

Religion, Spirituality, Health, and Medicine

Sociological Intersections

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When Michelle Bird, a white woman in her early forties, developed a rare form of cancer several years ago, she sought treatment at the Dana-Farber Cancer Institute in Boston. There she was cared for by Dr. George Demetri, an expert in the field. In addition to standard biomedical treatments, Michelle, a Catholic, received reiki and acupuncture at Dana-Farber and attended services and readings in the small interfaith chapel there. She met monthly with a priest to receive his blessings and carried books like Jerome Groopman's *The Anatomy of Hope: How People Prevail in the Face of Illness* with her to medical appointments. She described talking daily with God as a way of keeping up her strength and spirits: "I pray for strength, faith, and a cure, and I know that God is listening. . . . I've always believed in an afterlife, but I feel I've grown spiritually as a result of my cancer experience. . . . Without my faith, I don't think I would be making it through this" (Wisnia 2004, 15).

Michelle and the Dana-Farber Cancer Institute are not alone in thinking about the relationships between religion, spirituality, health, and medical care in the United States. Many of the nation's first hospitals were founded by religious organizations, and religion/spirituality has long been a source of support for people when they are ill. National surveys report that 80 percent of Americans think personal religious/spiritual

practices including prayer can help with medical treatments, and close to 25 percent say they have been cured of an illness through prayer or another religious/spiritual practice.¹ In a recent study, 60 percent of the public and 20 percent of medical professionals said they think it possible for an individual in a persistent vegetative state to be saved by a miracle (Jacobs, Burns, and Jacobs 2008). Just over 60 percent of Americans say they want physicians to ask about their spiritual histories if they become ill, and two-thirds of hospitals have chaplains (Cadge, Freese, and Christakis 2008).² Prayer chains on the Internet connect people with a wide range of medical conditions, and religious groups regularly hold services for health and healing in small towns and large cities across the United States (Barnes and Sered 2005).

These examples point to intersections among religion, spirituality, health, and medicine that are further evident in conversations taking place in newspapers, magazines, books, and scholarly journals. Some of this conversation is about religion, spirituality, and medical care, like whether pharmacists are obliged to dispense birth control when it conflicts with their personal religious values, or how medical teams should respond to families who are waiting for a miracle for a loved one the health-care team believes is terminal. Other pieces focus on the human condition more broadly through ethical questions about genetic

technologies, assisted reproduction, euthanasia, medical decision making, and especially the social processes of birth and death. Medical and religious professionals, journalists, and members of the public contribute distinctive voices to these conversations, tapping into core questions about what it means to be human, and how we as a collective value life and make difficult decisions about birth and death in the process.

Sociologists have been involved in discussions about religion, spirituality, health, and medicine more from the periphery than from the center of academic and public debates. Handbooks of medical sociology rarely include chapters about religion, and handbooks in the sociology of religion have only recently started to include chapters on health. While Max Weber, Emile Durkheim, Georg Simmel, and other early sociologists inquired about the role of religion in the development of modern societies, their narratives of secularization combined with the secularization of the academy partly explain these silences. The compartmentalization of topics within sociology as a discipline is also responsible, as questions at the intersections between religion/spirituality and health/medicine were left on the fringes of two subfields and failed to develop into a robust sociological literature. Outside a relatively narrow set of questions about whether religion/spirituality influences the health of individuals and a broader set of bioethical concerns, sociologists have paid little sustained attention to the intersections between religion/spirituality and health/medicine in the lives of individuals or institutions (Fox and Swazey 2008).

This chapter responds to these silences by identifying central sociological questions about religion, spirituality, health, and medicine, summarizing available research about these questions, and outlining several directions for future sociological thinking. We highlight the work of sociologists but also draw from other disciplines. Following Geertz (1973, 90), we conceive of religion/spirituality broadly as a "system of symbols which act to establish powerful, pervasive, and long-lasting moods and motivations in men by formulating conceptions of a general order of existence and clothing these conceptions with such an aura of factuality that the moods and mo-

tivations seem uniquely realistic." While scholars and the public tend to define religion in terms of institutions structured around the worship of sacred beings, and spirituality as related to the wider range of ways people find meaning in their lives, we use the terms interchangeably in this chapter because they are not used consistently in the research literature.³ We also focus primarily on biomedically informed conceptions of health and the presence of religion/spirituality in biomedical institutions in the United States.⁴

After a brief social history of religion and medicine in the United States and some basic descriptive information about contemporary Americans' religious beliefs and practices, we review the existing literature about the question sociologists working in this area have spent the most time investigating: whether religion/spirituality influences the health of individuals. We go on to highlight several promising lines of research at the institutional level and conclude by outlining directions for future research and pointing to the theoretical benefits of sociological approaches that consider multiple levels of analysis.⁵

A Social History of Religion and Medicine

Conceptions of "holiness" and "healing" share an etymology rooted in notions of wholeness and related to shifting distinctions between the body and the soul, mind, or spirit (Turner 1987). In the Christian context, people of faith were taught to offer charity to those in need, most especially the sick, through hospitals that emerged during the Middle Ages from houses of Christian charity (Mollat 1986). These medieval hospitals, which provided more solace and shelter than treatment, first institutionalized public care for the sick, which expanded dramatically in eighteenth- and nineteenth-century England and then through European, North American, and overseas Christian missions (Porter 1993; Risse 1999). Started as what some called "houses of God," it was not religious/spiritual concern but biomedicine that was new to hospitals as they developed in the modern context (Lee 2002).

