

Religion and Spirituality: A Barrier and a Bridge in the Everyday Professional Work of Pediatric Physicians

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We investigate how 30 pediatricians and pediatric oncologists who practice and teach at elite medical centers determine whether religion and spirituality are relevant to what Andrew Abbot (1988) calls their professional "jurisdictions." Through in-depth interviews we focus on their everyday interactions with patients and families. We ask: (1) How do they gather information about religion and spirituality and determine when that information is relevant to their professional work? (2) Do they perceive religion and spirituality to be a barrier or a bridge to medical care as they do what Thomas Gieryn (1983) calls "boundary work"? We find that pediatric oncologists more than pediatricians see religion and spirituality as relevant to their professional work, though still largely outside their professional jurisdiction. It is most relevant when families are making medical decisions and in end of life situations. Physicians tend to view religion and spirituality functionally, describing impermeable boundaries in medical decision making situations and more permeable boundaries at the end of life. Physicians view religion and spirituality as a barrier when it impedes medical recommendations and as a bridge when it helps families answer questions medicine inherently cannot. Such findings have implications for a wide range of professionals as they negotiate their jurisdictions, particularly around religion and spirituality, in everyday practice. Keywords: religion, physician, professional jurisdiction, boundary work, spirituality.

Dr. Carlton, a young pediatrician at a large academic medical center, rarely asks patients and families about their spiritual or religious backgrounds. Aside from not using blood products with the few patients she treats who are Jehovah's Witnesses, she would not know what to do with any information about religion or spirituality patients shared with her. "We're taught to think about interviewing people," she explained, by asking questions that influence the medical management of patients. Without a clear sense of the application, she sees no reason to ask patients about topics related to religion. Additionally, she explains, "I think there's a little bit of discomfort for people [physicians], just bringing up the whole religious issue." Such issues might become "more relevant when you're dealing with a child who is ill, especially . . . an illness that seems out of control," she explains, but in her work with mostly healthy children these cases are few and far between.

Dr. Patel, a pediatric oncologist at a similar large urban medical center, has a different approach. She explores questions of religion and spirituality with each of the patients and families in her care. This information, she explains, helps her understand "what else we could do to better help this family in terms of trying to cope with certain situations . . . so that we

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can provide them more support from all aspects." Not all of the children she treats with cancer go into remission. "Especially now when we deal with these end of life issues . . . we offer palliative treatment and I think at that point and time religion and spirituality really play a role in at least trying to help the patient go through whatever they need to go through until they actually die. I think it really helps in that regard."

Like Dr. Carlton and Dr. Patel, individuals in a wide range of professions determine whether particular topics—like religion and spirituality—are relevant to the professional services they provide; whether such topics are inside or outside of their professional "jurisdictions," in the words of Andrew Abbot (1988). Professions formally establish their jurisdictional boundaries through training and licensing, legal precedents, associations, negotiations with other professions, and other mechanisms. In addition to these formal jurisdictions, however, professionals also establish and clarify their jurisdictions informally in everyday practice, establishing what Lynn Mather, Craig McEwen, and Richard Maiman (2001:6) call "professionalism in practice" or boundaries between what is and is not a part of their professional work. While such boundaries are sometimes established by legal and institutional contexts, they often require professionals to do what Thomas Gieryn (1983) calls "boundary work," making ad hoc or negotiated decisions, especially when a topic or issue is newly introduced to their professional sphere.

The boundary work professionals do is wide ranging, focusing around issues as diverse as knowledge, technology, expertise, and emotion. In the legal sphere, for example, as the number of divorces increased in the last century, divorce lawyers had to determine whether managing clients' emotional and psychological issues fell within their professional jurisdiction. Most divorce lawyers decided it did not, sometimes forming partnerships or referral networks with psychologists, counselors, and other professionals who could provide such services (Mather et al. 2001). In medicine, physicians and nurses have long negotiated their professional expertise vis-à-vis each other (Allen 1997; Reverby 1987; Rosenberg 1987). More recently, nurses and other medical professionals have negotiated around knowledge, both formally and informally, in cases about whether aspects of complementary and alternative medicine fall within or are relevant to their professional jurisdiction (Shuval 2006; Shuval and Nissim 2004).

Issues related to religion and spirituality present unique cases through which to investigate how a wide range of professionals do boundary work, negotiating their jurisdictions around such issues in everyday practice. In medical contexts, such cases are intriguing because of the historically important role religious organizations and people played in the development of medical institutions and professions (Porter 1993). Additionally, survey data consistently demonstrate that religion and spirituality are often important to people dealing with health problems and that there are significant differences between the religious and spiritual backgrounds and experiences of physicians and patients, a gap which could require informal negotiations that significantly influence care (Curlin et al. 2005). A growing body of interdisciplinary research also attempts to demonstrate the positive effects religion has on health (Koenig, McCullough, and Larson 2001). This literature rarely, if at all, considers how physicians understand religion and spirituality and how, if at all, they see such topics as part of or related to their professional jurisdictions. Additionally, scholars trying to understand these questions tend not to ask how religion or spirituality might impede patient care, either through patients' own beliefs or through the assumptions and professional boundary work of physicians. More balanced research is critically important both for creating more nuanced health care training programs around religion and spirituality that will improve physicians' religious literacy and better inform the relevant operational standards in medical settings established by the Joint Commission (the professional body that sets guidelines all hospitals must meet to receive federal funding) (Prothero 2007; Staten 2003).

This article draws from research in the sociology of professions, medicine, and religion to ask two questions. First, how do pediatric physicians gather information about religion and spirituality in their work with patients and families and describe when, if at all, that

information is relevant to their professional work? Second, as they negotiate professional boundaries around religion and spirituality in everyday interactions with patients and families, do they perceive religion and spirituality to be a barrier or a bridge to medical care? We address these questions through in-depth interviews with 30 pediatric physicians (14 pediatricians and 16 pediatric oncologists) who practice and teach at elite American medical centers. Since these physicians do clinical work and hold faculty positions at top medical centers, we view them as thought leaders in their fields.

