Under the Umbrella of Religion and Health: What Makes Religion and Public Health Research Different from Religion and Medicine Research?

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Abstract

The body of research coming under the overarching umbrella of religion and health research has grown increasingly large and complex. It may be useful to draw a distinction between research directed at public health concerns and that which relates more directly to medicine. In this paper we lay out a series of examples and then attempt to draw out the features they illustrate. The paper has five parts: 1) a sketch of some historical and contemporary examples of religion’s intersection with public health practice; 2) a review of population-based research on religion as a social determinant of health; 3) a brief look at trends in religion and medicine research today; 4) a frank, if also brief, appraisal of the negative influence of religion on medicine and public health; and 5) a description of some remarkable institutions with religious origins or inspiration that seem to have sprung up spontaneously, without obvious forebears, into one or another public health breach. With this story of research and practice in religion and public health, we hope to articulate some useful distinctions within the increasingly large field of work under the religion and health umbrella.
As David Briggs’ writings for the Association of Religion Data Archives demonstrate, there is a lot of work fitting under the umbrella of research on religion and health. In his Nov. 3, 2009 column, “Religion in Sickness and in Health,” Briggs discusses research on life expectancy differentials by religious denomination, the likelihood of religious “switching” when diagnosed with one disease versus another, and the (absence of) desire for a religious funeral among persons with no religious affiliation — a real diversity of methods, topics, and findings. Speaking as longtime observers and participants in this work, it has been amazing to see the growth and development of a field that didn’t exist at all when some of us were trying to assemble dissertation committees. The religion and health research umbrella is big — maybe not a tent yet, but a golf umbrella definitely, and capable of putting up a canopy over a lot of very diverse research and practice.

Like the religious switching research that found that people diagnosed with mental illness and cancer were especially likely to change denominations or even faith traditions, some of the work has always been concerned with people who are sick as well as those in need of comfort, support, and meaning in their lives. And, like the life expectancy study that found Presbyterians and Jews had the longest remaining life expectancy at age 55, some work has always been focused on measurable “hard” outcomes in representative, population-based samples of persons for whom health levels and religious practice or beliefs may not be consciously linked at all. Religions are social institutions found in all human societies; they may be large or small, and simple in their social structure or very complicated, but they all have belief systems, symbols, rituals, or practices that bring participants to a state that transcends daily life. Health care, too, is a social institution with many possible forms and it similarly carries the weight of an institution that addresses ultimate issues of life and death. Not surprisingly, these two social institutions intersect at key moments in people’s lives. Religion has long had a role in the practice and organization of medicine, in the lives of patients, their families and social networks, health professionals, and the institutions in which they interact. Under the big umbrella of research on religion and health, this is the arena of religion and medicine. But religion is also a factor in the social environment among the many factors that to some extent determine the health of populations. We might describe this arena as religion’s role in promoting health and preventing disease at the individual level, and in determining health policies and access to resources at the social level. In other words, this is the territory under the umbrella known as religion and public health.
In this paper we will spend more time on the public health side because that story is less familiar. Our method is inductive: we will lay out a series of examples and then attempt to draw out the features they illustrate. The paper has five parts: 1) a sketch of some historical and contemporary examples of religion’s intersection with public health practice; 2) a review of population-based research on religion as a social determinant of health; 3) a brief look at trends in religion and medicine research today; 4) a frank, if also brief, appraisal of the negative influence of religion on medicine and public health; and 5) a description of some remarkable institutions with religious origins or inspiration that seem to have sprung up spontaneously, without obvious forebears, into one or another public health breach. With this story of research and practice in religion and public health, we hope to articulate some useful distinctions within the increasingly large field of work under the religion and health umbrella.

Religion and the Practice of Public Health

Writing in 1920, Charles-Edward Avery Winslow — water bacteriologist, League of Nations Health Assessor, faculty member at MIT and the University of Chicago, President of the American Public Health Association, and founder of the Yale Schools of Nursing and Public Health (Kaufman, Galishoff, Savitt, 1984) — declared the work of public health to be:

… the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through: organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles and personal hygiene, the organization of medical and nursing services for early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual a standard of living adequate for the maintenance of health; organizing these benefits in such a fashion as to enable every citizen to realize this birthright of health and longevity (Winslow, 1920).

