

Get Well Soon:

Exploring the Relationship of Healthcare and Religion

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Abstract:

This capstone set out to investigate and analyze the complex relationship between religion and healthcare in America today. The project begins by outlining the turbulent history that has led to religion and medicine existing as separate and distinct fields. Next, by drawing on contemporary scholars of religion, theology, and healthcare reform, the paper analyzes the ways that religious thought contributes to and clashes with the healthcare system today. After examining some of the present contributions that religion makes in both medical and mental health practices, the author scrutinizes the aims of the current healthcare system and its role in society. The project concludes by proposing that religious, mental health, and physical healthcare entities work together toward a more comprehensive goal of personal well-being. The author suggests that combining the positive effects of each of these sectors will better enable individuals to achieve a balance of physical, mental, and spiritual health.

Where do we go when we don't "feel well"? Who do we seek out to help us get "better"? And, most importantly, how do we define being "healthy"? These questions are often overlooked and rarely discussed, probably because the answers seem easy. We go to the hospital when we don't feel well, we seek out doctors to make us better, and we consider ourselves healthy when our bodies are working properly. These answers may be the first that come to mind, but they really only represent one perspective on health and wellness. All three answers presuppose that the questions deal with physical health and traditional health care. And while this perspective is not necessarily wrong, it limits the way we approach the needs of humans. Unlike other living beings, humans have the unique experience of mental and spiritual illness in addition to bodily and physical illnesses.

The traditional healthcare setting may be the first place people go for care, but clearly medicine falls short of addressing the needs of humans. This project aims at investigating the relationship between healthcare and religion as a means to proposing a more comprehensive caring system. By analyzing the history of the two fields, the way that they currently relate, and the ways that they can benefit each other, I arrive at a proposition that incorporates both fields and defends mutual collaboration.

Before delving into the investigation itself, it is critical to define the terms used throughout this paper. First and foremost, this paper deals exclusively with the mainstream American healthcare system. All references to “healthcare” and “the healthcare system” are meant to describe the current American system, including the government policies, hospital systems, private practice doctors, health insurance providers, and pharmaceutical companies that define our medical services. While this definition may appear vague, it would be unnecessary and cumbersome to define and explain each of the pieces that make up our healthcare system. This paper deals with the ethos that motivates the American healthcare system, not the individual steps or nuances within. Finally, it is noteworthy that this paper only discusses traditional Western medicine, which means that alternative therapies, traditionally Eastern or Native methods, and faith-healing are not considered.

To further clarify, mental health care is often discussed throughout this paper as part of the traditional healthcare system. While the original aim of this project was to investigate the relationship between religion and medical healthcare, it became apparent quickly that mental health is a necessary topic to include. Unfortunately, the line between mental and physical health care is blurry still, making it difficult to treat mental health as an entirely separate entity. Mental health is its own field, but it remains attached to

traditional (medical) healthcare in many ways. I have included studies about religion and mental health to support that religion has an important role in the broad healthcare setting. However, I later advocate for a more tripartite view of human wellness that would elevate mental health concerns. My hope is to present mental health care as an existing component of healthcare, but also to maintain the right to suggest its future role.

Besides healthcare, the term “religion” is often used and deserves explanation. Definitions of religion vary widely, but in this paper I will be referring to religion as defined by Webster’s Dictionary, which I believe is a comprehensive and still accessible definition. Religion here, then, is “a) belief in a divine or superhuman power or powers to be obeyed and worshiped as the creator(s) and ruler(s) or the universe (b) the expression of such a belief in conduct and ritual.... [or] a) any specific system of belief, worship, conduct, etc., often involving a code of ethics and a philosophy [e.g. the Christian religion, the Buddhist religion]; (b) any system of belief, practice, ethic values, etc., resembling, suggestive of, or likened to such system.”¹ With this definition in mind, religion encompasses the religious doctrines and practices that promote physical health, religious communities that attend to the health of their members, and religiously inspired ways of thinking about death. While I have not meant to exclude any individual religion from this discussion, most of the data and case studies presented focus on religious followers of the major religions in America, namely Christianity, Judaism, Hinduism, and Islam. I do mean to include all recognized religions when I use the term “religion,” and I believe that my conclusion applies to all forms of religion as well.

¹ “Religion,” *Webster’s Dictionary*, (1980), 1200.

Finally, the data I present has been gathered from a variety of scholars who are also interested in this topic. While they come from a variety of disciplines, some approach their studies with a specific, often Christian, perspective. A few of the cited scholars are theologians, but many others are academics with a background in psychology, medicine, or religious studies.

The conclusion to this paper draws on the data presented and synthesizes many of the scholars' suggestions. While the terminology and argument are my own, the solution echoes many previously hatched ideas for the future of religion and healthcare.

Part I: The Past and Present Relationship of Healthcare and Religion

“Formerly, when religion was strong and science weak, men mistook magic for medicine; now, when science is strong and religion weak, men mistake medicine for magic.” ~Thomas Szasz, *The Second Sin*, 1973

Healthcare and religion have a complex history and connection. Although they were at one point nearly the same practice and were highly influential on each other, the overall story is one of separation and increasing disassociation. Indeed if “religion and healthcare” were a love story, their relationship would surely qualify as more tragic than romantic. While each culture and subculture has seen a different progression, most societies can trace a time when religion and healthcare were nearly synonymous.