We find that pediatric oncologists are more likely than the pediatricians interviewed to see the religion or spirituality of patients as relevant to their professional jurisdictions. Rather than asking direct questions about religion and spirituality, like Dr. Patel, the majority prefer to ask broad open ended questions or to wait for patients and families to bring such issues up themselves, reflecting a certain jurisdictional ambiguity in the process. Like Dr. Carlton, the majority of the physicians interviewed see religion and spirituality as most relevant in difficult medical decision-making situations, in particular those made about end of life care. Overall, these physicians see religion and spirituality as both a barrier and a bridge to medical care. Physicians think it is a barrier when it impedes their work and/or care for children, especially care for children who are Jehovah's Witnesses, Orthodox Jews, or members of religious traditions that have existed in some tension with biomedicine. It is a bridge when it helps patients and families make sense of illness, adjust to difficult news, and answer questions that medicine inherently cannot.

The physicians interviewed conceive of religion and spirituality functionally and as relevant to their professional jurisdiction but not squarely within it. They negotiate professional boundaries around religion and spirituality less via religious professionals, such as hospital chaplains or families' spiritual leaders, and more via the actual beliefs and practices of patients and their families. They construct the most permeable boundaries between religion and spirituality and medicine when: (1) they perceive religious/spiritual beliefs or practices to help patients and families but not at the expense of medicine, and (2) when they have no more medical options to offer, like at the end of life. Such findings have theoretical relevance for the broader conditions under which professionals—physicians in particular—negotiate their jurisdictions in everyday practice.

Background

An ongoing line of research in the sociology of professions concerns how the professions establish what Abbot (1988) calls jurisdictions or claimed rights, which may include "monopoly of practice and of public payments, rights of self-discipline and of unconstrained employment, control of professional training, or recruitment and of licensing, to mention only a few" (p. 59). This is the process through which a profession attempts to establish its unique claim to an issue or body of knowledge, competing according to Abbot, with other professions to do so. Such claims are staked formally at the macro level as well as the micro, as members of professional groups do what Gieryn (1983, 1999) calls boundary work in everyday interactions, making claims about what they perceive to be both inside and outside of their professional spheres and relevant to those spheres. Both structural and individual factors likely influence professionals' everyday interactions and claims making, an issue much debated by scholars (Freidson 1976; Strauss 1978; Strauss et al. 1963; Strauss et al. 1964).

Medical sociologists have paid particular attention to how jurisdictions are established and professional boundaries drawn in medical settings. Scholars in the lineage of A. L. Strauss and colleagues emphasize how medical professionals negotiate responsibilities through boundary work and maintain social order (Maines 1977; Strauss et al. 1964). They pay particular attention to how these negotiations are shaped by institutional contexts and established ideas about particular professions and what influence these negotiations have on patient care (Anspach

1987; Hughes 1988; Millman 1977; Sudnow 1967; Zerubavel 1979). They also investigate how such negotiations take place when new treatments, technologies, or practices are being considered or introduced to medical settings. This research in medical sociology mirrors the concerns of sociologists in other subfields exploring questions of boundaries (Ajrouch 2004; Edgell, Gerteis, and Hartmann 2006; Gieryn 1999; Lamont and Fournier 1992; Lamont and Molnar 2002). These scholars ask how individuals and groups understand themselves to be different from others and create boundaries or mechanisms that maintain these differences via, for example, gender (Collins 1992; Epstein 1992), ethnicity (Hall 1992), social class (Lamont 2000), and other factors.

In everyday practice, religion and spirituality are not infrequently factors around which professionals (and others) do boundary work. Social service professionals make decisions about how to engage with client's personal religious or spiritual experiences just as teachers and coaches draw lines around the religious and spiritual practices that can take place in public schools. Lawyers may make decisions about what aspects of clients' religious/spiritual backgrounds are relevant to their cases while politicians carefully negotiate when and in what settings to use religious/spiritual language (Bruce 2006; Lindsay 2007). This boundary work involves professionals determining whether religion and spirituality, in various forms, is either within their jurisdiction or relevant to it.

Medical professionals are no exception. Scholars in the sociology of medicine, religion, and the professions, however, have rarely considered how medical professionals do boundary work around religion and spirituality, and medicine. This omission is ironic for three reasons. First, religion was central to the emergence of medical professions and institutions. Rich historical evidence shows that models of physicians emerged from ecclesiastical forms and the content of higher education in the Middle Ages. 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; Rosenberg 1987). Formal training for nurses also emerged in the United States in the late nineteenth century, and orders of religious or vowed nurses were then replaced by secular nurses over the next century (Coburn and Smith 1999; Nelson 2001; Reverby 1987).

Second, survey data consistently demonstrate both that religion and spirituality are often important to people dealing with health problems and that there are significant differences between the religious and spiritual backgrounds of physicians and patients, gaps which might influence care (Catlin et al 2008; Ecklund et al. 2007). Recent national surveys, for example, show that more than half of Americans regularly pray for their own health or the health of their family members. More than three-quarters of Americans believe prayer can have a positive effect on people who are ill, and close to three-quarters believe God can cure people given no chance of survival by medical science.¹ Despite these numbers, there has been, until recently, little academic or public interest in how physicians respond to such religious and spiritual beliefs in their work. More than exploring how physicians understand and respond to such issues, however, much current research focuses on the religious and spiritual lives of physicians (Chibnall and Brooks 2001; Crane 1975; Curlin et al. 2005; Daaleman and Frey 1999; Frank, Dell, and Chopp 1999; Olive 1995). This research demonstrates significant differences between physicians' religious/spiritual backgrounds and those of their patients. The first national survey of physicians conducted in 2003, for instance, showed that more physicians than members of the general public believe they are spiritual but not religious. Physicians are also more likely than the general public to be affiliated with minority religious traditions, including Judaism, Hinduism, Islam, Buddhism, and Mormonism (Curlin et al. 2005).

1. Data from a survey conducted by *Newsweek* dated November 1, 2003; available through Polling the Nation.

Just over half of physicians say their religious beliefs influence their practice of medicine, influences several studies have tried to document (Curlin et al. 2005). A recent study suggests that doctors who are religious are less likely than others to believe physicians must refer patients or disclose information about medical procedures they oppose for moral reasons (Curlin et al. 2007). In studies about the withdraw of life support and abortion, religion is also associated with physicians' decision making (Aiyer et al. 1999; Crane 1975; Imber 1986). In a study of Pennsylvania internists, for example, after controlling for independent variables, Catholic and Jewish physicians were less willing than other physicians to withdraw life support (Christakis and Asch 1995). And in a survey of Massachusetts' pediatricians who care for critically ill newborns, religious affiliation significantly influenced physicians' treatment decisions, a finding replicated in a large multinational survey of neonatologists (Barnes et al. 2000; Cuttini, Nadai, and Kaminski 2000). Documented differences between the religious/spiritual backgrounds of physicians and patients and of the effect religion and spirituality has on physicians' decision making point to potential gaps between physicians and patients that may require significant informal negotiation in clinical situations.