The model of the physician emerged from the ecclesiastical form and content of higher educa-

tion based in the Middle Ages and developed over subsequent centuries. Scientifically trained physicians evolved from physicians trained in religious universities, as physicians and religious leaders gradually mapped out separate spheres (Porter 1993). In the early American colonies, clergy provided much of the medical care, particularly in New England. This changed in the nineteenth century as scientific medicine and medical education emerged, and states enacted laws prohibiting clergy without medical training from practicing medicine (Numbers and Sawyer 1982). Formal training for nurses also emerged in the United States in the late nineteenth century following much informal nursing done by women in the home. Orders of religious or vowed nurses were gradually replaced by secular nurses over the next century (Reverby 1987; Coburn and Smith 1999; Nelson 2001).

Early U.S. hospitals were charity institutions for the poor, the gravely ill, and the desperate; everyone else was cared for in their homes (Starr 1982; Rosenberg 1987; Kauffman 1995; Kaufman 2005). When hospitals began to develop and expand numerically in the mid-nineteenth century, religion influenced the process. Catholic and Jewish hospitals were started for patients not treated well in other facilities, and for Catholic and Jewish doctors and nurses who could not find work in them (Vogel 1980; Lazarus 1991). Catholic hospitals offered not only ethnic identity but also the privilege of being treated as a paying patient rather than a charity case (McCauley 2005). Similarly, Jewish hospitals were started by members of the Jewish community to meet the needs of Jewish patients (Levitan 1964; Sarna 1987). Religious-affiliated hospitals were open to everyone and until the mid-twentieth century cared for more than one quarter of all hospitalized patients (Numbers and Sawyer 1982).

In the past century and a half, the formal organizational distance between religion and biomedical organizations has increased. Scientific developments and professional sectarian battles led to medicine's greater technological foci (Starr 1982; Stevens 1989).⁶ Religious ownership of hospitals has become less common and a source of contention, particularly when religious and secular hospitals consider merging (Uttley 2000).⁷

Despite the formal institutional secularization of medical care, some religiously based health-care organizations remain, and others have been started. Immigrants who arrived in the United States after 1965 have opened medical centers in a range of traditions. A Cambodian Buddhist temple began to offer Western counseling services supported by Buddhist healing practices in the 1980s, and in the 1990s the University Muslim Medical Association Free Clinic was established in Los Angeles, and other Muslim health-care organizations followed to offer free health care to all in the Muslim tradition of compassion (Aswad and Gray 1996; Orr and May 2000; Laird and Cadge 2007). Buddhist hospices have opened on the West Coast and many Christian congregations have started parish nursing programs (Garces-Foley 2003).

Despite the formal secularization of medical institutions, some indicators suggest that attention to religion/spirituality is stable or increasing in the medical community.⁸ The number of publications catalogued in the main biomedical search engine, PubMed, with "religion" or "spirituality" in the title or key word has increased, and elective courses about these topics are offered at many medical schools (Levin, Larson, and Pulchalski 1997; Barnes 2006). A growing number of assessment tools encourage physicians and other health-care professionals to ask patients about spirituality/religion, and institutional centers of religion, spirituality, and medicine exist at several prominent medical schools (Fosarelli 2008). While medical institutions have formally secularized, survey data show that many members of the U.S. public, including those who are treated and work in medical institutions, retain religious/spiritual beliefs and practices (Curlin et al. 2005).

Current Contours of Religion/ Spirituality in America

A 2007 national survey conducted by the Pew Forum for Religion and Public Life reported that 51.3 percent of Americans are Protestant, 23.9 percent Catholic, 1.7 percent Jewish, 1.7 percent Mormon, and less than 1 percent each Orthodox,

Muslim, Buddhist, Hindu, Jehovah's Witness, and other world religions. Just over 16 percent are unaffiliated. Among the 51.3 percent who are Protestant, 26.3 percent identify with evangelical denominations (the Southern Baptist Convention, Assemblies of God, Church of Christ, and various Pentecostal, Holiness, and independent churches), while 18.1 percent identify with main-line Protestant denominations (United Methodist, Evangelical Lutheran Church in America, Presbyterian Church USA, Episcopal, United Church of Christ, and American Baptist) and 6.9 percent are members of historically black denominations (such as the African Methodist Episcopal, National Baptist Convention, and Churches of God in Christ) (Pew Forum 2007). Surveys do not reliably estimate membership in small religious groups, which may include as many as six million Muslims, four million Buddhists, and more than one million Hindus (Smith 2002; Wuthnow and Cadge 2004). Since 1965, immigration has reshaped the U.S. religious landscape, particularly through large influxes of Catholics from Mexico and Central and South America (Jasso et al. 2003).

Two-thirds of Americans claim to be members of local religious organizations, a figure that has remained roughly constant since the 1970s (Gallup and Lindsay 1999). Membership tends to be higher among women than men, among blacks than whites, and in the South and Midwest than in the Northeast and West. According to the 1998 National Congregations Study, the median congregation had seventy-five regular participants and the median person attended a congregation with four hundred regular participants (Chaves 2004). The fraction of Americans that regularly attends religious services is smaller than the fraction that claims membership (Hout and Greeley 1998; Woodberry 1998; Hadaway and Marler 2005). The 2007 U.S. Religion Landscape Survey conducted by the Pew Forum reports that 54 percent of Americans attend religious services once or twice per month and 39 percent attend every week, with evangelical Protestants, black Protestants, Mormons, and Jehovah's Witnesses attending more frequently than members of other religious groups (Pew Forum 2007).