And in the first edition of the Encyclopædia of the Social Sciences (1937), Winslow began the long entry on public health with the words: “The earliest examples of practices [sic] designed to promote the public health are to be found, among primitive peoples, inextricably mingled with the ritual of religion” (Winslow, 1937:646). He follows this opening with numerous examples of religious injunctions for the quarantining of lepers, the burial of the dead, the preparation of meat, and the territorial marking of water supplies, from cultures all over the world. Late nineteenth and early twentieth century public health efforts in sanitation and sewage, particularly in urban centers, had already produced significant improvements in infant and adult mortality rates by the time of these
writings in 1920 and 1936, although infectious diseases were still the leading causes of death. In the
encyclopedia article, Winslow was drawing attention to the unintended or inadvertent effects of religious
practices on the health of populations. In his earlier statement the themes of community organizing and social
justice have strong roots in the fully intentional and self-conscious joining of religion and public health efforts of
the nineteenth century in both the U.S. and England.

Our first example of the important role religion has played in the development of the science and
practice of public health is in some of the less well-known aspects of the familiar story of Dr. John Snow, a mid-
nineteenth century London physician and scientist. Dr. Snow discovered the waterborne mechanism of the
transmission of cholera, and successfully intervened in the London cholera outbreak of 1854 by dramatically
disabling the water pump on Broad Street that had been source of the infection. Snow was already famous for his
innovation in the use of anesthesia in surgery and childbirth. His removal of the pump handle assured his place
in history as the father of epidemiology (Johnson, 2006). This is the familiar part of the story; much less widely
appreciated is the role of one Rev. Henry Whitehead, assistant curate of St. Luke’s Church (of England), located
on Berwick Street around the corner from Broad Street and the pump, in an area of crowded housing occupied
by the poor. The 600 deaths due to the September 1854 outbreak of cholera occurred among members of
Whitehead’s parish; he knew their families, homes, and ways of life personally. Whitehead was initially a
skeptic about Snow’s belief that the disease was waterborne. The prevailing theories that the disease was spread
in miasmatic clouds, or that it was related to how high above the ground the sufferer had lived were both to some
extent supported by the map Snow produced showing the close clustering of deaths near the pump. Whitehead
volunteered to collect data on the outbreak. In 1855 he visited the household of every deceased person, recording
their name, age, the position of the room they occupied, the household’s sanitary arrangements, its source of
water (Broad Street pump or other), the individual’s use of this water, and the hour of the onset of the disease. In
his report, Special Investigation of Broad Street (1855), he concluded that “… the use of water [from the Broad
Street pump] was connected with the continuation of the outburst” (http://www.ph.ucla.edu/epi/snow/whitehead.html). It was his research that led to the identification of the “index
case” that had started the epidemic — an infant living in the house nearest the pump, whose contaminated
diapers were emptied into a cesspool that leaked into the well that supplied the Broad Street pump. Snow died in
1858, just four years after the epidemic, leaving Whitehead as the authority on the research for decades afterward. Whitehead’s role in the research was indispensable because of his intimate familiarity with the community. He was a regular at the local pubs and a welcome visitor in the homes of residents before and after the epidemic; a trusted confidant and friend. Moreover, his initial skepticism added to the scientific legitimacy of the investigation. Religion and science were in no way at odds here.

In this same period in the United States, religion also played an important role in the work of several early pioneers in public health, including Robert Hartley (Rosenberg and Rosenberg, 1968). Hartley was a Presbyterian layperson and advocate of public baths, dispensaries, and the sanitation of milk supplies. His alarm at the increasing rate of infant mortality in New York, by comparison with the declining rates in London and Paris, motivated him to study and publish a report on the production and supply of cow’s milk in New York City, the “article of human sustenance” (Hartley, 1842). Hartley’s investigation found that the “milch” supplies were of such poor quality because of the conditions in which dairy cows in the city were kept and fed, including crowded, unsanitary pens and a primary diet of waste from the city’s distilleries. Hartley was a founding member of the New York Association for Improving the Condition of the Poor and, significantly, the New York City Temperance Society. Although (perhaps because) he was neither a scientist nor a physician, Hartley sent his unpublished manuscript for a kind of early peer review to a number of individuals whose “Recommendatory Notices” are published at the beginning of the book. They include physicians and professors of medicine, attorneys, a professor of philosophy, a pastor, and a college president. Hartley was both a member of the intellectual and scientific elite of the city and a reformer and institution-builder on behalf of the poor.