Finally, scholars' lack of attention to physicians' boundary work around religion and spirituality is surprising given a growing body of interdisciplinary research that attempts to demonstrate the positive effects religion has on health. One line of research investigates the relationship between religion and spirituality and mortality, with particular attention to religious service attendance (House, Robbins, and Metzner 1982; Strawbridge et al. 1997; Koenig et al. 1999). In a recent meta-analysis, Michael McCullough and Timothy Smith synthesize studies that examine the potential importance of religion on mortality. They conclude that "religious people had, on average, a 29 percent higher chance of survival during any follow-up period than did less-religious people" (McCullough and Smith 2003:197). Additional studies investigate how religion and spirituality influences people's physical and mental health. In a review of epidemiological research on religion and blood pressure, for example, Jeffrey Levin and Harold Vanderpool (1989) found people who are religiously committed to have lower blood pressure than those with no religious affiliation. While some researchers posit biological and physiological mechanisms, sociologists tend to focus on how religion and spirituality, variously defined, influences health via religious teachings, communities, and behaviors (Cadge 2009; Cadge and Fair forthcoming; Dwyer, Clarke, and Miller 1990; Nonnemaker, McNeely, and Blum 2006; Troyer 1988; Wallace and Forman 1998; Wallace and Williams 1997).

Studies of the relationship between religion and health are limited theoretically in their conceptions of religion and the religions studied, and methodologically by their almost exclusive reliance on survey data, an approach that tends to constrain the ways religion is understood to a small range of traditions and practices that may not adequately describe the experiences of patients and, in particular, of doctors. With few exceptions, researchers also tend to frame their questions about health in terms of the positive rather than the potentially negative effects of religion and spirituality (see Bjorck and Thurman 2007; Krause and Wulff 2004; Krause 2006; Pargament et al. 1998). Additionally, and most important for this article, this literature rarely, if at all, considers how physicians understand religion and spirituality and how, if at all, they see such topics as part of or relevant to their professional jurisdictions. Scholars asking these questions also tend not to ask how religion or spirituality might impede patient care, either through patients own beliefs or through the assumptions and professional boundary work of their physicians. One study demonstrates that more than half of physicians believe religion and spirituality influences health by helping patients cope, giving patients a positive state of mind, and providing emotional and practical support, again not looking in detail at possible negative relationships between religion and health (Curlin et al. 2007).

We respond to scholars' limited knowledge about how medical professionals do boundary work around religion and spirituality by focusing on one group, pediatric physicians. We ask two research questions. First, how do pediatric physicians gather information about religion and spirituality in their everyday interactions with patients and families and describe when, if

at all, that information is relevant to their professional work? Second, as they negotiate professional boundaries around religion and spirituality with patients and families, do they perceive religion and spirituality to be a barrier or a bridge to medical care? We draw theoretically from “lived religion” approaches in the sociology of religion that emphasize how individuals construct religion and spirituality in their day-to-day lives outside of religious organizations (Ammerman 2007; Bender forthcoming; Hall 1997; Orsi 1996, 2003) and from the boundaries literature, particularly that which explores how different groups of professionals establish their professional jurisdictions. We view this inquiry as a first step to be replicated among other physicians and groups of professionals.

Research Methods

Our data were gathered through in-depth interviews with 30 pediatric physicians (14 pediatricians and 16 pediatric oncologists) all of whom treat patients, teach, and conduct research at top U.S. hospitals, serving as leaders in their fields. These interviews are part of a broader mixed methods study of religion, spirituality, and ethics among pediatricians and pediatric oncologists at these hospitals. Pediatric faculty and pediatric oncology faculty included in the study were randomly selected from departments of pediatrics at 13 honor roll hospitals as defined by *U.S. News and World Report*.² The methodology to determine honor roll distinction combined hospital reputation, mortality data, and patient-care related factors; when six or more specialty areas showed “exceptional breadth of excellence,” the hospital placed greater than two standard deviations above the mean and was granted honor role status. The hospitals included are Stanford Hospital and Clinics, The Johns Hopkins Children’s Center, UCLA Medical Center, the University of Michigan Medical Center, Duke University Medical Center, University of Washington Medical Center, Mayo Clinic, Cleveland Clinic, New York-Presbyterian Medical Center, Massachusetts General Hospital, Hospital of the University of Pennsylvania, University of California San Francisco Medical Center, and Barnes-Jewish Hospital.

During a seven-week period from May through June 2005, 209 faculty-level general pediatricians were randomly selected from departments of pediatrics at hospitals in the sample. Similarly, 122 pediatric oncologists were selected for participation. This sample includes the complete population of physicians practicing oncology and hematology in departments of pediatrics in these honor roll hospitals. Rather than focusing on a single hospital, we drew our sample from these 13 hospitals to ensure that we surveyed and interviewed as wide a range of pediatric physicians as possible in this academic tier. Our goal was to maximize both the reliability of our results and the extent to which they could be generalized among pediatric physicians at other top tier academic hospitals. Generalizations to other pediatricians and pediatric oncologists are more limited, as discussed in the article’s conclusion.

In phase one of the study, a contact letter was sent to each respondent inviting him or her to participate in a short Web-based or telephone survey about religious identity, beliefs, practices, ethics, and the intersection of religion and science in the respondent’s field. Overall, 116 general pediatricians completed the survey (110 via Web and 6 by telephone), yielding a response rate of 56 percent. Also, 74 academic pediatric oncologists were recruited, yielding a response rate of 60 percent for the study (71 online, 3 by telephone). These survey data are published in other articles (Catlin et al. 2008; Ecklund et al. 2007). Systematic information about the population of physicians from which these samples were drawn does not exist, allowing us to recognize that selection bias may be an issue in who was surveyed, but we are not able to systematically measure it.