In addition to service attendance, many Americans have religious/spiritual beliefs and practices. According to surveys conducted by the Gallup organization, 95 percent of U.S. adults claim belief in God or a higher power, 79 percent believe in miracles, and 67 percent believe in life after death (Gallup and Lindsay 1999). According to the General Social Survey (1998), 50 percent of Americans feel God's love for them daily and 52 percent feel at least daily that they want to be closer to God. The U.S. Religion Landscape Survey reports that 58 percent of Americans pray at least daily, and close to half of all Americans report receiving answers to their prayers several times a year or more. Just over 80 percent of Americans say religion is very or somewhat important in their lives (Pew Forum 2007).

The ways in which religion/spirituality influences the health beliefs of medical professionals and laypeople represent an important area for future sustained sociological consideration. It is only recently that demographic information about religion/spirituality has been gathered among a representative sample of physicians (Curlin et al. 2005). One study demonstrates that more than half of physicians believe religion/spirituality influences people's health by helping them cope, giving them a positive state of mind, and providing emotional and practical support (Curlin, Lawrence, et al. 2007). Other articles show that religiously committed physicians are less likely than others to believe that when they oppose a medical procedure for moral reasons, they must refer patients to another physician or disclose their opposition to patients (Curlin, Sellergren, et al. 2007). Studies also suggest that religion/spirituality influences physicians' decision making about a range of topics (Imber 1986; Christakis and Asch 1995; Aiyer et al. 1999; Abdel-Aziz, Arch, and Al-Taher 2004). Among nurses, a recent survey conducted at a large academic medical center reported that 91 percent consider themselves spiritual and more than 80 percent think there is something spiritual about the care they provide. Almost none believe that promoting spirituality is at odds with medicine (Cavendish et al. 2004; Grant, O'Neil, and Stephens 2004).

Survey data suggests that religion/spirituality also shapes some Americans' health beliefs (e.g., Mansfield, Mitchell, and King 2002; Baker 2008). Conservative and moderate Protestants, for example, are less accepting than others of the practice of physician-assisted suicide and terminal palliative care, according to the General Social Survey (Burdette, Hill, and Moulton 2005). Differences among religious traditions are also evident in public opinion about euthanasia, family planning, and beliefs about the appropriate use of clergy as a source of mental health assistance (Ellison and Goodson 1997; Hamil-Luker and Smith 1998; Abrams 2000; Ellison et al. 2006; Moulton, Hill, and Burdette 2006). These studies are yet to be pulled into a synthesized body of research that clearly outlines how religion/spirituality influences health beliefs across religious/spiritual traditions, age, geography, issue, and so on. Glimpses of these relationships are further evident in studies of patient satisfaction and medical decision making, but attention is needed to systematically delineate precise relationships.

Does Religion/Spirituality Influence Health at the Individual Level?

Sociologists who have studied the relationship between religion/spirituality and health/medicine in the past twenty years have focused almost exclusively on epidemiological questions about whether religion/spirituality influences physical and mental health, based on quantitative indicators of health. These studies generally suggest a positive relationship but are limited by their reliance on survey data, their attention to individuals outside their institutional contexts, and their tendency to make causal arguments in the absence of longitudinal data, which raises concerns about reverse causality. Theoretically, they draw from Durkheim's classic insights about the "regulative" and "integrative" functions of religion. Scholars argue that healthy behaviors, social support within religious communities, psychosocial resources, and belief structures which give meaning to life are the mechanisms through which religion/spirituality may lead people to have better

health. We focus primarily on meta-analyses and overview articles written by sociologists to outline three main lines of research in this area.

Mortality

One line of research investigates the relationship between religion/spirituality and mortality, with particular attention to religious service attendance. Two large-scale longitudinal studies of healthy adult populations, the Tecumseh Community Health Study and the Alameda County Study, examine the frequency of people's religious services attendance in the context of other social activities and find it to be negatively associated with their mortality, particularly for women (House, Robbins, and Metzner 1982; Strawbridge et al. 1997). These findings are reinforced by studies by Hummer and colleagues and Musick and colleagues, who find self-reported rates of religious service attendance in a large nationally representative sample of adults to be negatively related to mortality in follow-up studies (Hummer et al. 1999; Musick, House, and Williams 2004). Likewise, a smaller but often-cited study of nearly four thousand older people in Piedmont, North Carolina, over a six-year period found that frequency of religious service attendance was related to lower mortality rates (Koenig et al. 1999).

Two recent meta-analyses consider the relationship between religious service attendance and mortality. After locating all relevant published and unpublished studies, McCullough and Smith (2003:197) estimated the association between mortality and religious participation based on over 120,000 respondents. They concluded that "religious people had, on average, a 29 percent higher chance of survival during any follow-up period than did less-religious people." Powell and colleagues conducted a similar analysis, concluding that church attendance reduced the risk of mortality by 25 percent after adjusting for appropriate confounders (Powell, Shahabi, and Thoresen 2003).

A less conclusive body of research focuses on the relationship between religion/spirituality and timing of death. For example, a popular study by

Idler and Kasl (1992) found that religious group membership influenced the timing of death for elderly people, with Christians and Jews less likely to die in the month before important religious holidays. Subsequent studies in the medical literature, however, raise questions about these relationships based on mixed empirical results.