Previously, people in many cultures understood the forces making their bodies sick as at least implicitly religious.² Scholars Joel James Shuman and Keith G. Meador discuss the

² Joel James Shuman and Keith G. Meador, *Heal Thyself: Spirituality, Medicine, and the Distortion of Christianity*, (Oxford: Oxford University Press, 2003), 21.

previous parallel between healthcare and religion. They point out that until relatively recently, healthcare and religion were really the same field. Shuman and Meador state,

For a long time in many cultures, both the individual human body and the social body of which the individual was a member were understood first of all as theaters of divine activity. That understanding shaped the way those cultures cared for their sick. When a person became ill, she went for help not just to physicians but also to priests or shamans; often, in fact, these were the same people... For both the medical and religious leaders of the community were concerned not only with the biological phenomenon of the patient's illness but also with her place in the wider community and the integrity of her relationship to the deity.³

But eventually things changed. The natural sciences erupted and began making massive discoveries about medicine, biology, and the human body. As soon as religion was no longer the most effective resource for physical healing, the divide between healthcare and religious practice appeared. Medicine emerged as its own practice and slowly made its alliance with science, effectively rejecting its former connection to religion. This schism resulted in the very distinct religion and healthcare systems we know today. While the two systems are noticeably separate now, their shared heritage means that these two areas have never completely divorced. The practice of medicine must respond to religious institutions, religious practices, and religious doctrine. Conversely, religious bodies, religious followers, and even religious doctrine must face the presence of secular healthcare and the important role it plays in our lives.

Due to their previous connection, it is not surprising that religion and healthcare are still interacting and attempting to overcome their differences. Scholars are beginning to investigate their interactions in hopes of identifying the benefits that a partnership may

³ Shuman and Meador, *Heal Thyself*, 21.

hold. While research on the topic is still new and developing, studies are revealing the many ways that religion and healthcare can, and possibly should, work together.

Religion and Health

Studies being conducted today can be divided into a few broad types. First, there are a number of studies investigating a correlation between religiosity and physical health. These studies look at factors associated with religiosity, including prayer, rituals, lifestyle choices, and worldview. Other types of studies look at the success of integrating spirituality and religion into medicine. These studies track the positive or negative reactions of patients and healthcare practitioners to the idea of integrating spiritual care into traditional medical treatment. Finally, scholars are interested in the role that religious communities play in staying healthy. These studies struggle to capture large-scale statistics, so they often capitalize on case studies of individuals with strong community support.

Dr. Koenig, a leading scholar on religion and health, is particularly interested in the role that spirituality plays in health and healthcare today. He has dedicated most of his career to studying the role of religion in healthcare, founded Duke University's Center for the Study of Religion, Spirituality and Health, and is now Director of Duke's current Center for Spirituality, Theology and Health.⁴ Koenig reviews nearly all of the major findings on religion and healthcare in *The Handbook of Religion and Health*, a mammoth of data and statistics compiled from studies conducted throughout the country. This encyclopedia of studies provides a comprehensive look at the ways that religion does (or does not) directly affect physical and mental health. Note that these studies focus on how religion changes *health*, not yet including studies on *health care*. I will review here a few of the most

⁴ "Harold G. Koenig, MD," <http://www.spiritualityandhealth.duke.edu/about/hkoenig>.

accessible areas of these studies- how religion affects health behaviors and how religion affects mental health.

First and foremost, there is simply not substantial evidence to support that mere religious *beliefs* positively or negatively affect human physical health. Believing in one doctrine, having especially strong faith, or being more or less spiritual does not, according to scientific data, give people better or worse health. However, there are numerous studies suggesting that religious *behaviors* impact physical health, and I will review those connections here. Additionally, I include studies that suggest how religiosity and beliefs may affect mental health and overall happiness; and finally, I incorporate studies and stories about the relationship between a strong religious community and health. Many studies investigate if religion fosters good health behaviors such as good dietary habits, maintenance of low serum cholesterol levels, weight control, exercise, abstinence from cigarette smoking, safe sexual practice, safe driving, avoidance of risk-taking behaviors, and regular sleep habits. While not all studies can be reviewed here, there is a strong correlation between religiosity and many of these healthy behaviors.

One clear example of religion influencing health behaviors is that religions such as Orthodox Judaism and Seventh Day Adventism endorse particular diets that have positive effects on cholesterol levels and weight. However, not all religions necessarily endorse healthy eating. Studies show that mainstream religions in the U.S. actually have negative effects on diet by not providing advice for what or how much to eat. Additionally, the tradition of these religious groups to host gatherings that incorporate eating may be another reason why religion is sometimes harmful to dietary health. The good news here is that many churches and congregations are becoming aware of this problem and taking

action against it. Churches in the U.S. are beginning to sponsor church diet plans, which incorporate scripture and provide support and accountability. The programs are new, but they have been largely successful and are growing in popularity.⁵

Besides diet, other healthy behaviors are also correlated with religion. Cigarette smoking is inversely related to personal religiousness according to a multitude of studies. The studies identified that this is true across all age groups and all religious affiliations, however the inverse relationship is strongest in young adults and adolescents.⁶ Risky sexual behavior is also inversely related to religiosity. Young people are evidently more likely to refrain from premarital sex, having multiple partners, and having extramarital affairs for religious reasons than for any other reasons.⁷ These practices lessen the chances that they will contract sexually transmitted diseases or face unplanned pregnancy. Interestingly, additional studies show that religiously devout people are *more* likely to wear a seatbelt, maintain healthy sleep patterns, and generally live a less risky lifestyle.⁸ All of these health behaviors are apparently related to religiosity, showing that in many ways, religion has an overall positive effect on physical health.

Besides its effects on physical health, religion is also suspected of changing peoples' mental health. There are a variety of ways that religion shapes what we think, how we feel, and how we perceive the world around us. Scholars are interested in how religious worldviews actually impact mental health and happiness.

⁵ Harold G. Koenig, Michael E. McCullough, and David B. Larson, *Handbook of Religion and Health*, (Oxford: Oxford University Press, 2001), 365.

⁶ Koenig, McCullough, Larson, *Handbook*, 371.

⁷ Koenig, McCullough, Larson, *Handbook*, 380.

⁸ Koenig, McCullough, Larson, *Handbook*, 381.