For both Hartley and Whitehead, the conceptualization of the public health problem in their midst was facilitated by their access to and familiarity with the living conditions of the poor in their cities. In London it was simply Whitehead’s parish; he was a regular and by contemporary accounts a *bon vivant* at the local pubs, a frequent visitor in the homes of those in St. Luke’s congregation, and a resident of the same neighborhood. Not unlike London, but without the Church of England parish-system, the New York City of the 1840s was marked by extreme social class division and the creation of tenement districts housing large numbers of the poor in crowded, “reeking”, and unhealthy conditions. Among the very few middle class people who ventured at all into those districts of the city were the “health missionaries” and temperance advocates of the New York City Tract
Society. Their reports provided the on-the-ground data for the city inspector’s public health reports during this period, and Hartley was the head of his church’s house-to-house missionary visiting program, through whom those reports were made (Rosenberg and Rosenberg, 1968). In an ironic contrast with Rev. Whitehead’s apparently friendly views on the use of alcohol, Hartley’s temperance (even abstinence) beliefs were undoubtedly a primary motivation in making his rounds of the city’s most impoverished neighborhoods. But regardless of the specific content of their beliefs, it was the institution of religion that brought both men to intimate familiarity with the lives of people on the front lines of the public health threats of their day, leading in both cases to significant advances in both science and practice.

Finally, a contemporary example of religion and public health in action is the work of the African Religious Health Assets Programme (ARHAP), a collaborative undertaking of several South African universities, Emory University, and the World Health Organization (http://www.arhap.uct.ac.za/). ARHAP has pioneered a two-pronged methodology for mapping health assets in the African context. Using “participatory inquiry” methods with local village leaders of diverse religious and community groups, ARHAP leaders systematically guide participants to identify the resources for health in their communities, and to locate them both geographically and cognitively — where they are and what they do. The meaning of health is very broad in these workshops, reflecting the cultures in which they take place. In fact the term “bophelo” — a Sesotho word — conveys “life in all its fullness” and essentially makes no distinction between health and religion. Not surprisingly, there is a particular emphasis within the workshop responses on resources for HIV/AIDS research and practice. The work of many individual workshops and extensive data gathering has resulted in the inventorying and geographic information system (GIS) mapping of hundreds of religious health assets (RHA) that have not been comprehensively known to governmental agencies or nongovernmental organizations, to the World Health Organization, or to the religious hierarchies.

With its combination of low-tech paper and pencil exercises with individuals in workshops in rural communities, and high-tech identification of coordinates for the location of these resources, along with coding of their structures and functions, ARHAP recapitulates the themes of its forebears in nineteenth century religion and public health practice. Researchers who are on the ground and legitimate in these communities engage participants to produce a vision of their community’s health resources that no one individual would have held
previously; the maps are a product of shared and negotiated knowledge. The maps that are produced with twenty-first century technology provide a vision of the distribution of health resources, the potential partners in each area, and the areas where resources are lacking, representing a powerful tool for the participants who generated the knowledge in the first place. Snow and Whitehead’s map showed the distribution of deaths from cholera. ARHAP’s maps show the distribution of resources for fighting death from a no-less-threatening twenty-first century infectious disease epidemic. In both cases these powerful visual tools would not be possible without the painstaking gathering of information made possible only by proximity, familiarity, and legitimacy — a shared “health world” to use the ARHAP language.

With these three brief examples of religion and public health practice, we will offer some preliminary generalizations about this area of the work under the umbrella. By comparison with research and practice in religion and medicine, work in religion and public health is focused on social, environmental, and behavioral pathways to the prevention rather than the treatment of disease. These efforts take a broad view of what health is, encompassing not only individual health, but also the health of families, neighborhoods, and communities. Efforts taken at the community level to improve the public’s health benefit all those who drink the water or the milk, regardless of whether the individual is a believer or not. There is an education component in these efforts, an attempt to provide knowledge to individuals in communities and to lift them up to a higher level of understanding of their circumstances. A community’s health knowledge contains a strong component of lay health knowledge, which can only be accessed on the ground. In these efforts, religious congregations play an important role, as sometime providers of health services, as sources for volunteer efforts, as employers of community activist clergy. They also provide, through their own hierarchies and ecumenical ties, links of the local congregation with regional, national, and international bodies with resources and influence. Individuals who are engaged in these efforts are often volunteers or self-sacrificing professionals, motivated not by profit or the search for social status, but by altruistic values and an orientation to serve others who are less fortunate. There is a strong element of community organizing and social justice in these efforts, to identify and address health disparities — disparities in socially-determined health problems — and access to treatment. There is also, interestingly, no incompatibility whatsoever between religion and rigorous science.
Population-based Health Research on Religion

Let us return for a moment to the two quotes of C. E. A. Winslow with which we began. The first was a description of research and practice in public health — intentional, science-based, socially-motivated efforts to promote the health of individuals and communities. The second was about religious practices — in dietary laws, the care of the dead, ritual washing and purification, healing and quarantining — that had unintended, inadvertent, but nevertheless real effects on human health. The latter is the insight of Winslow’s that underlies the long tradition of research on religion’s effect on population health that we turn to now.