Physical and Mental Health

A second line of empirical work investigates how religion/spirituality influences people's physical and mental health over the life course. While some researchers posit biological and physiological mechanisms, sociologists tend to focus on how religion/spirituality, variously defined, influences health measured in multiple ways. In a review of epidemiological research on religion and blood pressure, for example, Levin and Vanderpool (1989) found people who are religiously committed likely to have lower blood pressure than those with no religious affiliation. Religious teachings/communities inform some people's behaviors around alcohol and tobacco use, for example, which accounts for significantly lower rates of cancer morbidity and mortality in areas where there are high concentrations of members of particular religious groups (Troyer 1988; Dwyer, Clarke, and Miller 1990). A study of women in Utah found that Mormon women who attended church regularly had lower risks of cervical cancer than did non-Mormons (Gardner, Sanborn, and Slattery 1995). Similarly, studies investigate how religious factors protect adolescents from experimenting with smoking, drug use, and alcohol consumption through personal religiosity and public participation in religious social activities with religious peers (Wallace and Williams 1997; Wallace and Forman 1998; Nonnemaker, McNeely, and Blum 2006). Similar findings are evident in studies of virginity pledges among young people (Bearman and Bruckner 2001). A large interdisciplinary body of literature also investigates the relationship between personal religion/spirituality and recovery from alcohol, drug, and other addictions (e.g., Booth and Martin 1998).

Another large literature addresses the relationship between religion/spirituality and psy-

chological or mental health, as well as how the concepts should be measured.⁹ In one study, Ellison (1991) found a significant connection between religiousness and existential certainty, a concept associated with a sense of coherence known to promote psychological health. Following Durkheim's classic work in *Suicide*, much of this research focuses on how religion/spirituality influences depressive symptoms, including hopelessness and thoughts of suicide (Schieman, van Gundy, and Taylor 2001; Eliassen, Taylor, and Lloyd 2005). McCullough and Smith (2003) conducted a meta-analysis of the relationship between religion/spirituality and depression, concluding that people with higher levels of religiousness have slightly lower levels of depressive symptoms.

In addition to establishing relationships between religion/spirituality and psychological health, scholars are exploring mechanisms that may explain these connections. George, Ellison, and Larson (2002) present evidence connecting participation in religious organizations to psychosocial mechanisms such as self-esteem, self-efficacy, and mastery that are linked to aspects of mental health. Commerford and Reznikoff (1996), for example, found that people's feelings of mastery influenced the effect of religious service attendance and personal faith on their experiences of psychological distress. Other research has examined how the belief structure provided by religion and spirituality contributes to mental health (Bjarnason 1998; Ellison et al. 2001). For example, a study by Pollner (1989) suggests that a personal relationship with a deity is related to subjective well-being, which influences people's senses of coherence and emotional management. A study by Maton (1989) demonstrates how perceived spiritual support serves as a buffer against stress, which in turn promotes mental health.

Coping

A third line of research, closely related to the second, focuses on religious/spiritual coping, or the process through which individuals use religious/spirituality-based strategies to deal with physical and psychological illness. In some studies, religious/spiritual coping is seen as mediating the

effects of illnesses on the body, potentially limiting the physical and emotional distress caused by illnesses and disability (Pargament et al. 1990; Kendler, Gardner, and Prescott 1997; Pargament 1997; Pargament et al. 1998; Poindexter, Linsk, and Warner 1999; Chatters 2000; Nooney and Woodrum 2002; Pargament et al. 2005; Thune-Boyle et al. 2006; Klemmack et al. 2007). A central study in this area of research is Idler and Kasl's (1992) on elderly people in New Haven, Connecticut. Over a three-year period they found public religious involvement to protect men and women against physical disability, and private religiousness to protect recently disabled men against depression. The authors highlight how religion's ritualistic and symbolic aspects may influence health among the elderly more than do secular sources of support. In a related study, the spirituality of individuals born in San Francisco in the 1920s that resulted from adherence to non-institutionalized religious beliefs and practices did not have the same buffering or protective effects against depression in older age that traditional religious memberships had (Wink, Dillon, and Larsen 2005).

Populations Studied and Limitations

When considering research about the relationship between religion/spirituality and individual health, it is important to note that approximately half the studies in this area focus on people over the age of sixty.¹⁰ As a result, much of the religion/spirituality research relates to physical health issues often associated with old age, such as chronic illness, physical disability, and pain management (Idler and Kasl 1992; Levin and Vanderpool 1992; Krause 1993; Svetkey et al. 1993; Wachholtz, Pearce, and Koenig 2007). Similarly, studies of mental health ask how religion/spirituality buffers the psychological distress that can accompany decreased physical abilities and personal independence among older people (Idler 1987, 1995; Blazer, Hughes, and George 1987; Broyles and Drenovsky 1992; Krause, Ellison, and Wulff 1998; Murphy et al. 2000; Barkan and Greenwood 2003; Krause 2003, 2006; Jacobs, Burns, and Jacobs 2008). While older people are more

likely to have the physical and mental health experiences these studies investigate, the focus on older individuals limits the generalizability of study findings.

Although they do not regularly explore variation by age, these three lines of research do investigate variation across racial and ethnic categories, focusing especially on the health of black and white Americans and the historical centrality of the church in African American communities (Ellison 1993, 1995; Caldwell et al. 1995; Levin, Chatters, and Taylor 1995; Musick 1996, 2000; Krause 2004). A study by Ferraro and Koch (1994) suggests that black Americans are more likely than whites to turn to religion when having health problems and generally receive greater health benefits from religious practices (but not from social support) than do whites. A later study by Drevenstedt (1998) finds that higher rates of religious service attendance by blacks and Latinos does not fully dissipate the negative health effects associated with sociodemographic factors, such as lower levels of social support, income, and education. Other research shows that church attendance, and ministers in particular, serve as key psychological health resources for African Americans (Neighbors, Musick, and Williams 1998; Bierman 2006). Black Americans whose parents encouraged religiosity have also been found to have higher levels of personal religiousness and self-esteem at older ages (Krause and Ellison 2007).