Because we wanted to examine the perceptions of religion in medical practice as well as the norms involved in discussing religion within medical practice, we conducted a second

2. *U.S. News & World Report*. July 12, 2004, “Honor Roll Hospitals.”

phase of the study in which 30 of the general pediatric faculty who completed the survey were randomly selected to do in-depth interviews. Each pediatric oncologist and pediatrician who filled out the survey had the same chance of being selected to do a qualitative interview though those who were more interested in the topic may have been more likely to agree to participate, a limitation of this approach. Fourteen general pediatric faculty were interviewed, a 47 percent response rate. In addition, 30 of the pediatric oncology faculty who completed the survey were randomly selected to do in-depth interviews and 16 did, a 53 percent response rate. It is possible that there is selectivity in who in the survey sample agreed to be interviewed though the small number of interviews conducted makes meaningful tests of significance between the survey and interview samples not possible.

Each of the first two authors conducted a portion of the in-depth, semistructured interviews, which included questions about how religion and spirituality enters patient care and about the physicians' own personal beliefs and practices. A complete interview guide is included in Appendix A. All of the interviews were recorded—either in person or over the phone—transcribed, and systematically coded for themes related to the above topics. Since there is little prior qualitative research on how physicians do boundary work around religion and spirituality and medicine, these data were coded inductively using a grounded theory approach with particular attention to how physicians negotiated the boundaries between religion and their work as practitioners (Strauss and Corbin 1990). Once themes were developed in the coding, for example the theme of weak boundaries around end of life decision making, then each of the co-authors re-coded all of the interviews with attention to this particular theme.

Demographically, the 30 physicians interviewed include equal numbers of women and men. Sixty percent are white and just over one-quarter are Asian American. They range in age from 31 to 65, with an average age of 46. The majority is married and just over half of the physicians interviewed have children under age 18. They have been in their current position for between 2 and 32 years, 10.3 years on average. When asked about their personal religion and spirituality, 86 percent say they are spiritual, 34 percent say they are religious, and 41 percent belong to a religious organization. When asked about their religious affiliation, 43 percent ($n = 13$) say none, 23 percent ($n = 7$) say Jewish, 13 percent ($n = 4$) say Protestant, 10 percent ($n = 3$) say Catholic, and the remainder, 10 percent ($n = 3$), report another religion or the information was not shared.

Findings and Discussion

Everyday Conceptions of Religion and Spirituality

Before considering whether pediatric physicians see issues related to religion and spirituality as within their professional jurisdictions, it is helpful to understand how they define these terms in practice. They are close to unanimous in their descriptions of religion as structured, institutional, and often based around a notion of God, and spirituality as related to the wider range of ways people find meaning in their lives. A pediatrician defined religion “as a belief system, usually anchored in some universally accepted institution” and spirituality “as a state of being, how people actually see their lives and what their interior motives are all about” (Peds3_I1). Similarly, a pediatric oncologist defined religion as “specific belief systems that exist in the world, so whether you are Roman Catholic or within Christianity or Jewish or Buddhist” and spirituality as “the essence of your soul, the essence of your person and sort of what you believe in” (PedsOnc1_I1). While “religion” describes a set of principles usually related to a higher power and established in an institution for these physicians (and the American public more broadly), spirituality is personal and focused on how individuals find meaning in their lives, a definition also shared by physicians and members of the general public (Armstrong 1996; Wuthnow 1998; Zinnbauer et al. 1997).

Overall the physicians received almost no formal training about religion or spirituality in their medical educations, suggesting that medical educators view the topics as outside the jurisdiction of physicians.³ Of the two physicians who did mention formal medical training about religion or spirituality, one implicitly framed religion as at odds with medicine in describing an ethics class that included discussion about how to respond to patients who refuse treatments because of certain beliefs. About one-third of those interviewed described learning about religion and spirituality through informal conversations with colleagues in medical school or residency. Several mentioned getting to know hospital chaplains personally and learning through informal conversations with them. These conversations tended to focus on specific topics such as death and dying, families' decision making, and how to respond to patients and their families who are very religious, such as Jehovah's Witnesses and Orthodox Jews. With the exception of one physician, who told a story about watching an attending physician baptize a baby in a neonatal intensive care unit, these physicians did not describe learning about religion and spirituality as they often learn other skills, by observing more senior physicians demonstrate and model them.

Gathering Information about Religion and Spirituality

Given their limited formal education about religion and spirituality in medical contexts, it is not surprising that the majority of pediatric physicians rarely ask patients and families directly about their religious/spiritual backgrounds, reflecting an implicit lack of jurisdiction or formal boundary between medicine and religion and spirituality.⁴ Pediatric oncologists are more likely than pediatricians to think religion and spirituality is relevant and to want to cross this line, but describe crossing it indirectly, doing what we call boundary work and reflecting a certain jurisdictional ambiguity in the process.

Only one of the pediatricians described directly asking patients about religion and spirituality regularly. The other pediatricians established a boundary between their work and such topics, feeling that direct conversations about religion were generally not relevant or too personal, reflecting a boundary between public and private that puts religion on the side of private and other things on the side of public medical discussion (Wolfe 1997). To the extent that such discussions are ever relevant, these physicians thought they should be brought up by patients and families, such as when a child is very ill. Physicians often perceive all of the information they gather from patients as connected to a specific purpose or function; several pediatricians were not clear what the function of information about religion and spirituality would be. Dr. Carlton described above remarked, "I mean . . . people [physicians] wouldn't necessarily know what to do with that information . . . if somebody says, 'Well, I'm Hindu' . . . your thought is, 'What do I do with that?' Does that mean they're vegetarian or we just order up different trays or . . .?" (Peds2_I2). Coming from a Protestant physician who considers herself both spiritual and religious and belongs to a religious organization, this comment is insightful both because it raises questions about the assumption that the boundary between religion and medicine is lower for physicians who are themselves religious and because she selected the Hindu tradition, a non-Western, smaller, and lesser publicly known religious group, with which to make the point. It also illustrates the extent to which even physicians who are religious themselves perceive their own lack of knowledge about traditions outside their own to be a barrier.

3. This was the case for older and younger physicians alike, raising questions about the extent to which religion and spirituality really is entering medical curricula in a way students remember after the fact (Barnes 2006; Puchalski and Larson 1998).

4. Aside from asking respondents how they understood religion in relation to spirituality, we deliberately did not distinguish between religion and spirituality in these interviews recognizing that these are slippery terms. Instead we allowed the physicians to define these concepts in their own language as they answered the questions. For a further discussion of such distinctions see Schmidt 2005 and Wuthnow 1998.