Koenig overviews the many studies done on religion and what he terms “well-being.” According to Koenig, “well-being is the positive side of mental health,” synonymous with “happiness, joy, satisfaction, enjoyment, fulfillment, pleasure, contentment, and other indicators of a life full and complete.”⁹

Koenig’s description of “well-being” is not the same one I will suggest later, but the studies that he reviews are important indicators of religion’s health effects. In order to link religion and happiness, Koenig identifies external predictors of happiness and then investigates how religion may promote these factors. Koenig describes eight areas that predict happiness and are supported by religion: marital status, healthy living, activities, social support, optimism, hope, purpose and meaning in life, and internal locus of control.¹⁰

The first, marital status, does not require extensive explanation. Married people report higher levels of happiness than divorced, separated, and never married people, and marital satisfaction is one of the leading factors for happiness.¹¹ Most religions endorse being married, and even more importantly discourage being divorced or separated. To help couples stay together, religious communities often provide counseling and support. Studies have shown that regular religious attendees are more likely to have stable, intact families.¹² The second area that contributes to mental health is, not surprisingly, physical health. The ways that religion contributes to physical health have been discussed already, but it is worth noting here that religious involvement generally also reduces drug and alcohol use, two activities that are detrimental to physical health, mental health, and reported happiness.

⁹ Koenig, McCullough, Larson, *Handbook*, 97.

¹⁰ Koenig, McCullough, Larson, *Handbook*, 99-100.

¹¹ Koenig, McCullough, Larson, *Handbook*, 99.

¹² Koenig, McCullough, Larson, *Handbook*, 99.

Koenig also reports that being involved in “activities” is a predictor of happiness. While he admits that this is not strongly supported by studies, he believes that activities contribute to happiness, particularly in the elderly, and sees a clear connection between religion and activities.¹³ Bible studies, volunteer activities, pilgrimages, and social gatherings are just a few of the activities attributed to religious groups. Closely related to activities is the fourth predictor of happiness- social support. Religion provides this through the activities and rituals associated with the religious bodies and being united by common beliefs.

The final four predictors suggested by Koenig (optimism, hope, purpose and meaning in life, and internal locus of control), are notably more abstract than the first four. Koenig supports each suggestion with a study that connects religion, the factor in question, and happiness. One such study by Sethi and Seligman in 1993 and 1994 involved 623 people of different religions in the U.S. Based on the beliefs and practices of the religions, they labeled them as fundamentalist, moderate, or liberal. Through surveys, interviews, and observations, the scientists found that fundamentalists were significantly more optimistic than liberals, while moderates fell in between. They also identified more optimistic themes in fundamentalist religious materials (sermons, prayers, and songs) than in the other two groups. Their conclusion was that optimism stems from the amount of religious materials a person is exposed to as well as their level of religious involvement.¹⁴ The same team also found that the religiously devout are more hopeful than the non-religious or moderately religious.

¹³ Koenig, McCullough, Larson, *Handbook*, 98.

¹⁴ Koenig, McCullough, Larson, *Handbook*, 100.

Similarly, numerous studies (Koenig cites 13) show that religious involvement provides people with a sense of purpose and meaning in life.¹⁵ This connection is understandable as many religious doctrines teach that existence and life are not accidental, but rather intentional and even directional. Finally, Koenig argues that while it may seem easier to connect the belief in an omnipotent God to an *external* locus of control, religion actually supports a greater feeling of control *internally*. He suggests that having the ability to appeal to a merciful and active higher power enables the individual to feel more in control than if they must rely on other people in authority.¹⁶ Rather than feeling controlled by chance and the actions of strangers, religious people feel they have a clear and active role in determining their own fate.

Still, these factors for happiness are questionable because it is unclear if they actually contribute to happiness or just result from it. Perhaps happier people are simply more optimistic and feel more in control. Koenig addresses this problem by providing examples of studies that isolate the relationship between happiness and each separate factor. Unfortunately, without many clinical trials studying the addition of said factors, it is difficult to say with confidence that the relationship is causal in only one direction.

There have only been a small number of clinical trials of religion and happiness. One such “intervention study” investigated the effects of faith healing on blood pressure in 120 volunteers, but the researchers also measured well-being as an outcome variable. The study divided the participants into 3 groups. Group 1 received healing by laying on of hands, group 2 received healing from a distance by “thought projection,” and group 3 was the control group with no change. After 15 consecutive weeks of their alternative

¹⁵ Koenig, McCullough, Larson, *Handbook*, 100.

¹⁶ Koenig, McCullough, Larson, *Handbook*, 101.

treatments, results showed that 80% of group 1 reported improved well-being, compared to 43% and 41% in groups 2 and 3 respectively.¹⁷

Besides the clinical trials investigating the effect of religion on happiness, there has also been recent research on the biological effect that religious values have on mental health. Although it would be unfair to generalize about all religions, it is accurate that most religions promote an attitude of selflessness by connecting humans with something in a “higher” realm.

Dr. Gregory S. Berns of Emory University has been pioneering research on the effects of altruism and selflessness on mental health. Dr. Berns employs magnetic resonance imaging (MRI) to track the differences in brain activity between people exhibiting either greedy or cooperative behavior. Volunteers in one experiment played the standard psychological game called the prisoner’s dilemma, in which they received different cash rewards for either cooperative (selfless) or greedy (self-serving) responses. Dr. Berns discovered surprising connections from this study.

The MRI scans of players in Dr. Berns’ study showed that when they exhibited selfless behavior instead of being self-serving, the areas of their brains known to respond to pleasure glowed brightly on the screens, indicating they had been activated. The study showed that the precise portions of the brains active during cooperative behavior were rich in neurons responsive to dopamine, the chemical associated with pleasure. In other words, the researchers’ MRI scans were actually revealing the helper’s high in real time.¹⁸

¹⁷ Koenig, McCullough, Larson, *Handbook*, 116.