There are few studies of religion/spirituality and health linkages among members of other racial/ethnic minorities (for recent studies of Mexican Americans, see Levin, Markides, and Ray 1996; Reyes-Ortiz et al. 2008). Likewise, little research has examined how the conceptualization of religion/spirituality itself may vary across race and ethnicity (Neff 2006). But contemporary research has become more attentive to the gendered dynamics of religion and health (Mirola 1999; Ferraro and Kelley-Moore 2002; Krause, Ellison, and Marcum 2002; Idler 2003).

When reading and evaluating studies about the relationship between religion/spirituality and health among individuals, it is important to keep several key limitations in mind. First, almost all of this research is epidemiological, based on the

analysis of survey data about individuals outside of their familial, religious/spiritual, and other institutional contexts. While indicators of these contexts can be gathered in surveys, they are only indicators and not representative of the detailed information about social processes and intersecting causal factors that can be gathered in interviews, participant observation, or multimethod projects. Second, with few exceptions (see Pargament et al. 1998; Krause and Wulff 2004; Krause 2006; Bjorck and Thurman 2007), researchers generally frame their questions in terms of the positive effects of religion/spirituality, likely leading this literature to underrepresent the negative effects of religion/spirituality on health.

In addition, this body of research has numerous methodological weaknesses, as pointed out by other researchers, including inconsistent definitions/conceptualizations of religion and spirituality, the use of self-reports of key measures, reliance on cross-sectional data, and a tendency to make causal arguments in the absence of longitudinal data and without attention to issues of reverse causation, which raises significant questions about the findings (Levin and Vanderpool 1987; Levin 1994, 1996; George et al. 2002; Flannelly, Ellison, and Strock 2004; Hall, Koenig, and Meador 2004; Regnerus and Smith 2005; Vaillant et al. 2008). Researchers rarely recognize variation within religious traditions in these studies or include members of non-Christian or non-Jewish traditions in their studies. Expanding conceptions of spirituality and religion to include meditation, yoga, and other spiritual practices would also reshape and challenge many of the assumptions underlying these studies.

The Individual in Organizational and Institutional Contexts

The focus on individuals apart from the social contexts and institutions that shape them in the studies reviewed in the previous section leaves several distinctly sociological contributions to conversations about religion, spirituality, health, and medicine to be made. Specifically, we know little about the relationship between religion/spirituality and medicine as institutions, such as how religion/

spirituality is currently present in medical organizations and how health and medicine are present and significant in religious and spiritual organizations. We highlight several promising lines of research, among many possibilities, at the institutional level, focusing on policies of the Joint Commission, the work of hospital chaplains, and the way local religious organizations address health issues, including through public health initiatives.

Joint Commission Policies

Started in 1910, the Joint Commission establishes guidelines to ensure the provision of safe and quality health care at hospitals, nursing homes, and other health-care organizations across the United States. These organizations are required to meet Joint Commission guidelines in order to receive federal funding through Medicare and Medicaid programs.¹¹ To understand how religion/spirituality is present and significant in medical institutions, it is helpful to start with the Joint Commission's first statement about religion in hospitals, made in 1969 and yet to be explored by sociologists: "Patients' spiritual needs may be met through hospital resources and/or through an arrangement with appropriate individuals from the community." During the 1970s and 1980s, this guideline was expanded to state that religion had to be assessed in patients being treated in hospitals for alcoholism and drug dependence. In the 1990s, issues around religion and spirituality were reframed in the guidelines as a "right," treated primarily under the heading "Patients Rights." The Commission replaced the language of "religion" with the more inclusive language of "spirituality" and expanded the range of topics for which spirituality could be relevant to include end-of-life issues. In 1995 the guidelines incorporated the rights of hospital staff related to spirituality and religion by directing hospitals to address conflicts between staff members' cultural or religious beliefs and their work.

In the 1990s there was discussion and transition in the standards for hospitals about what the spiritual care of patients should be called and who specifically might provide it. In 1996, the Joint Commission stated that hospitals were

to demonstrate respect for "pastoral counseling," a phrase replaced with "pastoral care and other spiritual services" in 1999 after leaders in hospital chaplaincy argued this phrase better reflects what they do. While the Joint Commission has not established specific guidelines or licensing requirements about who should or can provide spiritual care, in the late 1990s pastoral services departments and pastoral personnel from outside the facility are mentioned as possibilities. For example, small hospitals could "maintain a list of clergy who have consented to be available to the hospital's patients in addition to visiting their own parishioners," while larger hospitals could "employ qualified chaplains who have graduated from an accredited Master of Divinity degree program" (CDC 1999). Following similar discussions in the medical and nursing literatures, the Joint Commission also described "spiritual assessments" that, in the words of the Joint Commission's associate director of standards interpretation, "determine how a patient's religion or spiritual outlook might affect the care he or she receives. . . . At minimum the spiritual assessment should determine the patient's religious denomination, beliefs, and what spiritual practices are important to the patient" (Staten 2003, 55).