Emile Durkheim’s book *Suicide* (1897) and Victor Fuchs’ chapter “A Tale of Two States” (Fuchs, 1974) represent two early reports of differential rates of mortality by religious group. Durkheim’s study of suicide rates in European countries found, among other things, that heavily Roman Catholic and Jewish areas had lower suicide rates than Protestant areas. Durkheim’s general theory was that religion, along with marriage and/or membership in other small-scale groups, protected individuals from the growing forces of alienation and anomie in the modern world; moreover, some religions protected better than others. According to Durkheim, Protestantism did not provide a “sufficiently intense collective life,” or the necessary levels of social support and rules for living that individuals need to overcome the social forces operating to increase suicide rates. Health economist Victor Fuchs’ chapter also focused on differential rates of mortality, not for religious groups *per se*, but for two states with very different religious profiles, Utah and Nevada. Fuchs found excess mortality at every age, beginning with infant mortality rates that were 40 percent higher in Nevada than Utah, two states that are otherwise similar in climate, geography, income, schooling, and levels of medical care. For cause-specific deaths, the differentials were even greater, including deaths from respiratory cancer that were 296 percent higher and deaths from cirrhosis of the liver that were 111 percent higher in Nevada. The driver of these differences is that Utah, with its large majority of Mormon residents, has a population with very low smoking rates, high marriage and low divorce rates, high geographical stability, and very low levels of alcohol consumption. This restrictive lifestyle is one extreme on a continuum that is in many ways anchored on the other end by the lifestyle of Nevada residents — and Fuchs’ conclusion was that human behaviors have health consequences. He also notes that processes of self-selection no doubt reinforce the membership in groups with such restrictive lifestyles, increasing and underscoring the differentiation. For Fuchs and Durkheim it is important to keep in
mind that the patterns studied were at the level of the group, not the individual; the statistics being compared were mortality rates of states or regions, i.e. populations, chosen for their religious differences. This methodology, with its group-level measures, and focus on the prevention of behaviorally-related causes of mortality clearly comes under the religion and public health part of the umbrella.

There were many more such aggregate-level studies when epidemiologists discovered the “low-risk populations” of Seventh-Day Adventists (some 30 percent of whom are lacto-ovo-vegetarians), the Amish, religious orders, and clergy of all denominations, in addition to the Mormons. The data analyzed in these studies were usually presented as standardized mortality ratios comparing the all-cause or cause-specific mortality rates of the religious group with a relevant denominator, usually the rates of the state or county. My review of these studies found 23 of this type published from 1959 to 2008 (Idler, in press; see also Jarvis and Northcott, 1987; Levin and Vanderpool, 1987). They showed consistently and sometimes dramatically lower rates of death from cardiovascular disease and cancer, as well as mortality from all causes, in religious groups when compared with the total population. A striking example is the discovery that Roman Catholic nuns had virtually no cervical cancer whereas the rate was very high among prostitutes, leading to the correct and fruitful hypothesis that the cause of cervical cancer is an infectious disease transmitted through heterosexual contact. The bulk of these studies were published in the 1970s and 1980s, but the data being analyzed were taken from death records of the 1950s, 1960s, and 1970s when the identification of risk factors for cancer and cardiovascular was still in its infancy. Interestingly, there were notable gender differences when rates for males and females were reported separately; males consistently showed sharper differences with the standard population (more benefits) than females. One major reason for this is that smoking is prohibited by Seventh-Day Adventists and Mormons. Also, men’s smoking rates were far higher than they are today; by contrast women’s smoking rates were low to begin with and therefore were changed little if at all by religious proscriptions.