A number of pediatricians illustrate the boundary between their work and patients' religious/spiritual lives by adopting a public/private sphere dichotomy to describe religion and spirituality, seeing such topics as "personal" and using the language of "prying" when discussing conversations about religion and spirituality (Weintraub and Kumar 1997; Wolfe 1997). These conceptions are revealing in the context of physicians who routinely ask questions about other generally "private" topics such as family history, family dynamics, drug use, sexual activity, and school performance. When talking about religion, physicians invoked a language of privacy. For example, one pediatrician told us that to ask about religion would "sort of feel in a sense" like "prying" because he does not know how he would use the information. It feels to him like patients would share such information with him if they wanted him to know, and he is afraid patients might think he would treat them differently as a result (Peds10_I1). Such sentiments were echoed by other pediatricians, including one who runs a clinic for children with a particular chronic disease, who described developing "intimate" relationships with families she has come to know over more than 20 years. To ask about religion and spirituality, she told us, "I think that probably to some extent it would almost be viewed—I think I would almost view it as like an invasion of privacy . . ." (Peds2_I1). Another physician said that asking about religion would be like "crossing the line" and also repeated fears expressed above that some groups might view it as "almost profiling" and feel "uncomfortable" (Peds8_I1). Almost none of the pediatricians regularly inquire about religion and spirituality directly, viewing such information as separate from their work as physicians, too personal, and in these examples, something that could lead to difficulty and misunderstanding rather than any kind of improved care or positive physician-family dynamics.

A few more pediatric oncologists than pediatricians ask patients and families directly about religion and spirituality and many more want access to this information, constructing a slightly more permeable boundary between religion/spiritual and medicine in the process. One of the physicians who said he asks about the faith traditions of families directly does so, "in the beginning with a new diagnosis because that can be a source of comfort for families, and we try as a team to offer very comprehensive care" (PedsOnc6_I2). Similarly, constructing religion or spirituality as a source of personal and community support, another physician told us he "usually ask[s] if they [patients/families] belong to a faith community" (PedsOnc7_I2).

Rather than asking about issues related to spirituality or religion directly because they feel it is too personal and could make people uncomfortable, more pediatric oncologists actively gather information about such topics indirectly through broadly framed questions, reading cues from patients or waiting until patients and families raise the subject. They want to have this information but experience some discomfort asking direct questions about it, suggesting a certain jurisdictional ambiguity. It suggests, perhaps, that the information may be part of or relevant to the professional jurisdiction of pediatric oncologists, but not the process of gathering it. One pediatric oncologist said that asking about religion and spirituality is too personal so she asks, "Is there anything with respect to other areas in your life that we can help you with that will make this process easier for you?" thereby allowing families to define the boundary for themselves (PedsOnc2_I2). Similarly, another physician asks "whether there's anything that could be helpful for you as this stressful thing you're going through" and occasionally asks if families would like to see a chaplain (PedsOnc6_I2). Others describe looking and listening for "cues" because, as one explained, ultimately what is important is "their source of support and comfort . . . and how it can help me help them better" (PedsOnc3_I1). A number of other pediatric oncologists just wait, finding that at some point religion and spirituality will come up if it is important to families. Pediatric oncologists describe feeling comfortable with these broad questions and careful observations because they allow patients and families to define the relationship between religion and spirituality and medicine that feels comfortable to them. They allow patients and families, in other words, to decide whether religion and spirituality is relevant to the physician's jurisdiction rather than requiring the physician to decide.

While pediatric oncologists were more open overall to information about patients' religions and spiritualities—perhaps because they perceive the information to have more of a function in the care they provide—several shared concerns that asking about it could make some patients uncomfortable and careful negotiation may be required. One physician expressed this generally, saying that if religion and spirituality does come up with patients or families she tries to “follow their lead a little bit in terms of just trying to be supportive, but not . . . necessarily too much beyond that.” She expressed concern about being perceived as “imposing” something religiously or spirituality on people by being present for such conversations (PedsOnc8_I1). Another physician said that she would support having questions about religion and spirituality be a standard part of hospital intake forms but absent a uniform policy she worries that some patients might feel singled out in being asked questions. As a Jewish physician she fears that Muslim patients might feel uncomfortable with her if she asks them such questions (PedsOnc5_I1). While pediatric oncologists are more open to information about patients' religions/spiritualities than are pediatricians and tend to think this information could influence patient care, many remain concerned that this information be gathered in uniform ways that allow patients and families to themselves establish the boundaries and that, at least in the last example, keep religion and spirituality largely in the private sphere.

Professional Relevance of Religion and Spirituality: Medical Decision Making and End of Life Situations

When we asked pediatric physicians when and how religion and spirituality is present and relevant in their work, both pediatric oncologists and pediatricians spoke about serious medical problems such as when families have difficult medical decisions to make or when patients are dying. Connections between religion and spirituality and problems or difficulties were clear in how physicians framed their answers. When we asked a pediatrician how, if at all, religion and spirituality comes up in her work, she said she is working “exclusively in the nursery . . . so these things don't come up very often in my particular work. Things are generally pretty happy” (Peds2_I2). While it is conceivable that religion and spirituality could be part of how new parents celebrate happy news, this was outside the scope of religion and spirituality or “these things” as this physician conceived of them. Other physicians described religion and spirituality only coming up “if everything's turning for the worse” (Peds1_I1), in “crisis-oriented discussions . . . death-oriented . . .” (Peds2_I1), and when things are “going badly” (Peds3_I2).

Medical Decision Making: Impermeable Boundaries One time pediatricians and pediatric oncologists both said discussions about religion and spirituality came up and were relevant to their professional work was when families were making medical decisions. While physicians often framed religion and spirituality generally in terms of painful or difficult situations for patients, adding decision making to the mix led physicians to speak largely in terms of particular religious traditions with histories of existing in some kind of tension with medicine. Rather than talking about how religion and spirituality might shape decisions for Protestants, Jews, Catholics, and members of other religious traditions that have a large number of adherents in the United States, doctors focused on Jehovah's Witnesses, Christian Scientists, Orthodox Jews, and other traditions that have existed in some tension with biomedicine and have few adherents in the United States (Gallup and Lindsay 1999). In talking about medical decision making, physicians mentioned these religious traditions in numbers vastly out of proportion to their populations in the broader population.