The 2008 Joint Commission standards for hospitals state: "Patients deserve care, treatment, and services that safeguard their personal dignity and respect their cultural, psychosocial and spiritual values," and hospitals need to accommodate the "right to pastoral and other spiritual services for patients." The Commission provided additional guidelines about religion and spirituality in relation to dietary options, pain concerns, resolving dilemmas about patient care issues, end-of-life issues, and the treatment and responsibilities of staff. Little to no research charts these policy developments, examines how hospitals and other health-care organizations have responded to changing policies, or considers how spiritual assessments take place in hospitals across the country. While health-care providers have developed a range of templates for conducting spiritual assessments that could be analyzed by sociologists, little is known about how they are actually used and responded to by health-care providers and patients (LaPierre 2003).

Health-Care Chaplains

At some hospitals, religious and spiritual issues are addressed primarily by hospital chaplains. Data collected by the American Hospital Association in its annual survey of hospitals suggest that 54–64 percent of hospitals had chaplaincy services between 1980 and 2003, with no systematic trend during the period. As in smaller studies, larger hospitals, those in more urban areas, and hospitals that are church affiliated were more likely to have chaplains in 1993 and 2003 than were others (Flannelly, Handzo, and Weaver 2004; Cadge, Freese, and Christakis 2008). Researchers estimate there are more than ten thousand hospital chaplains in the United States, many of whom belong to professional organizations, including the Association of Professional Chaplains, the National Association of Catholic Chaplains, the National Association of Jewish Chaplains, and the Association of Clinical Pastoral Education (Weaver et al. 2004). Chaplains include women and men who are laypeople and ordained leaders in their religious traditions.

Despite chaplains' positions at the intersections of medical and religious organizations, sociologists have devoted almost no attention to their work and professional evolution. Hospital chaplaincy developed in the late nineteenth and early twentieth century through the work of Richard Cabot, Anton T. Boisen, Helen Flanders Dunbar, and others in parallel with Clinical Pastoral Education (CPE), an initially Protestant-based movement designed to train theological students in the work of bedside ministry, which remains centrally present at many large academic hospitals (Hall 1992; Lee 2002; Angrosino 2006). CPE students likely provide a fair amount of care to patients at hospitals where they are trained because federal Medicare funds will reimburse hospitals for a portion of the students' work, a form of graduate medical education (McSherry and Nelson 1987; White 2003). Otherwise, chaplains' work is not reimbursed by health insurance or other groups and is paid for from a hospital's bottom line (for more on financing see VandeCreek and Lyon 1994–1995).

Glimpses of chaplains are evident in some hospital-based ethnographies, but sociologists

know very little about who they are and how they work with other medical and religious professionals (Kudler 2007). Limited social science research conducted by chaplains themselves suggests that at some hospitals, chaplains are employed directly by the hospital, while at others they are exclusively volunteers or are employed by local Catholic dioceses, churches, or Jewish social service organizations. In some cases, particularly in New York City through the work of the Health-care Chaplaincy, outside organizations hire and supervise hospital chaplains (VandeCreek et al. 2001; Flannelly et al. 2003).

The daily work of chaplains at individual hospitals may include providing emotional, practical, ritual, and crisis intervention services to patients, families, and staff individually or as members of health-care teams (Carey 1973; Bassett 1976; Barrows 1993; Rodrigues, Rodrigues, and Casey 2000; Flannelly et al. 2005; Sakurai 2005). Increasingly, hospitals are working on multi- or interfaith models where individual chaplains work with people across traditions rather than only with those who share their religious/spiritual backgrounds. In a study of chaplains working at Memorial Sloan-Kettering Cancer Center, researchers found that chaplains worked with family members and friends in addition to patients; received referrals, particularly from nurses; and spent more time with patients after surgeries than before (Flannelly, Weaver, and Handzo 2003). At a community hospital, chaplains were most often called for patients with anxiety, depression, or pregnancy loss (Fogg et al. 2004). Various hospital constituencies perceive chaplains' roles and importance differently, with the largest number of referrals to chaplains often coming from nurses and social workers (Thiel and Robinson 1997; Bryant 1993; Fogg et al. 2004).

As a group, hospital chaplains have become professionalized in recent years, a process perhaps best described through Freidson's famous work on professions (Freidson 1970; De Vries, Berlinger, and Cadge 2008). As chaplains shift from the subjective to the official labor market, they develop and redevelop certification processes and outline criteria for "board certification," which currently includes the certification of a faith tradition, a graduate level theological degree, and

four units of clinical pastoral education.¹² Related to efforts to professionalize and the emergence of evidence-based medicine, studies have begun to assess the relationship between patients' visits with hospital chaplains and patient satisfaction with the overall hospital experience (Parkum 1985; VandeCreek and Connell 1991; VandeCreek and Lyon 1997; Clark, Drain, and Malone 2003; Fitchett, Thomason, and Lyndes 2008), as well as to describe how chaplains work differently with different populations depending on age of the patient, severity of illness, religious/spiritual tradition, presence of family, or availability of local clergy (VandeCreek and Lyon 1997). Evolving relationships between medical and religious organizations and professionals set the backdrop for chaplains' daily work and professionalizing processes in hospitals and other health-care organizations, a case and example of the kinds of insights sociologists could bring to questions at the institutional level.

Local Religious Organizations

In addition to biomedical institutions, health concerns are often addressed in local religious congregations in regular services and special gatherings. Some congregations regularly act around health and healing in communal prayers and rituals. A primary prayer for spiritual healing and physical cure in Judaism, the *Mi Sheberakh*, is often recited in synagogue by an individual or a family member of someone who is ill. Similarly in many Christian congregations, sick individuals are publicly named during prayers and rituals in the context of weekly services.