¹⁸ Douglas M. Lawson and Harold G. Koenig, *Faith in the Future: Healthcare, Aging, and the Role of Religion*, (London: Templeton Foundation Press, 2004), 129.

Dr. Bern's study shows that there is a biological connection between being altruistic and feeling happy.

The Emory study supports that there is an important connection between selflessness and mental health, but researchers at other institutions have taken the research even further and have been investigating the connections between altruism and physical health. Studies at UCLA found that a positive attitude, defined as feeling optimistic and altruistic, can open pathways between the mind and the body that strengthen the immune system.¹⁹ Other studies suggest that compassionate acts and an altruistic outlook increase the amount of immunoglobulin-A, a powerful defense against infection in the body. The scholars making these discoveries promote volunteering, healthy personal relationships, and positive emotional attitudes to bolster the immune system and improve overall health. The same scholars cite case studies of people volunteering and serving others who are well into their nineties and beyond. While this data does not prove that these individuals are healthy because they continue to volunteer, the correlation certainly exists. Scholars also point out that many elderly people who continue to volunteer exhibit a remarkable level of mental aptitude and life satisfaction.

Utilizing Religion in Health Care

Besides the studies showing religion's effects on overall happiness and mental well-being, there is also evidence that religion plays a strong role in helping us cope with our physical illnesses. This data suggests that religion does more than provide stability for our daily mental health; it may help us combat the acute mental health risks that accompany medical hardships.

¹⁹ Lawson and Koenig, *Faith in the Future*, 131.

According to Dr. Koenig, religious coping is a common method for persons with chronic illnesses, terminal illnesses, and permanent disabilities.²⁰ Throughout studies on specific population groups and types of medical diagnoses, religion was listed as a major device used for coping. While discussing the overall findings of studies on this topic, Koenig reports that,

Between one third and one half of patients report that religion is the most important strategy used to cope with the stress of medical illness and health problems. Religious beliefs and behaviors are particularly important for coping among African American, the elderly, and women. Religious coping appears to increase as the severity of the medical condition and the level of distress increase, perhaps as people turn to religion for comfort as their health becomes less and less under their control.²¹

These statistics support that religion is already naturally included in the healthcare setting. When people walk into a doctor's office, they bring their religious beliefs and practices with them. Whether healthcare intentionally engages with religion or not, people will continue to relate them when they face health crises. Since people already utilize religion to cope with illness, some professionals have begun combining religion with secular healthcare tactics in order to better relate to their patients. One method of incorporating religion and healthcare is to counsel them using the religious terms and practices. This technique, dubbed pastoral counseling, is one active way that religion and healthcare can work together to treat mental health concerns.

Pastoral counseling is a relatively new practice that incorporates spiritual care into secular psychotherapy methods. Pastoral counseling has always been a function of clergy and religious leaders, but it was formally systematized for practice beginning in the early 20th Century. Although there are now professional pastoral counselors who are not

²⁰ Koenig, McCullough, Larson, *Handbook*, 94.

²¹ Koenig, McCullough, Larson, *Handbook*, 94.

technically religious leaders, most pastoral counseling still occurs under the pretense of “regular” pastoral care. Some estimates calculate that religious professionals who work at a church, synagogue, or other house of worship spend a cumulative 150 million hours providing mental health services each year. This number, already staggering, does not include some 100,00 full-time nuns and chaplains who are also providing this care.²²

Although priests, rabbis, and pastors are likely given some training in formal counseling, they are not educated as mental health counselors and are unqualified to serve in such a capacity. The separation between religious care and mental health care results in spiritual leaders who are unable to address the needs of their congregations and mental health counselors who cannot address the spiritual and religious aspects of their patients’ lives. While specific training in pastoral counseling is becoming more available, the field of pastoral counseling is still a controversial combination of religion and psychology. Just as spiritual care within medical practice is contested, incorporating religious thought into the secular areas of psychotherapy and psychology is highly contentious.

Indeed, many influential psychologists and psychiatrists believe that religion is actually harmful to the psyche and therefore bad for the patient’s health. Sigmund Freud, the father of psychotherapy, famously criticized religion as a system that maintains delusional beliefs and unhealthy complexes. In his books *Totem and Taboo* (1913), *Future of an Illusion* (1927), and *Moses and Monotheism* (1939), Freud dissects religious beliefs and practices in order to illustrate how they cause harmful psychological attitudes. Freud’s views, while extreme, nevertheless had a great affect on the use (or rather neglect) of religious thought within mental health practices.

²² Koenig, McCullough, Larson, *Handbook*, 55.

Freud's theories and the subsequent bias against religion within psychotherapy are unfortunate because they served to deepen the divide between the religious and healthcare sectors. While the long-standing separation is regrettable, we have seen it shrink as fields like pastoral counseling emerge. The success of pastoral counseling suggests that the inclusion of religion into therapy (when the patient welcomes it) is effective and necessary. Besides the positive effect that religion has had on mental health, there is also evidence that including religious discussion in medical care can improve the doctor-patient relationship.

There is a growing concern for how healthcare practitioners react to their patients' religious concerns. Clearly a doctor's knowledge of and sympathy for her patient's spiritual concerns can greatly impact the patient's perceived level of care. Additionally, healthcare professionals' reaction to religious questions has a large effect on the potential for cooperation between the two sectors. In addition to the views of professionals, it is also important to consider how patients feel about incorporating their spiritual concerns with their medical needs. If every doctor were open to discussing spiritual concerns but every patient felt uncomfortable discussing them, then clearly a conversation would be inappropriate. Fortunately, scholars have collected data on this very question.

