Preventive Medicine Reports 4 (2016) 344–350

Contents lists available at ScienceDirect

Preventive Medicine Reports

journal homepage: http://ees.elsevier.com/pmedr

Review Article

Partnerships between the faith-based and medical sectors: Implications for preventive medicine and public health

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ARTICLE INFO

Article history:
Received 13 June 2016
Received in revised form 9 July 2016
Accepted 24 July 2016
Available online 27 July 2016

Keywords:
Religion and medicine
Spirituality
Preventive medicine
Public health
Health promotion

ABSTRACT

Interconnections between the faith-based and medical sectors are multifaceted and have existed for centuries, including partnerships that have evolved over the past several decades in the U.S. This paper outlines ten points of intersection that have engaged medical and healthcare professionals and institutions across specialties, focusing especially on primary care, global health, and community-based outreach to underserved populations. In a time of healthcare resource scarcity, such partnerships—involving religious congregations, denominations, and communal and philanthropic agencies—are useful complements to the work of private-sector medical care providers and of federal, state, and local public health institutions in their efforts to protect and maintain the health of the population. At the same time, challenges and obstacles remain, mostly related to negotiating the complex and contentious relations between these two sectors. This paper identifies pressing legal/constitutional, political/policy, professional/jurisdictional, ethical, and research and evaluation issues that need to be better addressed before this work can realize its full potential.

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http://dx.doi.org/10.1016/j.pmedr.2016.07.009

1. Religion and medicine: The history of encounter

The history of the encounter between religion and medicine is marked by contention and controversy. Indeed, just the phrase "religion and medicine" or its equivalents—faith and medicine, faith and healing, spirituality and medicine, and so on—evokes strong responses from many people, not necessarily positive, and for good reason. The encounter, at times, has been "a messy story" (Cadge, 2012, p. 14), characterized, in the minds of many of us, by lurid images: phony television faith healers, medieval torture of scientists and healers, execution of Jews accused of spreading the plague in 14th-century Europe, bombing of family planning clinics, misinformed consumers who substitute sketchy new-age therapies for validated medical treatments, and more. These images dominate public discourse on religion and medicine. But there is another narrative to unpack, one more positive and hopeful. It does not negate these troubling images, but offers a more complete and accurate picture of the fullness of the ways that the worlds of religion and faith, on the one hand, and of medicine and healthcare, on the other, have encountered each other throughout history.

Within respective faith traditions, this encounter has been more about cooperation, mutuality, and shared values (see Marty and Vaux, 1982). In certain traditions, the encounter has even occurred within the same person. For example, in Judaism, many of the greatest rabbinic sages were also people of medicine and science (see Berger, 1995): Moses Maimonides, 12th-century Spanish rabbi, physician, and philosophical theologian; Moses Nachmanides, 13th-century Catalan rabbi, physician, and philosopher; and Ovadiah Sforno, 16th-century Italian rabbi, physician, and philosopher. This trend still exists today; for example: Abraham Twerski, American rabbi and psychiatrist; Fred Rosner, American rabbi, internist, and bioethicist; and Avraham Steinberg, Israeli rabbi, neurologist, and bioethicist. The most famous 20th-century Christian exemplar is Albert Schweitzer, physician, philosopher, theologian, Lutheran minister, professor, and medical missionary.

Institutionally, the encounter between religion and medicine has been multifaceted and dynamic, and remains so in the present. The many intersections between these two institutional sectors offer productive opportunities for cooperation and collaboration in service to the promotion of health and prevention of disease within populations (Levin, 2014a). It is these intersections or interconnections that are elaborated here. It may be a bit early in the paper for this, but here, in advance, is the take-home point: *The intersections of the faith-based and medical sectors are multifaceted and of long standing.* As this paper will show, collegial relations have existed between these two sectors for centuries, and continue so today. That these relations coexist alongside the negative and contentious examples noted above underscores the complexity of the encounter between religion and medicine, and suggests that the overall relationship cannot be captured by a single adjective or pithy phrase. But, for purposes of honest disclosure, the present paper will focus on the more hopeful possibilities.

One of the earliest systematic efforts to map the influence of religion on the medical sphere and on human health was a classic review essay by Kenneth Vaux, published in this journal's sister publication, *Preventive Medicine*, 40 years ago (Vaux, 1976). This important article became a starting point for subsequent empirical research on the impact of religious beliefs and behaviors on population rates of physical and psychological morbidity and mortality. It also provided a baseline for efforts to understand the mediators of religion-health associations observed in the, by now, thousands of published studies on this subject (see Koenig et al., 2012; Levin, 2001). But whereas the faith-health conversation up to now has been largely about presenting and trying to interpret empirical data on the health impact of religion, there is another dimension or octave to this conversation that has been mostly neglected: the dynamic interactions between faith and medicine at an institutional level. More specifically, this involves relations between what could be termed the faith-based and medical sectors.

