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Religion and the Practice of Medicine

Religious Congregations as Factors in Health Outcomes

by Rev. Gary R. Gunderson, MDiv

As other articles in this issue of the *Journal* indicate, religion is frequently an important component of the physician's self-understanding as they share defining moments both tragic and happy in the lives of people in their community. Apart from their private religious experience, how should religion be a component in one's practice of medicine?

It is increasingly well-documented that religious practices have as strong a correlation to positive health outcomes as smoking or poverty does to negative ones.[1] A stream of articles and books in a wide range of disciplines points toward the religious phenomenon as a factor in health. The exact pathways remain unclear as do the full implications the knowledge may have on the daily practice of physicians and other health leaders.[2] In recent years many diverse disciplines have explored the personal health implications of spirituality.[3] However, a review of the literature quickly indicates that much of the focus has been on how religion functions at the individual level reflecting the medical orientation of the question: what is happening to my patient? This tends to miss the most obvious aspect of religious experience, which is that it happens mostly in meetings and usually in ongoing social structures we know as congregations. No major religious tradition suggests it is possible or even desirable for a solitary human being to carry on a healthy life, much less one properly oriented to ultimate things. The focus on the healing effect of private spirituality also misses the most significant health impact, which is found in religion's role in prevention and health promotion.

Health experts looking for opportunities to affect the health of the public observe that a very large fraction of the actual causes of death are linked to behavioral choices in diet, exercise, dangerous substances such as alcohol or tobacco.[4] Some call these "diseases of meaning," including depression, certain accidents, substance abuse and violence.[5]

The health effects of religion are best understood by looking to the nature of the congregation and the experience of participation in it. From the perspective of one responsible for encouraging the health of a patient or a community, the point of effective engagement is the congregation. When the *Healthy People 2000* goals were presented to the nation a companion document was offered by The Carter Center and the Park Ridge Center, *"Healthy People 2000: A Role for America's Religious Communities."*[6] The document suggested a number of actions congregations could take that could contribute to the measurable improvement of the health of their communities.

It would be disingenuous to ignore the fact that religious organizations often make a negative contribution to their community when they make open discussion of health phenomenon difficult or dangerous. Teen sexuality, violence, substance dependency and stigma associated with mental illness often demand prevention strategies that are complex and controversial. Simplistic ideological arguments prevent the dialogue that is so necessary for a community to adapt to new data and explore answers to its most pressing problems. Religious rhetoric can be a public health risk factor if it lays a religious haze over reality. Religion can also provide the courage, hope and compassion to push though the fog. In every one of the most controversial areas one also find religious coalitions working with health experts to explore for answers.

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It is only recently that scholars have looked carefully and critically at the religious congregation, the landmark of which is the 1994 publication of the two-volume study, *"American Congregations."*[7] Only last November at an internal forum at the Centers for Disease Control and Prevention examining the scientific basis for collaboration with faith groups was this field of scholarship introduced to health strategists.[8]

The scholarship recognizes that for most of the last 300 years the level of participation in U.S. congregations has hovered in the neighborhood of 30-35% of the citizenry. Today the roughly 350,000 U.S. congregations represent the single most common and consistent form of voluntary association in the national experience. U.S. congregations of nearly all theological persuasions show a similar social form marked by a high level dependence on lay leadership and tendency to provide far more than purely "devotional" services.[9]

Although few congregations would describe themselves as health organizations, members do consider health events as religious matters. A vast majority of prayer requests concern personal health issues including crises and chronic conditions. Many religious rituals have been developed to mark health events, birth, death, puberty and healing as well as other life passages with enormous health consequences such as marriage and divorce. Parkland Hospital in Dallas now asks Hispanic priests to bless not only the infant, but the new car seat during the traditional christening ceremony. Usage and the attendant drop in infant injuries is dramatically lower among the, literally, blessed seats.

Much of the mundane organizational work within a congregation is designed to keep people connected to each other as they pass through these health crises or engage long term chronic conditions. As relational technologies have evolved from sidewalks

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to cars to phone to the Internet, the congregation adapts to opportunities to make sure that people are not left to themselves to experience or interpret their life passages alone.[10] This experience of connection has profound health implications for the one experiencing diminishment, and for the ones accompanying them. Wendy Lustbader, a Seattle social worker, suggests that one's expectation of being cared for rests largely on whether one has cared for others, thus experiencing the reality of compassion and connection.[11] A congregation offers opportunities to develop and trust such patterns so that illness or weakness is not seen as isolation.

Congregations have enduring strengths that help someone to find meaning and belonging. They don't just *describe* these assets, but actively nurture them by providing roles, mentors, and opportunities to practice what it promoted.[12] The Interfaith Health Program analyzes the role of congregations in shaping healthy communities in terms of eight capacities that can be systematically built on: the strength to accompany, convene, connect, frame meaning, bless, pray, provide physical sanctuary and endure.[13] These capacities offer a framework for strategic planning by congregational leaders and their partners in other community organizations.