Dr. Koenig provides survey results about how each group feels regarding the inclusion of religion and medicine. According to Dr. Koenig's results, most Americans feel comfortable with doctors talking about spirituality when it is appropriate. One study in 1996 polled 1000 people in the USA and found that almost two thirds of respondents felt that it is good for doctors to talk to patients about spiritual faith (60% of persons ages 18-34 and 67% of those ages 55-64).²³ Although 63% were in favor of doctors talking to them

²³ Koenig, McCullough, Larson, *Handbook*, 94.

about their spiritual faith as a factor of physical health, only 10% indicated that their doctors had ever done so.²⁴

The response of healthcare professionals reflects similar attitudes. Only 31% of physicians believed that the religious needs of the older patient should be entirely left up to clergy.²⁵ This indicates that most medical professionals are open to incorporating their patients spiritual concerns. It is not surprising, then, that around one-third (37%) of physicians reported praying with patients at least once. Out of the physicians who reported praying with patients, 89% indicated that they believed this had helped their patient.²⁶

Besides the response of individual physicians being generally positive, it seems that the broader healthcare community also feels that spirituality is an important topic. This trend can be seen in healthcare training institutions as well as medical associations. Medical schools across the U.S. are quickly adding classes about spirituality and medicine. While there were only three classes offered on this topic in 1992, today nearly two-thirds of America's 126 medical schools teach required or elective courses on the subject.²⁷ The topic is so important that the John Templeton Foundation has decided to stimulate the addition of these classes by issuing a Templeton Curricular Award in Spirituality and Medicine. Additionally, the Association of American Medical Colleges added a spirituality component to its "Medical School Objectives Report III," the standard by which medical schools shape their curriculum.²⁸ This report recommended that medical students should

²⁴ Koenig, McCullough, Larson, *Handbook*, 94.

²⁵ Koenig, McCullough, Larson, *Handbook*, 94.

²⁶ Koenig, McCullough, Larson, *Handbook*, 94.

²⁷ Lawson and Koenig, *Faith in the Future*, 103.

²⁸ Lawson and Koenig, *Faith in the Future*, 104.

seek an understanding of their patients' religious and spiritual background as a means to provide more compassionate care and to increase understanding and respect for clergy and faith-based practices. These trends show that spirituality is being introduced to the practice of medicine, and, more importantly, that the reception from healthcare professionals has been largely welcoming.

Hindering Cooperation

Despite the recent inclusion efforts from the medical sector and the number of positive effects we have evidence of, many people still think of religion and healthcare as strange bedfellows. Since their division into two distinct sectors, the relationship between religion and healthcare has been filled with disagreement and conflict. These disagreements usually result when religion dictates health care for individuals and sometimes limits care options for patients. Cases of religion impinging on healthcare options are plentiful. Some of the most well known cases involve Jehovah's Witnesses refusing blood transfusions or Christian Scientists choosing to pray for healing instead of choosing modern medical care. While these cases are the most widely recognized, there are a variety of other circumstances where religion hinders, or at least dictates, health care choices.

Examples of religion interfering with health care include Muslims refusing insulin that is pork or beef based, sometimes leading them to refuse treatment outright; traditional Eastern cultures relying on teas, herbs, acupuncture, and other alternative treatments instead of contemporary western methods; and even some fundamentalist and other denominational Christians who delay or deny care in the hope that prayer and spiritual

healing will be adequate.²⁹ Besides these cases of refusing modern medicine to treat illness, there are also numerous examples of religious doctrine dictating preventative medicine or practices. These cases include the Catholic Church's disapproval of birth control, the Church of Christian Science's forbidding of immunizations, and a widespread religious condemnation of abortion.

While religious decisions to refuse healthcare are difficult to understand and, particularly for healthcare professionals, sometimes hard to respect, refusing healthcare on religious ground becomes especially sensitive and complex when the decision is made on behalf of children. In her book *When Parents Say No*, Luanne Linnard-Palmer examines the issue from both religious and healthcare perspectives. As a pediatric nurse, religious follower, and scholar, Palmer draws on her own experiences to explore the issue of religiously grounded pediatric care. She incorporates an overview of the legislation on the topic, responses from nurses, doctors, and clergy, and religious doctrine to explain why these cases are especially sensitive.

For pediatric care, most state laws protect the safety of the child over the religious views of their parents. This means that when a parent wants to deny medical care for a child, the state is able to take temporary guardianship of the child and mandate the care. Refusing to treat a child can be considered a type of child abuse or neglect, and in 48 states parents can be charged if they choose not to treat their children.³⁰ However, in the case of

²⁹ Luanne Linnard-Palmer, *When Parents Say No: Religious and Cultural Influences on Pediatric Healthcare Treatment*, (Indianapolis: Sigma Theta Thau International, 2006), 9-10, 87.

³⁰ Linnard-Palmer, *Parents*, 36.

preventative care, state laws trend the other way, with 48 of them allowing religious exceptions to mandatory immunizations.³¹

According to Linnard-Palmer, parents' responses to the state's actions vary. As can be expected, many are defensive, angry, offended, and non-compliant when they feel their beliefs are being violated. For some, the care that their child receives, while life-saving, may be condemning them in the afterlife or making them unclean before God. This tension understandably makes many parents distraught about the decision. However, for some, the action of the state is a relief. While making the decision to give the child a potentially sinful treatment would make the parents culpable, they find that when the decision is taken out of their hands they are no longer guilty. The desired outcome for these parents is not that their child die or suffer, but rather that they maintain a life that is consistent with their beliefs; so when the state mandates care, they do not violate their own beliefs nor lose their child.

Cases of religion dictating health care, especially in the case of children, are very controversial. For obvious reasons these scenarios leave a bitter taste in both medical professionals and religious followers. The clash of ideals points to a lasting tension that lies between the two sectors and helps explain why people do not think of religion and health care as compatible types of care.