In fact, one might argue that the findings of these studies are more about sex, smoking, drinking (caffeine and/or alcohol), and dietary sources of cholesterol than they are about religion, that they were “natural experiments,” and that religion was important only to the extent that it supported the “real” causes of the mortality rate advantage. This view, however, would overlook the effectiveness of these religious social institutions in controlling the ubiquitous, pleasurable, legal, and otherwise publicly approved and socially
encouraged behaviors of drinking coffee or wine, eating meat, engaging in sex, or (until recently) smoking a cigarette. Religious groups control their members’ behavior through rewards and sanctions; those who do not comply may be punished or ostracized, or they may select themselves out of these high-lifestyle-control groups. In telling us about the effect of religion on the lifestyle and health risk behaviors of members of these groups, such studies tell us about influences on population health. Although their direct influence may be limited to observant members of the group, the presence of these groups in the population, especially when they are concentrated in regions or states, has an impact on the whole. Moreover, there may be carry-over benefits that derive to the larger population living in proximity to concentrations of Mormons or Seventh-Day Adventists, by means of the limitation of the number of bars, drunk drivers, and outlets for cigarette sales, or through the improvement of the quality of vegetables available in markets, or a reduction in second-hand smoke in public places.

If the early wave of these epidemiological studies was mostly analysis at the aggregate level, the second wave was fed by newly-collected data at the individual level. The first of these studies was the landmark Alameda County Study (Berkman and Syme, 1979). It found that socially-isolated individuals had consistently higher rates of mortality from all causes than individuals with social ties to marriage, families, voluntary associations, and religious congregations, even when individuals with similar health and social status were compared. My review of the research located 28 U.S. and international prospective, population-based studies with an individual-level measurement of some aspect of religiousness and a dependent variable of mortality (Idler, in press). The key to considering these studies in the under-umbrella realm of religion and public health is that they are based on probability samples of regional, state, or national populations, and that the findings can be generalized to the larger population from which they come. Studies of patients or other non-random samples may be interesting and informative but do not refer directly to any larger population base, and therefore belong in the realm of religion and medicine. Samples that have been generalized are also notable because they include all of the religious groups in a population; usually these studies overlooked religious group membership altogether and focused only on measuring directly whether an individual was observant or not, no matter what faith tradition they belonged to.
As a whole, the population-based individual-level studies nearly always treated frequency of attendance at religious services as the indicator of religiousness. They also included adjustments for baseline health status, to avoid the confounding that would come from individuals in poorer health being simultaneously unable to attend religious services and at a higher risk of mortality. Compared with the aggregate-level studies, the individual-level studies do not show such dramatic differences between the mortality rates of religious and nonreligious individuals, nor were there any gender-specific patterns. A clear majority of the studies, however, did show significantly higher mortality rates for the nonobservant, compared with individuals who attended religious services frequently (Idler, in press; see also systematic reviews with similar conclusions by Powell, Shahabi, and Thoresen 2003; McCullough, Hoyt, Larson, Koenig, and Thoresen, 2000). This was still the case even when baseline health status, as well as behavioral risks such as smoking and overweight, and psychosocial factors such as social support and depression, were taken into account. The introduction of such additional known mortality risks often reduced the statistical effect of religious attendance but usually did not altogether eliminate it.

To sum up, research on religion and health has been conducted for more than a century and has evolved over time. Religious practice or group membership has been the most frequently studied dimension and shows more effects on mortality than other dimensions such as feelings of religiousness or private beliefs. Some of the pathways for the effect of religious involvement on mortality, such as smoking and social support, are scientifically plausible and supported by the research. There is some evidence for gender differences in the effect on cardiovascular disease and smoking-related cancer, because religion may have a bigger effect on changing men’s health risk behaviors than women’s, which are fewer to begin with. But overall, there is by now a quite large body of well-done research at regional and national levels, in the United States and other countries, showing that religious affiliation and practice are associated with longer life expectancy. This is a strong basis for arguing that religion should be included among the social determinants of the health of populations.

**Trends in Religion and Medicine Research**

Research in what we’re calling the religion and medicine realm under the umbrella is more recent and has been more successful at capturing media and public attention. Covers of *Time* and *Newsweek*, and their in-
depth stories inside have focused attention on the role of prayer in healing and the power of faith to save lives. The stories are those of individuals, not populations, and the emphasis is on the current, momentary, frequently crisis-oriented subjective experience of belief, rather than the less dramatic record of regular participation in religious services. Some research published in clinical journals has gained popular attention; the randomized clinical trial of intercessory prayer by Randolph Byrd (1988) is often cited as proof of “the power of prayer.” In this study, patients in a coronary intensive care unit were randomly assigned to be prayed for (or not) by teams of “participating Christians” who did not know the patients. The researcher analyzed data with 63 outcomes; there were statistically significant effects in six cases, with the prayed-for group having the better outcomes, and for 57 outcomes there were no differences. The author concludes that “…prayer to the Judeo-Christian God has a beneficial therapeutic effect in patients admitted to a CCU.” Some might dismiss the study as aberrant, or lacking in any plausible mechanism of effect, but its influence in characterizing the field of research in religion and health should not be underestimated; we have heard it mentioned approvingly from pulpits.

