose questions about the evolution of caring in a society in which we have seen a shift from a "give your life" to a "live your life" ethic.

By drawing together scholars interested in health, wellness, and spirituality in liberal democratic healthcare settings, I hoped to enhance the conversations we might have not just among ourselves but with our friends, clinicians, and family members. Although the pandemic is not entirely over, it seems no longer to be front of mind for all of us. We learned during those hard four years that even though roughly seven million people died, the COVID-19 survival rate was actually quite high for most groups. Nonetheless, as epidemiologists and physicians have reminded us, this was a foretaste of a potentially much more devastating pandemic. As such, it is prudent for all of us to learn what we can—about healthcare institutions, medical and caring professionals, the shortcomings in our social systems, and spiritual and religious responses to disorientation and human suffering—so we are better prepared to respond to the next global health crisis.

Notes

[1] In addition to the chapter-authors who participated in the workshop in Victoria, several other scholars and clinicians were also involved but did not submit essays to this collection: Rachel Brown, Chris Goto-Jones, Laura Farrell, Pamela Klassen, Mitch Lewis-Hammond, Jane McNaughton, Vic Neufeld, Anne Nguyen, Karen Palmer, Bernie Pauly, Kelly Stajduhar, Coby Tschanz, and Bruce Wright.

[2] Here is a useful definition of the former field: "Health Humanities champions the application of the arts and humanities in interdisciplinary research, education and social action to inform and transform health and social care, health or well-being. It aims to be inclusive of viewpoints and contributions from within and beyond medicine; value the experiences and resources of the public; explore diverse approaches to achieving, maintaining or recovering quality of life; and strives for demonstrable impacts, not least in providing new evidence and insights for the education or practices of those planning, organising or working for the health of any population" (http://www.healthhumanities.org/). A workable definition of the latter is: "Medical humanities is a multidisciplinary field, consisting of humanities (theory of literature and arts, philosophy, ethics, history and theology), social sciences (anthropology, psychology and sociology) and arts (literature, theater, cinema, music and visual arts), integrated in the undergraduate curriculum of Medical schools." (Batistatou et al. 2010).

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Spiritual Care Providers and Spiritual Coaches in Quebec: Shared Calling – Distinct Status[1]

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Introduction

Therapeutic practices based on mind-body techniques such as mindfulness, neurolinguistic programming (NLP), tarot, and yoga flourish among members of Quebec's wider population. These practices are also popular with healthcare practitioners, who sometimes appropriate them informally for the professional services they offer in public institutions (Meintel and Mossière 2011). I argue that the growing use of mind-body techniques in Quebec has helped practitioners to overcome certain deficiencies in the province's healthcare system. For example, the COVID-19 pandemic highlighted the fact that public resources were insufficient to meet the healthcare needs of the population, and biomedical approaches could provide neither the desired cure nor the expected care. Mind-body practices have expanded the limits of the