Thus far I have reviewed a variety of facts and findings about the relationship between religion and healthcare. On the positive side, scholars believe that religion and religiosity are generally beneficial to physical health and mental well-being. Religion has been shown to improve mental health by promoting positive mentalities and providing a

³¹ Linnard-Palmer, *Parents*, 45.

coping mechanism for sudden illness. Additionally, patients and doctors are open to incorporating spiritual and physical care and recognize the positive effect it has on the doctor-patient relationship. Finally, professions like pastoral counseling have been successful at bridging the divide between spiritual and secular care, but not without some criticism. Besides looking at the positive interactions between the fields, I also reviewed many of the ways they continue to clash. Psychologists and mental health professionals have historically degraded religion, and religion's most noted role in healthcare has been to prevent people from receiving medical care. These findings leave us questioning still. Can healthcare and religion really play nice? If so, why do we continue to separate them in practice?

Part II: The Aim of Healthcare

"The physician should look upon the patient as a besieged city and try to rescue him with every means that art and science place at his command." ~Alexander of Tralle

To continue this investigation and better understand how religion and healthcare interact, it is helpful to look at the theoretical underpinnings of medicine. Understanding the goal of medicine will hopefully uncover why healthcare excludes spiritual and even mental concerns. We scrutinize healthcare professionals for efficiency, safety, and correctness, but we rarely question what these professionals are actually trying to accomplish.

The methodology and values of Western healthcare are usually traced back to the Greek physician Hippocrates, who wrote the famous Hippocratic oath. The Hippocratic oath has been adapted to reflect the issues in modern times, but most of the principles found in the original document still shape the new versions. The classic Hippocratic oath

requires a number of promises from physicians. Perhaps the most famous one is the statement that “I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.”³² Along with this famous pledge to “do no harm,” the oath ensures that physicians do not abuse their authority, respect the privacy of their patients, and treat all patients with equal care and attention.

The Hippocratic oath has served as the guidepost for most bioethics, but it also points out key differences between healthcare in the past and healthcare today. Whereas the Hippocratic School of medicine focused on prognosis and individual patient care, medicine today operates using a diagnostic method.³³ This means that the aim of health care was previously to address the various needs of each patient, but now the goal is to categorize and classify the patient’s ailments.

The values and methods once advocated by Hippocrates no longer reign in medical practice. Today we have a diagnostic medical system that focuses on classifying the problem instead of treating the needs of the whole patient. Reviewing the many reasons for the departure away from prognostic medicine are not important to this discussion, but it is critical to recognize that the blame cannot be placed wholly on the medical system. Many of the misguided aims within the healthcare system have developed to reflect the ethos of our society. We have created the system that now fails us, and we must acknowledge the role we play. Scholars offer a variety of theories for why and how society has shaped the current

³² Peter Tyson, “The Hippocratic Oath Today,” *PBS*, March 27, 2001, <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>

³³ Ogan Gurel, “What’s More important in Medicine: Diagnostics, therapeutics, or prognosis?” *Medic Exchange*, November 29, 1999, <http://www.medicexchange.com/Radiology-Articles/whats-more-important-in-medicine-diagnostics-therapeutics-or-prognosis.html>.

medical model. All the scholars reviewed here also provide a response to this dilemma, but first let's examine the ways that they see healthcare adapting to cultural demands.

First and foremost, scholars agree that healthcare is aimed at meeting society's demands. Our mentality and ethos about health is reflected in the care we receive. Just like any other industry, the product offered by the healthcare sector is going to cater to the potential consumer. This points to the first problem that scholars identify. Healthcare has become a good for sale. Doctors can no longer focus on providing the best possible care for patients because they have to worry about making a profit, paying for malpractice insurance, and not stepping outside of any regulations. As one cynical physician put it, "There are really only two diagnoses to choose from: reimbursable or non-reimbursable."

The problems with the economic model of healthcare are vast and are outside the scope of this project, but without too much exploration we can see how this ethos damages the care that patients receive. Because the healthcare industry is only concerned with turning a profit, it is really the consumer that suffers. As scholar Paul Simmons points out, "to commodify health care is to objectify the person... It becomes an economic transaction, but health care is different because it has to do with health and well-being."³⁴ Whereas other economic industries are selling a product that we may or may not need, health is not a luxury good. Simmons continues by saying, "loss of health is a threat to the person's capacity to pursue values and goals essential to life and its meanings."³⁵ While I do not want to idealize the notion of "perfect" health, the implications of making health care a profit-driven practice are nonetheless grave.

³⁴ Paul Simmons, *Faith and Health: Religion, Spirituality, and Public Policy*, (Macon, Georgia: Mercer University Press, 2008), 79.

³⁵ Simmons, *Faith and Health*, 79.

The purpose of healthcare should not be to make gains from the individual, but, again, placing the blame fully on the industry is forgetting that they are catering to a specific audience- us. The health care system is able to survive as a profitable industry because it feeds off of our fundamental fears of aging, dependency, and mortality. These three things shape our perception of health and drive our insatiable appetite for medical care at nearly any cost.

Our society's fear of aging is seen in our approach to health care and our endless attempts to maintain youth. We spend millions each year on beauty products, spa treatments, cosmetic surgeries, and gym memberships just to prove that we are not growing old. The respect and reverence that we formerly held for our elders has been replaced with a stigma. We now believe that growing old means getting physically weaker, mentally slower, and generally smellier. Older people are seen as a burden to care for and a financial liability. We act on these ageist beliefs by hiding our elders in facilities and hoping they become someone else's problem.

Much of our hatred of aging is born out of a fear of dependency. Being wholly dependent on others is seen as a failure in our capitalist, Western society. The American ideal is an independent, hardworking individual who is self-sufficient and relies on his own merit. We glorify strength and vilify weakness, making the weakest among us also seem like the worst. We confuse strength and capability with dignity, often assuming that becoming dependent warrants less respect. Since our dependence on others naturally increases as we age, we fervidly strive to avoid both old age and dependency.