There has been a real focus of work on religion and its role in care for patients at the end of life, and this would clearly come under the religion and medicine side of the umbrella. Some of the best-known and most generously-funded work today concerns “spiritual assessments” of patients, particularly those at the end of life. Centers at George Washington University (http://www.gwish.org/) and Duke University (Koenig, 2006) have developed instruments for spiritual assessments, to be used by physicians in clinical interviews. Patients expressing spiritual needs can then be referred to chaplain or pastoral care services if they are available, but there is a clear message that the initial assessment should be done by the physician.

I would argue that it is primarily the religion and medicine area under the umbrella that has elicited the now ten-year-long critique developed by Columbia University psychologist Richard Sloan. Beginning with an article in the Lancet in 1999, Sloan has criticized both methods and findings in the broad field of research in religion and health and, as his website says: “…identified significant ethical, practical, and even theological problems associated with making religious activity an adjunctive medical procedure.” His concerns about proselytizing with vulnerable individuals, and the potential undue influence of particular religious groups are concerns that, frankly, we share to some extent. His views on the population-based research are more open to debate, but nevertheless he has established himself as the public skeptic when new research gains media
attention, and has probably brought more attention to the field in the popular media than it would otherwise have had.

One emerging research area focuses on the power of contemplative religious practices to provide stress reduction and reduce stress-associated disease. This area falls somewhat between the areas of medicine (in that often the interventions are clinic-based) and public health (in that the intention is to promote health). The field grew out of a recognition of the longevity of Buddhist monks and has rapidly developed into funded trials of various contemplative practices.

Here are a few closing observations on a subject that obviously could have had much more attention in a longer work. In research in the religion and medicine area, like research in religion and public health, there is an enhanced, broader view of what “health” is. Individual patients are conceived of not only as physical, mental, and emotional beings, but spiritual ones as well. There may even be a consideration of the patient’s family and religious community, adding a social dimension to the patient’s identity, if a small-scale one. But the research is sharply focused on individual patients, not on representative samples. It takes place in clinical settings, outpatient and inpatient. There is a certain instrumentality to the approach when spirituality can become a tool to improve patient outcomes, and a dimension of power in the relationship between physicians and patients that may make the addition of spiritual care to the physician’s responsibilities problematic. There is the potential for role conflict between physicians and those who have been trained as chaplains, clergy, or other spiritual care providers in clinical settings. The outcomes in the research are sometimes “soft” ones, such as better quality of life or improved well-being, but may also include “hard” ones, including inpatient length of stay, remission of major depression, or mortality following surgical procedures. This is not research on prevention or the promotion of health, but on the spiritual or religious dimensions of the experience of illness, while patients and their families are in the midst of it.

The Potential for Conflict under the Umbrella

Durkheim’s initial formulation of the relationship between religion and suicide rates contained the clear possibility that religion could lead to bad outcomes as well as good. If too few rules or too little intimacy could lead to increased rates of suicide, so could excessively strict regulation of human behavior by the group, or a
society’s suffocating closeness. The modern examples of the Guyana People’s Temple and San Diego Heaven’s Gate mass suicides are dramatic instances of the power of religion to motivate self-directed violence. The examples of religion’s role in other-directed, politically motivated violence are sadly far more numerous, and come even more easily to mind. Only the naïve would argue that the relationship between religion and medicine, or religion and public health is always a constructive partnership.

Faith-based, medical, and public health institutions find themselves in tension over numerous issues in societies around the world. Religious beliefs and practices are frequently at cross-purposes with medical and public health professionals in their daily work, most notably in the opposition of the Roman Catholic Church authorities to abortion or birth control, or to the distribution of condoms in the effort to prevent HIV/AIDS. In fact, Roman Catholic women have the same or higher rates of abortion as Protestant women do, possibly as a result of trying unsuccessfully to practice acceptable birth control methods (including abstinence) while achieving the family size they desire. The religious beliefs of Jehovah’s Witnesses, who refuse blood transfusions, or parents who refuse medical care for their children are other examples of ways in which religious beliefs could have significant negative individual and public health consequences. A more subtle form of tension may occur when “faith-based” public health interventions garner Federal, state, and private financing. While on the surface, this may appear to be an example of religious and health institutions working together toward a common goal, religious leaders may feel “used” by the more powerful, funded health side of the partnership. Religious beliefs may be at the center of conflicting cultures and fundamentally different understandings of the meaning of health and healing (Fadiman, 1997). Patients who struggle with religious doubt or guilt add a layer of meaning to their mental or physical illness that secular health professionals may see as a distracting and unnecessary complication, and such struggles have been empirically associated with negative outcomes (Pargament et al. 2001). Yet another example is the recent study finding that end-stage cancer patients who scored high on positive religious coping were less likely to have signed advance directives or to use hospice care, and more likely to receive aggressive, expensive, and ultimately futile care at the end of life (Phelps et al., 2009). Some of these “relationships in tension” may be due to the head-on collision of religious and health values, where individuals in the path may be forced to make intentional choices for one side or the other, and with potentially serious sanctions from either side. Other situations may be more like ships passing in the night, under
the guidance of different stars, with different destinations intended. As we noted at the outset, both religion and health have equal claim to relevance to ultimate human values, but those values are different, as are the practices that enact them. To return to Richard Sloan’s critique, the very introduction of the topic of spiritual and religious care into medical settings may be seen by some as inappropriate, risking conflict, and simply asking for trouble. There is tension, often competing with partnership, under the umbrella.