A few physicians spoke generally about wanting to take patients' religion and spirituality into account when helping them make difficult decisions, while others expressed frustration about working with members of religious traditions that have claims on knowledge at odds with medical claims and professional jurisdiction. One physician, speaking generally, likened

religion to racial and ethnic, geographic, and other kinds of differences between people. He said that he tries to “understand” whether what he is suggesting “coincides with their beliefs, whether it’s either religious or . . . geographic or whatever” (Peds8_I1). Another spoke about working with the Hasidic community, which he says has different guidelines in different geographic regions of the United States about code status and maintaining life, a “major factor in decision making for many families” (PedsOnc7_I2).

Many more physicians expressed frustration, speaking about religion and spirituality as an impediment to care because of the ways it influences medical decisions made by very religious patients. One physician explained, religion or spirituality can “really impede” patients’ “ability to . . . accept treatment in a meaningful way and that sometimes provides or creates a situation of—in my view—unnecessary guilt.” He first described a recent case in which a child was diagnosed with leukemia and her family, for religious reasons, refused medical intervention for some time. He then spoke of another case in which a child “who was clearly at the end of life with a progressive tumor” was “kept alive on a ventilator for weeks far beyond the time when any reasonable medical judgment of survival was past because the family was hoping for a miracle.” What he calls the “irrationality of religious dogma” caused the family to make what he considered to be poor medical decisions, which led to unnecessary suffering for this child and was “adverse to the right patient care” (PedsOnc7_I1).

In addition, physicians described the presence of religion and spirituality in their work in ways that put religious/spiritual knowledge not just outside their jurisdiction but at odds with their own medical knowledge, judgments, and decisions. A pediatrician spoke of “an Orthodox Jewish family who wants to be discharged from the hospital on a Friday afternoon so they can spend the Sabbath at home when they probably should stay another day” (Peds4_I1). Many spoke of Jehovah’s Witnesses as cases where, in the words of one pediatric oncologist, “strong religious beliefs often come up head-to-head against what we think is medically in the best interest of a child, and we have to deal with that” (PedsOnc9_I1). Pediatric hematologists, in particular, describe how they “deal” with Jehovah’s Witness teachings that prohibit the use of blood products by framing themselves as advocates for children in these situations. One described how she explains to Jehovah’s Witness families the need for blood products and respects their position until it is “adversely affecting the child’s health,” at which point she “stands up for that child, even if it is in conflict with the parents’ wishes” (PedsOnc4_I1). A second describes his approach in a similar way, often taking responsibility for taking the decision away from the parents, informally if not formally.

My approach has been to explain over and over and over again to them [Jehovah’s Witnesses] why I want to transfuse their kid . . . I take the onus upon myself to . . . be able to convince them that what I’m doing is in the interest of their child, and oftentimes they’re actually happy to have the decision taken away from them. And we don’t do it in any conscious way, but, you know, just to say: “You know, we really need to do this and I’m going to do it at some point . . . it’s going to make a huge difference in terms of a matter of deteriorating versus improving . . . I’m going to make that decision. And I’m going to do it irrespective of whether you agree with me or not, which I can do *legally*.” And then they’re just happy to say, “Okay, if you have to do it, do it,” kind of thing.

About three-quarters of the time, this process happens informally while in the other quarter of cases this physician says that the “risk management” group at his hospital gets involved and he formally treats the patient “over the objections” of the parents (PedsOnc1_I1). In this example, the physician invokes the power of the law as part of what helps him negotiate the jurisdiction and boundary between religious and medical knowledge with parents.

These examples are revealing less in their details and more in what they suggest about where and how physicians see religion and spirituality present around medical decisions in their work. Rather than selecting examples that include people from a range of religious traditions confronting a range of health and medical situations, physicians see religion (much more so than when they discuss spirituality) as bounded and in a separate sphere

that becomes relevant in difficult decision-making and crisis-oriented situations, particularly when Jehovah's Witnesses and others who belong to religious traditions historically at odds with biomedicine are involved. While some physicians simply acknowledge these religious traditions, others see these beliefs as challenges and impediments to medical knowledge or care and view themselves as advocates for the best interests of the child in their care.

End of Life Situations: More Permeable Boundaries In addition to medical decision making, the main situations in which physicians describe religion and spirituality as relevant in their work with patients is at the end of life. With the exception of the example above, very few physicians see religion and spirituality as an impediment in these situations, more often describing it as a comfort when patients and families are asking the "why" questions that medicine can inherently not answer. Given their patient population, these frames were especially evident among the pediatric oncologists who, when they have no more medical options to offer, seem comfortable moving back and forth between subjects traditionally delineated to religion or spirituality and medicine.

As one pediatric oncologist explained, religion usually comes out "early in the course of diagnosis, families that feel devastated . . . or later in the course when a patient takes a turn for the worse or . . . the disease comes to a point that as their providers we can longer provide curative means" (PedsOnc3_I2). At each of these points, physicians described families drawing from their religious/spiritual traditions as they try to answer the "why" questions—why their child is ill, why something so rare hit them, why there has been a reoccurrence of the disease, why they are faced with this crisis, etc. (PedsOnc5_I1, PedsOnc6_I1). As one physician explained, religion and spirituality almost always comes up when things are not going well, "The old adage that there are very few nonbelievers in fox holes applies in this setting also" (PedsOnc4_I2). Another explained that religion and spirituality may come up during treatment when there is a "reasonable sort of likelihood of a decent outcome" but comes up almost universally "when someone's actually going to die" (PedsOnc8_I2).

Interestingly, some pediatric oncologists believe religious and spiritual beliefs help patients and families make and cope with the shift from curative to palliative care, perhaps because they see these beliefs suddenly have a function in coping and support in the medical system they did not previously. As one explained, "there are families who have really relied on their faith to help them adjust to their loss" (PedsOnc7_I2). In the words of another:

frankly those who do have religious convictions . . . there's a belief . . . that there's something beyond this world, they seem to handle better, even the patients quite a bit better. And it's easier to talk about death with those families and those patients. There's an underlying belief that there's something beyond this world that is basically a better world. It is much easier to discuss in a much more helpful manner than with families that do not (PedsOnc3_I2).