Simmons summarizes our fear of aging and dependency by stating that human beings have a unique ability to "reflect upon the past, contemplate the present, and

anticipate the future.” He says that, “Only people can alter circumstances and thus change outcomes. In this is human dignity.”³⁶ Dignity is what grants us autonomy, and dignity is what we think we lose when we age and become dependent on others. It is no mystery, then, why we rely on health care to counteract the effects of aging and thwart the dependency we fear.

But preventing the effects of old age is not the only, or even the most prevalent, demand on health care. The overriding goal of health care, which addresses our most deeply seeded fear, is to prolong life and prevent death. Humans have always been fixated on death and how to avoid it. We want to maintain our lives as long as possible and we are willing to put ourselves through extraordinary measures to do so. In fact, not wanting to prolong life is viewed as perverse, irrational, and unnatural.

This fear and its impact on healthcare are noted by a number of scholars. Brent Waters, a theologian particularly interested in American healthcare, writes extensively about our obsession with our own mortality. Waters argues that this obsession drives the healthcare system, fuels our need for more extreme and expensive medicine, and creates unreal expectations for what health care can provide.

Waters asks, “When we become fixated on mortality, is it not a natural reaction to find some way to fight against, overcome, or otherwise cheat this cruel fate? ... May we not say that our current fascination with employing medicine to extend longevity reflects a similar obsession with mortality?”³⁷ He continues by explaining the problem with this quest. “Ironically, our success in extending longevity has fixed our attention more

³⁶ Simmons, *Faith and Health*, 95.

³⁷ Brent Waters, *This Mortal Flesh: Incarnation and Bioethics*, (Grand Rapids: Brazos Press, 2009), 134.

relentlessly upon death. “³⁸ Waters points out that a culture obsessed with cheating death creates an ethos of fear and elevates health care to an almost demi-god status.

Waters is not the only scholar who challenges our obsession with mortality.

Theologians Shuman and Meador also find great fault with the American healthcare system and the mentality it represents. They make a similar argument about the purpose of modern health care being only to extend life at all costs.

Increasingly, we see a long, vigorous life as our inalienable birthright and medicine as the protector of that right. ‘Hardly anyone,’ says Daniel Callahan, ‘speaks openly of immortality as the aim [of medicine], but that is beside the point, it is built into the research imperative.’ Medicine’s research imperative, he suggests, holds that: ‘Death is a series of preventable diseases.’ From this perspective, the researcher is like a sharpshooter who will pick off the enemy one by one: cancer, then heart disease, then diabetes, then AIDS, then Alzheimer’s disease, and so on.³⁹

But Shuman and Meador do not merely recognize that fending off mortality drives the consumer and the producer of health care; they also make a case for why this mentality is problematic.

Our society’s fantastic expenditures on healthcare and inordinate attention to the extension of life span and vigor are signs that we have lost our way and that we are in ways more significant than we can imagine, a culture seriously diseased. Nevertheless, we turn to medicine more than ever, with the hope that it can unravel and solve for us the deepest mysteries of what we believe are our all too mortal bodies.⁴⁰

Taken together, these scholars suggest that our culture holds a strong bias against aging, accentuated by our negative beliefs about dependency, and emphasized by our fear of dying. These mentalities foster a healthcare system to fit. We turn to medicine to help us feel young, help us avoid feeling weak, and help us stay alive for as long as possible. We are so invested in these ideals that we feed the system we hate. Although the healthcare system

³⁸ Waters, *This Mortal Flesh*, 134.

³⁹ Shuman and Meador, *Heal Thyself*, 10.

⁴⁰ Shuman and Meador, *Heal Thyself*, 20.

leaves us feeling like a consumer instead of a person, often fails to make us “better,” and does not respond to our diverse human needs, we endorse the structure and comply with its every request. Instead of demanding or even suggesting a change, we continue promoting modern medicine as the only method for fighting against mortality and improving our narrowly defined idea of “health.”

Conclusion: A Treatment Plan For Getting Well

“The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated.” ~Plato

The problems with our healthcare seem overwhelming. The system no longer functions to serve the people, yet the people maintain the system as it stands. The problem is complex and by no means easily solved. While it was never my objective to suggest a solution to the massive healthcare problem, my original aim of investigating religion and healthcare does inform some potentially beneficial changes.

Recall from the first section that religion and healthcare were previously synonymous, but their relationship eroded into two very distinct fields. Despite their separation, research shows that religion still largely affects health and healthcare. Religion changes how people maintain their physical and mental health, how they approach illness and cope with mortality, and how they decide on their own medical care. Despite these uses, religion is rarely included in modern medical practice and healthcare is equally excluded from most religious dialogue. Sadly, this formal divide may actually be detrimental to both sides. Evidence supports that incorporating aspects of religion when it is appropriate would be beneficial to health care, that patients are in favor the inclusion,

and that practitioners are open to this change. Furthermore, using some religious teachings and doctrines can help us steer away from the harmful mentalities that we hold about aging, dependency, and mortality.

What I propose is a change in our approach to healthcare, the way we define it, seek it out, and prescribe it in our lives. Instead of focusing our attention on physical health, I believe we should instead be striving for a sense of well-being. Unlike the way Koenig uses well-being to mean a mental state similar to happiness, I see well-being as a holistic descriptor. Well-being should encapsulate being physically healthy, mentally healthy, and spiritually healthy on equal footing. While each deserves attention, none should supersede or overrule the others. Physical health decisions should only be made after considering the potential effects on mental and spiritual health as well. Spiritual perspectives should inform how we treat our bodies, care for our minds, and prepare for death. And finally, mental health should be a priority for both health care professionals and religious leaders. Well-being implies not only addressing physical and emotional pain, but also attempting to overcome human suffering as well.