It is common to talk about improving health outcomes by "moving upstream" to engage the determinants of health. From a health perspective it may be more accurate to talk about moving *underground*. The better image is the aquifer, the existence and quality of which is invisible, but yet directly related to the survival of the economy and all life. If the aquifer is poisoned or depleted, everything dies. My own religious tradition looks to Isaiah and learns that when one is in right relationship to God it will affect how one relates to the poor, to one's family, to the whole city. If one lives in right relation to these, health and wholeness will result and one will be known as "a spring that never fails." Of course it is beyond the intellectual capacity or life span of any human to create an aquifer, which is just the kind of point one might expect from a religious person. Health depends on things we do not create.

Why does one person respond well and quickly from a health crisis and the next, apparently similar person succumbs or lives on diminished and bitter? Why does one community thrive while the next experiences a epidemic of the diseases of meaning: violence, substance abuse, mental issues, teen pregnancy and so on? In recent years, driven partly by the new understanding of the function of the immune system, a new paradigm presents health as dependent on flexibility, adaptivity and resilience, rather than the capacity to resist, repel and

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remain inviolate.[14] This implies a new focus on health as the functional capacity to play one's (always-changing) role in family, neighborhood, church.

The new paradigm explains some of the richness of the deep dialogue between health and faith practitioners.

People bring with them and continue to live an odd amalgam of astrology, various streams of Christian, Greek and Asian, each stirred into a modern stew of ideas and behaviors. It is unlikely that a physician or other health professional will have the time or expertise to explore their patients' religious experience in any depth. However, it is possible and often critical to gain some understanding of whether the person has any access to the strengths of a particular congregation. This can indicate whether they are likely to be alone in their dependency, or supported in the plethora of tangible ways from food to advice to loaned equipment to rides and reminders to keep medical appointments. The nature of the congregational experience is also likely to be a clue of what the illness means to the patient and what implicit roles they may feel they will play. If one assumes the role of a fatalistic victim of a capricious universe it unlikely that any pill the physician has is likely to work very well. The mediating structure between the universe and the person is the congregation, the fellowship with which most people explore the relationship between finite and ultimate things.

How does a health professional engage the religious aspects of their patients and their community? An unsurprising suggestion from a religious person such as myself is to begin with *humility*. The growing recognition that health issues involve spiritual and religious factors moves those on both sides of the convergence toward partnership. The key is to build on the durable strengths of the congregations, the social units that are in and accessible to their communities. A recent report of the Interfaith Health Program called "Strong Partners" recommends "aligning the strengths" of health, religious and community factors. There is no lack of models that are ready to be adapted to one's specific social environment. Hundreds of people every day visit the Interfaith Health Program website (www.IHPNET.org) to find promising models and to ask questions. Organizations that can provide specialized training for professionals and volunteers are plentiful and accessible. In practice, most health and faith projects are interdisciplinary, interfaith, and intersectional collaborations. In Atlanta, IHP built on an existing Baptist Community Center with a rich diversity of interfaith congregations, Emory University School of Nursing, a Catholic Hospital and the county health department.[15]

The Interfaith Health Program sees the broad convergence of health and faith sectors as a movement which has the potential to alter in a positive direction the quality and perhaps duration of life for millions of people. Georgia is blessed with some of the

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key components of the movement, especially in terms of the intellectual and training infrastructure found in its seminaries and health schools. The faculty at Emory University, the Interdenominational Theological Center, Morehouse School of Medicine and Columbia Seminary have joined to create the Faith and Health Consortium in order to develop new interdisciplinary curriculum and research the models of best practice that be implemented in the state. Four other cities (Columbia, SC; St. Louis; Pittsburgh; and The Bay area) have developed similar consortia under the leadership of the IHP with seed funding from the Templeton Foundation. In other cities like Dallas, large health institutions are forming a city-wide collaborative with religious networks in order to conduct broad health promotion campaigns. The health systems are training health personnel and placing them directly in the congregations to increase the capacity for the religious networks to play a serious role in improving the health outcomes of the city.

Despite occasional outbreaks of controversy around issues such as pregnancy prevention campaigns, all over the nation health leaders and their religious counterparts are finding themselves drawn to common problems and opportunities ranging from AIDS to aging, handgun safety to immunization, Alzheimer's to mental health. Health and faith structures care about the same people and often engage at the very same crises and passages in their lives. It is not too much to suggest that the next frontier in health improvement lies in improved understandings of the social nature of health, of how we help each other understand what life means and how we belong. Brooks Holifield, an Emory University historian, noted that "anyone who would understand either of these quests in America – for meaning or for belonging – will have to attend to the study of congregations."[16]

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