**Innovative Institutions**

From one perspective, whatever else they are, religion, medicine, and public health can all be seen as large-scale social institutions, or regular solutions to the recurring human problems found in all societies. Each of these social-system-wide institutions is made up of many individual small-scale institutions that directly address the particular and changing needs of individuals and their families in their local settings. Most local congregations, hospitals, and public health services have long histories that extend back into the past, well beyond the memory of the individuals who presently make them up. New institutions modeled after existing ones may be formed, but institutions with entirely new structures or functions, unlike those already in existence, come along rarely. And yet, religious institutions have shown a remarkable capacity for social invention in the field of public health, in creating innovative social arrangements, especially in response to emerging social and health needs.

Some of these inventive social arrangements have taken on the character of social movements, and replicated themselves widely. One example would be the La Leche League, whose influence on the rate and practice of breastfeeding worldwide has been dramatic. The La Leche League was founded in 1956 by a group of Roman Catholic women in Franklin Park, Illinois, who began discussing the subject at a church picnic. One of the founders, Edwina Froelich, was having her first pregnancy at the time, at age 36, and she had been told by her obstetrician that she was “too old” to breastfeed (Bazelon, 2008). In this period following World War II, and at the height of the baby boom, U.S. breast-feeding rates had declined to little more than 20 percent, so the founders were bucking the cultural trend of “modernizing” infant feeding. Other more supportive physicians advised them on the health aspects of breast-feeding and they began organizing meetings and support groups for new mothers in homes. By 1960 a group was meeting in Quebec, Canada, and by 1964 the organization became
the La Leche League International, as it is known today, with chapters in 68 countries
(http://en.wikipedia.org/wiki/La_Leche_League_International) and
http://www.lilli.org/LLLihistory.html?m=1,0,0). Today, 70 percent of infants in the United States are being breastfed at the time of discharge from the hospital.

The religious roots of the organization certainly derive from the nursing Madonna iconography of the Roman Catholic Church, and the specific name is taken from a shrine in St. Augustine, Florida. One wonders about the additional influence of the story of Sarah, wife of Abraham, who gave birth to their first-born son Isaac when she was “old, advanced in age” (Gen. 18:11), and who then exclaimed “Who would have said to Abraham that Sarah would suckle children? Yet, I have borne him a son in his old age.” (Gen. 21:7). The early organizers considered themselves feminists, and they had ties to the Christian Family Movement, a progressive, ecumenical social justice movement of the 1950s that promoted “like ministering to like” counseling strategies. And who better to teach new mothers to breast-feed than other mothers? While beginning as a middle-class movement, they quickly started programs for women in poverty in housing projects in Chicago, and in Latin America and South America. The La Leche League was a truly new social institution. With biblical models for what they wanted to do, the audacious idea of ordinary, nonprofessional mothers teaching strangers about intimate bodily processes became both plausible and legitimate. And with structural models from religiously based community organizing, they were given a method; with respect to both the structure and the function of this new social institution, then, the connection to the faith community was critical. And the public health impact of the movement worldwide has been incalculable.