The first area where religion becomes instrumental in maintaining well-being is in the traditional healthcare setting. I do not expect doctors to be trained as theologians and I would never advise them to ask each patient about their religious beliefs before prescribing a treatment. However, professionals in health care should be cognizant of their patient's holistic concerns. A person diagnosed with cancer is not just worried about their body failing; they are also thinking about their family, the side-effects of treatments, their finances, and how to tell their friends. Many people turn to religion to cope with these challenges, even if they were previously not religious. For a doctor to ignore these concerns

and exclude the patient's coping method is for them to lose an element of humanity that should be ever-present in healthcare.

Daniel Callahan, a medical Ethicist at Harvard Medical School, provides a dynamic solution for this massive problem. He points out that, "in the current clinical paradigm, money and prestige accrue to those who cure patients," but there will never be a cure for everything; death will always conquer our human bodies.⁴¹ Callahan calls for reform to the current healthcare model, arguing that the growing number of elderly patients "will be ill-served by a healthcare system that puts curing first and often discounts the concept of emotionally supportive care."⁴² According to Callahan, adequate care would need to include the patient's spiritual requirements. Callahan has developed a hierarchy of curative and caring priorities for medical practitioners, summarized as follows:

1. Maximizing mental and physical function.
2. Preventing dependency and pursuing autonomy.
3. Relieving pain and suffering.
4. Enhancing a sense of physical and psychological security.
5. Realizing psychological and spiritual needs.⁴³

The goal of Callahan's list is to transfer the focus away from curing and onto caring for elderly and terminal patients. While it is unreasonable to expect physicians to fill this role, effective spiritual care is achievable with chaplain and volunteer support. Scholars Lawson and Koenig cite many examples of congregations that provide support to their aging members, as well as examples of healthcare and elderly residential facilities that prioritize this care. They argue that while the sole aim of healthcare professionals is most

⁴¹ Lawson and Koenig, *Faith in the Future*, 153.

⁴² Lawson and Koenig, *Faith in the Future*, 154.

⁴³ Lawson and Koenig, *Faith in the Future*, 153-154.

often to cure illnesses and fight the effects of aging, they should be incorporating a concern for patients' emotional and spiritual health as well.

Practically speaking, health care professionals can start by asking patients how they plan to cope with their health issues. If necessary, doctors and nurses should make referrals to mental health professionals, pastoral counselors, or chaplains. But before medical professionals can make these referrals, the resources must be in place and readily available. The need for such programs points to another area that will benefit from a focus on well-being: religious bodies and communities.

The large divide between religion and healthcare is regrettable, but the health care system is not the only side at fault. Religious bodies have historically made little effort to endorse preventative medicine, offer healthcare guidance, or cooperate with medical initiatives that appear religiously controversial. Religious organizations, particularly those that involve the largest number of Americans, should develop an official stance that incorporates religious doctrine and practical healthcare application. Programs should exist that teach the importance of good nutrition and healthy living, help the elderly navigate the intricate healthcare and Medicare systems, and assist members as they make difficult ethical decisions about treatments and end of life care. While it may seem like I am advocating for every church to function as a spiritual-medical clinic, what I am really proposing is to create a religious culture of awareness and acceptance toward medical discourse. By being aware of the medical challenges that congregants face, churches and religious bodies can impact lives more deeply and ultimately foster a greater sense of well-being.

Finally, the third space that will benefit by focusing on well-being is our society at large. Religion can act as a powerful force in efforts to change the mentalities that plague us and severely confuse the medical model. Our cultural ageism and obsession with preventing death have created a healthcare system that exists exclusively to address those issues. While getting older, being dependent on others, and eventually dying are inevitable for all people, we cannot continue to rely on medicine to assuage our fears. Not only is medicine unable to save us or prevent all illness, expecting these results can hinder the greater successes possible through modern medicine.

Religion, on the other hand, provides a response to these large fears. The majority of religions provide guidance for life on earth as well as theories for what happens after death. It is human nature to fear death, and suggesting that religion erases that fear would be inaccurate. However, religion can and often does provide people with a hope for life and a satisfying outlook on mortality.

As an example of how religion can soothe these concerns, we can look at the common religious belief in continued life after physical death. This doctrine, which is found in various forms throughout the major world religions, helps people approach death without the paralyzing fear of the unknown. Because of their belief in the continuation of life, religious followers often encounter physical death without the trauma that others feel. As Brent Waters eloquently demonstrates from a Christian standpoint, believing in eternal life undermines the fear that aging, dependency, and mortality once maintained.

Death is faced, then, as a powerful but already defeated enemy... This is not an easy moral and religious stance to take, for death is real and cannot be cheated. Jesus did not avoid death, and neither will his followers. Death remains an enemy that should never be warmly embraced, but it should be struggled against on God's terms and not ours. This is why regarding aging as a disease that can be treated, and perhaps cured, is not only futile, but also misdirected. Waging a war against aging and death is misguided because there is

noting inherently unnatural, irrational, inconvenient, tragic, or unjust that humans grow old and die. Aging is simply not a disease, but a sign of our status as finite creatures.⁴⁴

This project set out to outline the current relationship between religion and health care, to examine the ways they benefit each other, and to expose the areas where they clash. Using this information and the work of other scholars, I have proposed that the divisions between spiritual care, mental health care, and medical care should be replaced by a unifying ethos toward total well-being. By aiming for well-being instead of a more narrowed goal, patients will receive more comprehensive and effective health care, congregants will be better equipped for the inevitable failures of their physical bodies, and our culture will better accommodate the aging population and all dependent persons. Religion and healthcare have had a long and turbulent relationship, resulting in much distrust and enduring apprehension. Despite their differences, the research presented in this project supports that striving for well-being is a goal that can only be accomplished when religion and healthcare work together.

⁴⁴ Waters, *This Mortal Flesh*, 141.

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