Across traditions, groups also have separate gatherings and rituals for health and healing. Many Episcopal congregations, for example, have healing services that include anointing people who are ill with oil, laying hands on them, and praying with them. These rituals create spaces in which those who are ill can speak publicly about their illnesses and receive support. Health and healing is rarely restricted to physical health in these contexts, and instead encompasses emotional and spiritual processes not limited to the body (Hollis 2005). Similar kinds of specialized

communal services for health take place across religious contexts in the contemporary United States (Barnes and Sered 2005; Jacobs 2005).

Along with communal gatherings, individuals in some traditions address health concerns privately with their spiritual and religious leaders. Thai Buddhist monks in the United States, for example, offer chants, amulets, and herbal remedies intended to effect cures. Others encourage practitioners to obtain a treatment and diagnosis plan from a physician and then work with the individual around meditation and other trainings for the mind that make it easier to follow the doctor's instructions (Numrich 2005). Private rituals in the Thai Buddhist tradition and others take place in religious centers, individuals' homes, and hospitals. These rituals supplement the regular visiting and counseling many religious leaders do with their congregants (Chalfant et al. 1990; Moran et al. 2005).

In addition to working with their congregations, some religious leaders actively facilitate relationships with biomedical health programs. Individuals often seek such assistance from religious leaders, who refer congregants to health-care providers (Daaleman and Frey 1998). Religious leaders also bring health-care services to religious centers in the form of information, public health screenings, health promotion efforts, and religiously based health centers (Djupe and Westberg 1995; Chatters, Levin, and Ellison 1998). A smoking-cessation program facilitated through local congregations in Baltimore, for example, proved more successful than self-help models (Voorhees et al. 1996). Blood pressure screenings, blood drives, and healthy eating and exercise programs also regularly take place in religious centers (Griffith 2004). Such efforts may influence health behaviors inside and outside religious organizations; some studies show that highly religious individuals may be more likely to privately seek out care from biomedical institutions. For example, studies by Benjamins and colleagues find, across denominations, frequent service attendance associated with increased use of preventative health services, such as mammograms, pap smears, and prostate and cholesterol screenings (Benjamins and Brown 2004; Benjamins 2006; Benjamins, Trinitapoli, and Ellison 2006).

Health efforts in African American congregations have been the subject of particular research attention. Studies point to the importance of fostering relationships between black churches and a range of physical and mental health providers (Moore 1992; Caldwell et al. 1995; Adkison-Bradley et al. 2005). Clergy are often a first contact point for African Americans, particularly for people with mental health concerns (Neighbors, Musick, and Williams 1998). Substantial numbers of African American congregations also have programs that offer assistance with family, health, or social service needs (Taylor et al. 2000). The size of a congregation and the educational attainment of its clergy were found to be the most significant predictors of whether it has church-sponsored community health outreach programs (Thomas et al. 1994).

Parish nursing is another way that religious organizations address public health issues. Started by Granger Westberg in the mid-1980s, parish nursing programs in Protestant and Catholic contexts attempt to combine the work of physicians, nurses, and religious leaders by providing limited health-care services through local congregations. The first parish nurses were employed at Lutheran General Hospital in Chicago and also began to care for people at local churches. Today parish nurses are employed or volunteer within local churches or hospitals to provide health-care services ranging from routine screenings and immunizations to more involved medical follow-up and coordination. The American Nursing Association recognized parish nursing as a specialty in the late 1990s. No sociological research has been conducted about its history, demographics, practices, or organizational models (Solari-Twadell and McDermott 1999; Orr and May 2000; Vandecreek and Mooney 2002).

Directions for Future Research

Given the variety of ways religion, spirituality, health, and medicine intersect in the contemporary United States, existing sociological studies have just begun to map the terrain. To better understand how religion and spirituality influence health and medicine, and vice versa, sociologists

of medicine and religion need only look around and turn their observations into sociological research questions.

At the individual level, sociologists might begin to develop a robust qualitative literature about the relationship between specific religious/spiritual beliefs and practices and individuals' health beliefs and behaviors. Rather than starting with existing survey data that furthers the epidemiological questions researchers have investigated, sociologists might begin with individual interviews embedding those individuals in the familial, religious, work, and other institutional contexts that shape the ways they think about health and religion/spirituality. Researchers might ask about the extent to which religion/spirituality influences health, as well as how health events, particularly seriously illness, influence people's religious/spiritual beliefs and behaviors (e.g., Ferraro and Kelley-Moore 2002). Such studies could also explore in more detail how individuals combine religious/spiritual practices and biomedicine (as in McGuire 1988; Eisenberg et al. 1993). In addition to generating new insights about the relationships between religion/spirituality and health, such interviews might generate theoretically grounded testable hypotheses about the relationships explored in existing epidemiological studies. Research designs that systematically compare people across religious/spiritual traditions, health experiences, professional backgrounds, and so on would further develop this literature analytically.

In addition to embedding individuals within their social institutions, researchers might further consider how different medical and religious institutions relate to one another organizationally as modeled in the examples here. In individual cities, they might ask how leadership overlaps and religious/spiritual and medical professionals play roles in both sets of organizations. More detailed attention could be paid to the processes by which medical organizations secularize, the ways mergers between religious and secular health-care organizations happen, and the ways religious/spiritual organizations from Buddhist groups to African American congregations address health concerns in the day to day. Such studies could be conducted at the city or state level of analysis or at the national level, as modeled by Blanchard and col-

leagues (2008) in their work about the relationships between religious ecology and population health. Similar approaches might compare how religion/spirituality is present formally and informally in different types of medical institutions through Joint Commission policies, the work of hospital chaplains, the presence of hospital chapels, and the formal and informal conversations that take place between medical staff, patients, and families (e.g., Cadge and Carlin 2006; Cadge and Daglian 2008; Cadge, Ecklund, and Short 2009; Cadge and Ecklund 2009). While some of this research has been conducted around end-of-life issues, recent survey data about medical professionals' and laypeople's beliefs about miracles call for further investigation.