A second example of religiously inspired social invention is not a worldwide movement but a single local institution with a mission to “Empower Lives, Invite Justice, Alleviate Hunger” (http://www.elijahspromise.net/index.htm). The organization, founded in 1989, is called “Elijah’s Promise.” In 2009 it served 100,000 meals in its soup kitchen in a poor neighborhood of New Brunswick, New Jersey, to children, middle-aged people, and the elderly. There are many soup kitchens and nutrition programs run by religious institutions in cities throughout the country — this in itself is not a new idea. Elijah’s Promise is special because, in addition to serving hot meals and providing a food pantry for the needy in the neighborhood, it runs a Culinary School for young people in New Brunswick, to train them for the large and successful restaurant
industry in the city, which is the county seat and location of major cultural institutions including three theaters and the flagship campus of the state university. The Culinary School lifts the standards of nutrition and the quality of the food served at the soup kitchen, at the same time that it trains young people for “livable wage jobs” in their own community. In addition, it runs a successful catering business, providing jobs to their own trainees.

Most recently, Elijah’s Promise has teamed up with a church in the town across the river to open “A Better World Café,” serving lunch five days a week, using the “community café” model pioneered by “One World Everybody Eats” in Salt Lake City, Utah (http://www.oneworldeverybodyeats.com/saltlakecity.html), where customers may either pay what they can or work for their food, which is fresh, locally-grown, or fair trade.

The promise of the prophet Elijah was made to a widow from the town of Zarephath in ancient Israel, where there was drought and famine. Although she had very little grain and very little oil with which to feed her family, the Lord, through Elijah, commanded her to share what she had with the prophet. And Elijah promised her that, while he was there, and until the rains returned, her jar of meal and her jug of oil would never be empty, and they were not (I Kings 17: 8-16). Thus the story inspiring the name of this innovative institution is a story of help in hard times, and faith in God, and the power of sharing, even among those who have little. The development and success of Elijah’s Promise is attributable to its knowledge and understanding of its community. It feeds the needy for the day, and provides them with marketable skills for feeding themselves (while feeding others!) in the future. It engages with the larger community by inviting local churches and synagogues to bring and serve food themselves, by being a service learning site for students from the university, and by providing an important access point for health and social service agencies in the community to reach out to those who need their services.

The La Leche League and Elijah’s Promise, and many others we could name, including such visionary institutions as continuing care retirement communities, hospice organizations, and the L’Arche Communities, have taken religious models from biblical or historical sources, and used them to respond to public health needs in their community, with novel functions or structures, or both. They put the resources right where the needs are, at the local level, and frequently existing religious institutions in the community provide the support that they need to get started — places and opportunities for meeting, facilities for providing services, financial support, and very importantly, legitimacy and acceptance in the eyes of the community. The existing faith communities...
also provide ties to their larger ecclesial structures and to their ecumenical partners, linking the fledgling institution to networks of supportive structures with long histories in the community. And if the new institution establishes itself successfully, it can serve as a model that communities with similar needs can adopt for themselves. The better connected it is with local faith communities, the more likely all of these things are to happen.

In Closing

The kinds of health problems we face as a society have shifted dramatically from Henry Whitehead’s time to our own, but, surprisingly, religion is as relevant now as it is then. It did not have to turn out that way. The infectious diseases that were the concern of Rev. Henry Whitehead and Charles Edward-Avery Winslow were the primary causes of death in their time. Today, in all industrialized countries, the primary causes of death are from heart disease, cancer, stroke, diabetes, and other chronic diseases with completely different mechanisms of transmission and effect. That religion could be linked to lower mortality both in their time and ours is really quite amazing.

As we look to the future, both religion and health are moving targets, suggesting that their evolving relationship will again take on new forms. While some regions of the world are secularizing, the importance and influence of religion over the daily lives of individuals is surging in others. Increasingly rapid globalization brings those working in the fields of medicine and public health into more frequent contact with a diversity of faith traditions and corresponding opportunities for conflict or cooperation. At the same time, the rapid, unprecedented, and dramatic aging of the populations in the industrialized world will present all of those societies with challenges they have not faced before, in caring for larger and larger numbers of older persons with physical and cognitive impairments. Religious institutions have shown a creativity and inventiveness in providing compassionate care for the aged that could prove to be a considerable resource in both research and practice in the decades ahead.

Population-based research on disease prevention and health promotion locates religion among the social determinants of health. Faith-based public health practice concerns itself with the health needs of the underserved and disadvantaged members of the population in an effort to reduce those disparities. The field of
research in religion and medicine, on the other hand, takes the social institution of medicine as its location, with
individual patients and their relationships with health professionals, families, and faith communities as its subject
matter. Under the umbrella, then, research on religion and public health has a history and development that is
different from research and practice in religion and medicine, a distinction that should be useful for framing
questions for research and drawing up proposals for practice, not to claim priority for one or the other, but to see
the balance, complementarity, and interrelatedness of the two.
References


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