Whether patients and families who have spiritual or religious resources adjust to the news of a child's impending death better or whether it simply has made it easier for this physician to talk with them is an open question. What is important here is that religion and spirituality seem to be welcomed by some of the pediatric oncologists interviewed because of its function, the help and support they see it providing at the end of life. A function at that point that presents no challenge to medicine.

Religion and Spirituality: Barrier or Bridge to Medical Care?

As they do boundary work around religion and spirituality, the physicians interviewed perceive it to be both a barrier and a bridge to medical care. It was perceived as a barrier in medical decision making, as described above, that can prevent children from receiving the health care they need and get in the way of medical recommendations. Physicians describe

situations in which families, particularly those in a small range of religious traditions, allow religious or spiritual knowledge to trump medical knowledge, getting in the way of medical recommendations. Physicians perceive religion and spirituality as a bridge to sources of support and means of coping in end of life situations, as described above, as well as in other situations when it can help patients make sense of things, adjust to difficult news, and answer questions that medicine inherently cannot. When they describe religion and spirituality as a bridge, however, physicians mostly describe it as a bridge to nonmedical forms of support.

In describing religion and spirituality as a barrier to care, physicians focus on religious and spiritual beliefs and traditions that they perceive as challenging and getting in the way of medical knowledge and recommendations. In the words of one pediatrician, it is frustrating when “somebody’s . . . religion is different than established medical thought or practice” and requires different kinds of negotiations (Peds9_I1). One pediatrician, for example, focused on people’s beliefs describing a lot of “old wives tales and beliefs in the Hispanic population . . . especially things like refusing lumbar punctures and that kind of stuff” that create “fears” and get in the way of people seeking care (Peds5_I1). Others focus on traditions, again with attention to Orthodox Jews, Jehovah’s Witnesses, and traditions they perceive to be in tension with biomedicine. One physician spoke of an Orthodox Jewish child who died. The physician needed permission from the rabbi for an autopsy, necessary to understand why the child died, permission that he felt should have been automatic and “shortchange[s] our children’s health care” (Peds1_I1). Another also spoke about Orthodox Jewish families in which there are often “cloaks of secrecy around what the children know who have a disease and what other family members know” that must be negotiated and may limit or act as a barrier to care (Peds2_I1).

As a bridge, physicians see religion and spirituality helping patients and families make sense of things, adjust to difficult news, and answer questions that are beyond the scope of medicine and do not get in its way. When patients and families are in difficult situations one pediatrician explained, religion generally and prayer specifically can help them feel they are in more “control” (Peds2_I2). In times of tragedy others described religion as “the source of succor and strength” that can help to “alleviate the pain” and the “sense of loss” (Peds6_I1). They describe rituals that “bond families and people to one another, in terms of helping them through times of tremendous stress and tragedy” (Peds6_I1) and faith that “amazes” them (PedsOnc2_I2). This pediatric oncologist, for example, spoke of a patient with a form of cancer that was not curable and working with family and religious leaders to find comfort; “it’s always amazing to me the amount of faith that people have in situations that would challenge anybody’s faith” (PedsOnc2_I1).

Other physicians mentioned the answers religion and spirituality can provide that are beyond the capacity of medical science. One pediatric oncologist explained that “if people’s religion and spirituality play such a central role in their lives as a way of explaining how things happen and maybe even why things happen . . . how can we say that you have to leave that at the admitting desk?” (PedsOnc6_I1). Another spoke directly about the inherent limits of medicine and her inability as a physician to answer the “how” and “why” questions that people ask. “If you have been working many years in medicine you know how limited medicine is . . .” she explained, “we are not machines.” While some physicians may try to “hide” themselves “in the technology” they do not have answers to the how and the why questions she believes makes religion essential (Peds3_I1). Similarly, another physician explains, “as long as medicine . . . does not have the answers to everything and as long as we recognize that fact, there will always be a need for religion or spirituality or for whatever else, because there are questions that we can’t answer, and people find solace in religion and spirituality . . .” For some families, this physician argues “religion and spirituality will help [them] understand . . . or at least help them deal with [it] if they can’t understand it” (Peds9_I1).

Physicians, particularly pediatric oncologists, also described the ways religion and spirituality can connect people to nonmedical forms of support. A few also spoke of personally trying to bridge the gap sometimes presented between people's religious or spiritual beliefs and medical norms. A physician who works with children with brain tumors, for example, says that when he has a family with a "strong faith-based tradition" he tries to address it directly. "I'll say, 'Look . . . I'm respectful of the fact that you have a strong faith-based tradition, and . . . that's fine, that's good, you know. So now the question is how can we marry those two things and try and meet some of the therapeutics that I would prioritize with some of the therapeutics that you prioritize, which in this case may be prayer or that sort of intervention'" (PedsOnc2_I1). Rather than trying to ignore or overlook people's faith, this physician tries to use it as a way to talk about the medical treatments he would prioritize and the religious or spiritual treatments, in his example prayer, that the family might. Similarly, another pediatric oncologist attempts to work around medical and religious boundaries, seeing religion and spirituality as one of many ways people find comfort, comfort that he is committed to providing. He explains, "part of what I've tried to do is to look at where that family's strength and supports lie and try to access that in whatever way possible . . . I'm very comfortable talking about what folks need in the way of personal refreshments, spiritual refreshments, and the like" (PedsOnc4_I2). While these few physicians attempt to overcome the often impermeable boundaries between religion, spirituality, and medicine outside of end of life situations, they were not the majority among those interviewed.

Conclusions

Combining insights from the sociology of professions, medicine, and religion, we find that pediatric physicians, pediatric oncologists more so than pediatricians, see religion and spirituality as relevant to their professional jurisdictions but not squarely within them. Reflecting a certain degree of jurisdictional ambiguity, these physicians see how information about patients' religion and spirituality can be relevant to their work but are hesitant to ask about it directly in everyday practice.

Religion and spirituality are closest to their jurisdictions, and most relevant to their work they believe, when families are making medical decisions or when a loved one is dying. The physicians interviewed describe impermeable boundaries in medical decision-making situations with religious/spiritual and medical knowledge in distinct spheres. They express frustration when religious/spiritual knowledge trumps medical recommendations for families, and highlight the challenges of working with Jehovah's Witnesses, Orthodox Jews, and members of other religious traditions that may value religious/spiritual recommendations as on par with or more important than medical ones. From listening to these physicians one would be surprised to learn that religion and spirituality supports people in joyful periods of their lives and sometimes helps Christians, rather than just members of smaller religious groups that have historical tensions with biomedicine, make decisions about medical treatments (Barnes and Sered 2005). In end of life situations, physicians describe more permeable boundaries between religion and spirituality and medicine. Perhaps because they have no further medical options to offer or because they see religion and spirituality as presenting fewer risks and having a new function, physicians are more welcoming to such topics when a patient is dying.