Perhaps more important than specifically focusing on individuals or institutions, however, sociologists might best follow the examples of journalists and anthropologists by investigating topics and issues at the intersections of religion, spirituality, health, and medicine that are often in the news, aiming to speak to a broader audience in the process (e.g., Fadiman 1998; Rapp 1999; Kaufman 2005, Cadge 2009). While some of these topics are explicitly about religion/spirituality, such as questions about whether pharmacists are obliged to dispense birth control and whether intercessory prayer heals, many others are about broad ethical issues with strong moral undertones. When Terry Schiavo's case brought end-of-life issues and decision making into the public view, for example, sociologists could have asked how people's religious/spiritual backgrounds shaped their opinions about the case, their own actions around living wills and health-care proxies, and their reactions to the religious leaders often shown on television praying in front of the hospice where she was cared for. Responding to public debates about stem-cell issues, sociologists might consider the underlying factors that lead these issues to come into and out of the public view. And in response to post-1965 immigrants, sociologists might further explore the range of new religious-inspired health organizations these immigrants are starting and the ways their religious beliefs and organizations mediate their access to health care, especially in refugee communities.

Regardless of the specific topics sociologists decide to investigate, a generative and robust sociological literature about religion, spirituality, health, and medicine needs to consider the interactions among these concepts at multiple levels of analysis. Studies need to be designed around analytically based comparative questions, including comparisons between religious traditions and countries whenever possible, that privilege multiple ways of knowing (epidemiologic, ethnographic, etc.). Throughout, sociologists need to be aware of how religion/spirituality and health are conceptualized and measured and whom their conceptualizations include and exclude (see, e.g., Laird, de Marrais, and Barnes 2007).

Notes

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1. Survey by CBS/New York Times, April 29, 1998. iPOLL Databank, the Roper Center for Public Opinion Research, University of Connecticut. ropercenter.uconn.edu/ipoll.html. Retrieved August 6, 2008.
2. Survey by Princeton Survey Research Associates/Newsweek, October 30–31, 2003. iPOLL Databank, the Roper Center for Public Opinion Research, University of Connecticut. ropercenter.uconn.edu/ipoll.html. Accessed August 6, 2008. For details about this debate in the medical literature see Ehman et al. 1999.
3. The distinctions between the terms "religion" and "spirituality" and the emergence of the category "spiritual" in the medical literature deserves its own article following the example of Roof (2003).
4. Readers interested in accounts of religious healing, studies focused outside the United States, or both should refer to the work of anthropologists, religious studies scholars, and public health researchers in these areas (such as Marty and Vaux 1982; Fox 1984; Numbers and Amundsen 1986; Gevitz 1988; Hufford 1988; Dole 2004; Barnes and Sered 2005; Porterfield 2005; Barnes 2006). Similarly, studies of complementary and alternative medicine (CAM) in the social science and medical literatures inconsistently include prayer and other spiritual/religious practices, leading to fragmented overlap

between the literatures we leave for other scholars to delineate (Ruggie 2004).

5. For additional interdisciplinary review articles on the relationships between religion, spirituality, health, and medicine, please see Ellison 1998; Ellison and Levin 1998; Sherkat and Ellison 1999; Chatters 2000; George et al. 2000; Koenig, McCullough, and Larson 2001; Miller and Thoresen 2003; Weaver and Ellison 2004.
6. Interestingly, however, the American Medical Association established a Committee on Medicine and Religion in the mid-1960s, which included a column in the *Journal of the American Medical Association (JAMA)* to facilitate work between physicians and religious leaders (Rhoads 1967; O'Donnell 1970). *JAMA* has continued to address questions about religion and medicine, though they are clearly peripheral to the journal's other emphases (Rosner 2001).
7. A small body of research considers other differences between Catholic and non-Catholic hospitals in terms of compassionate care, services available, etc. (White and Begun 1998–1999; White 2000; White, Begun, and Tian 2006; Prince 1994).
8. The process of secularization is also not without its critics (Bull 1990; Grant, O'Neil, and Stephens 2003).
9. For interdisciplinary reviews, see Ellison 1991; Payne et al. 1991; Levav et al. 1997; Scott, Agresti, and Fitchett 1998; Weaver, Kline, et al. 1998; Weaver, Samford, et al. 1998; Leventhal, Idler, and Leventhal 1999; Hackney and Sanders 2003; Salsman and Carlson 2005; Nonnemaker et al. 2006.
10. For interdisciplinary overviews of the religion-health relationship among older adults, see Chatters and Taylor 1994; Idler 1994; Koenig 1995; Krause 2005.
11. For more information, see jointcommission.org/AboutUs/joint_commission_history.htm.
12. For more information, see [acpe.edu/acroread/Common percent20Standards percent20for percent20Professional percent20Chaplaincy percent20Revised percent20March percent202005 .pdf](http://acpe.edu/acroread/Common%20Standards%20for%20Professional%20Chaplaincy%20Revised%20March%202005.pdf).

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