As a group, these physicians see religion and spirituality as both a barrier and a bridge to care. It is a barrier when it gets in the way of medical treatments and impedes care, again especially for members of minority religious traditions. It is a bridge when it helps people make sense of illness and answer questions that are beyond the limits of medical science. While a few of the physicians interviewed actively try to connect religious and spiritual to medical

forms of support, the majority do not. Perhaps surprisingly, the negotiations around religion and spirituality physicians describe are not primarily negotiations between professionals—them as medical professionals and religious professionals such as hospital chaplains or religious leaders. Rather they are negotiations between physicians, patients, and families, reflecting an inherent power dynamic few spoke of directly.

The ways pediatric physicians see religion and spirituality as relevant to their professional work and do boundary work are perhaps not surprising given the demographic differences in religion and spirituality between physicians and patients described above and physicians' own limited training about these topics. These findings suggest that this demographic gap may influence patients' experiences, if not their care, and is worthy of more in-depth study. These findings are more surprising in the context of the large literature about the positive relationships between religion and spirituality and health. When physicians are included in such studies and questions are asked in ways that allow for negative relationships, these findings suggest that religion and spirituality is a barrier as well as a bridge. The boundary work physicians do around religion and spirituality, especially related to medical decision making, may influence medical care and, in turn, people's health. The extent to which these findings hold for pediatricians outside of large high ranking U.S. hospitals and for broader groups of physicians is an open question. The personal backgrounds and training of pediatricians outside of the academy might make them more welcoming of religion and spirituality than the physicians studied here. Geography is also likely an important factor, though the physicians interviewed here work in medical centers throughout the United States, seeing patients and families from a range of religious, race/ethnic, class, and national origin backgrounds. To the extent that these findings are replicated in future studies, they might inform medical curricula and the standards about religion and spirituality in medical institutions set by the Joint Commission.

Apart from physicians, this study points to the importance of considering how other medical professionals establish jurisdiction and do boundary work around religion and spirituality. Nurses, for example, have been more informed about religion and spirituality historically and worked more closely with patients than have physicians, suggesting a professional division of labor (Emblen and Halstead 1993; Koenig et al. 1991; Meyer 2003). Hospital chaplains, the religious/spiritual professionals in the hospital, are also worthy of more sociological study, particularly with attention to how they negotiate with other professionals, if they do, for their own jurisdiction and responsibility (Angrosino 2006; Berlinger 2008; Norwood 2006). And social workers, like other medical professionals, have developed guidelines to help them engage with patients around such issues, guidelines that, when compared to those of other medical professionals, may provide helpful illustration of how hospitals are attempting to understand religious/spiritual knowledge (Hodge 2003, 2006).

Outside of medical settings, this study encourages future work about how professionals determine whether particular topics are relevant to their professional services and how they act based on their determinations. Such factors might include individual demographic factors not clearly relevant in this study, or features of how professionals were trained and the organizational and institutional contexts in which they work. Much as some divorce lawyers began to partner with counselors to help manage their clients' emotions—issues previously seen as firmly within the private sphere—they also decide when, if at all, emotional pain and suffering is relevant in divorce arguments and cases. Such jurisdictional determinations influence not just the work of individual professions but their ecological arrangement and placement within systems of professions. Recognizing the multiple individual and context factors that shape how professionals do boundary work generally and in particular situations, like at the end of life in this case, will enhance studies of particular professions and of boundary work more generally. Professional boundary work takes place not just at the macro level, but also in everyday interactions as professionals enact their conceptions of professionalism in practice.

Appendix A: Interview Guide for Pediatric Faculty

Background/Education

1. To start, could you describe briefly how you decided to become a doctor, specifically a pediatrician/pediatric oncologist?
2. How long have you worked where you currently do? And in what capacity? What is the balance between your clinical/research/teaching responsibilities?
3. Do you find there is something different or unique in working with children rather than adults? How would you describe it?
4. Are there aspects of your work with children as patients that cause you pain or tension? How do you respond to it?
5. In what ways has your work led you to think about bigger existential or religious questions about ultimate meaning?

Religion and Spirituality in the Workplace

I'm specifically interested in learning about how spirituality and religion came up in your training and now in the course of your work.

6. I'm going to use the words religion and spirituality interchangeable here but there is a lot of public discussion about the differences between the terms. Could you say a bit first about how you understand these terms/concepts?
7. How were issues related to spirituality/religion addressed in your medical school, residency, or fellowship training, if at all?
8. How do issues related to spirituality/religion come up now in your work?
9. In your work now, do you normally ask patients/their families about their spiritual or religious backgrounds or affiliations? Why or why not? If yes, what exactly do you usually ask?
10. Are there certain kinds of situations in which you find that religion/spirituality regularly becomes relevant for patients/families? (Like when?)
11. When, if at all, does the issue of prayer come up in your interactions with patients and families? (In what circumstances? Who brings it up? If relevant, do patients/families ever ask you to pray with them? How do you respond?)
12. What place do you think spirituality/religion should occupy in hospitals and medical practices that serve children?
13. Have you had any contact with the chaplain or department of pastoral care in the hospital where you work? (If yes, what kind of contact?)

Personal Experiences

14. Before we conclude, would you feel comfortable saying just a bit about your own spiritual/religious background?
 - a. Are you affiliated with a particular tradition? Organization?
 - b. Do you consider yourself a religious or spiritual person?
15. Apart from when patients ask you to pray with them, do you pray or think about your patients in the context of your private religious or spiritual practices (if you have them)?
16. I'm interested in the relationship between your spiritual/religious values and your work. How does one influence the other, if at all?

Conclusion

17. I very much appreciate your willingness to participate in our research study. Is there anything we haven't talked about that you would suggest I keep in mind as I learn more about religion and spirituality in the lives of pediatricians/pediatric oncologists?

18. Just for the record, could I ask you some questions about your demographics? What is your academic rank? Age? Ethnic group? Married/long-term partnership? Children? If yes, ages?

Thank you!

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