Mapping these interconnections is the topic of the present paper. It is hoped that this review will complement the Vaux article and encourage a broader discussion and analysis of the institutional linkages of religion and medicine, much as the earlier piece did for the links between personal religiousness and health status 40 years ago in *Preventive Medicine*.

2. Contemporary intersections of the faith-based and medical sectors

As noted, the intersections of religion and medicine, especially institutionally, are multifaceted. These multiple dimensions of intersection or interconnection are an elaboration and expansion of ideas discussed recently, and briefly, in a community health context (Levin, 2014b). The ten points of intersection that follow (summarized in Table 1) probably do not exhaust all possible points of connection between the faith-based and medical sectors, but they highlight important institutional encounters between religion and medicine that have tangible implications for preventive medicine and public health.

2.1. Denomination-sponsored healthcare institutions

Religious institutions were instrumental in establishing the first hospitals, clinics, and medical care institutions, as long ago as the first millennium of the Common Era. This was a worldwide phenomenon, extending to Chinese Buddhists, Hindus in the Indian subcontinent, and Muslims throughout the Middle East (Sullivan, 1989). The earliest hospitals in the West were founded by the major Abrahamic traditions, hundreds of years ago. Note today how many medical centers are branded as Catholic, Lutheran, Baptist, Methodist, Presbyterian, Episcopal, Adventist, Jewish, and so on (Numbers and Amundsen, 1986). Within Roman Catholicism, orders of religious own and operate community-based hospitals, regional academic medical centers, and healthcare facilities of almost every type (Stempsey, 2001).

The presence of religiously branded hospitals, clinics, and care facilities in most communities speaks to a ubiquitous understanding that God's love can and must be externalized, through the agency of religious institutions, to meet worldly needs of human beings, including and especially health and healthcare needs. The presence of a servant's heart—and concomitants that such a value mandates, as far as service to others—can be found in the vision and mission statements of hospitals across the religious spectrum, not just among Christian-owned institutions that use such language explicitly (Chapman, 2003). Jewish hospitals, for example, often include in such statements references to *tikkun olam* (repairing the world) and *tzedakah* (Katz, 2010), the latter of which is usually translated as charity but which more accurately connotes the concept of justice.

2.2. Medical and public health missions

For the past couple centuries, Christian missionaries have provided medical, surgical, nursing, and dental care and shepherded environmental health infrastructure and health-impacting economic development projects in the underdeveloped world (Good, 1991). Medical

Table 1
Intersections of the faith-based and medical sectors.

Denomination-sponsored healthcare institutions
Medical and public health missions
Healthcare chaplaincy and pastoral care
Congregation-based health promotion and disease prevention
Community-based outreach to special populations
Clinical and population-health research on religion and spirituality
Academic spirituality and health centers
Religious medical ethics
Faith-based health policy advocacy
Federal faith-based initiatives

missions are sponsored by almost every major Christian denomination. Christian medical missions, today, encompass truly global outreach, with efforts ongoing on six continents. Organized medical missions programs exist in partnership with non-governmental organizations, academic institutions, government agencies, secular foundations, and philanthropies, and serve as agents of social justice and change as well as means to address public health disparities (Holman, 2015).

Medical and public health missions are not solely sponsored by Christians. A notable example: the Tobin Health Centre serves Abayudaya Jews and their Muslim and Christian neighbors in Mbale, Uganda. It was established in 2010 with the support of Be'chol Lashon ("in every tongue"), a multi-ethnic research and community-building initiative sponsored by the Institute for Jewish and Community Research, a U.S. non-profit based in San Francisco (Tobin et al., 2005). The center specializes in diagnostics and primary care and has made headway in addressing malaria, infant mortality, and other perinatal health concerns.

2.3. Healthcare chaplaincy and pastoral care

The pastoral care profession, and healthcare chaplaincy in particular, has existed as a professional field for nearly a century. Pioneers include Richard Cabot, who in 1925 proposed clinical training for ministers, and Anton Boisen, who found the Council for the Clinical Training of Theological Students, in 1930. Leading institutions include the HealthCare Chaplaincy Network, founded in 1961, a New-York-based educational and research organization; the Association for Clinical Pastoral Education (ACPE), founded in 1967, a multicultural and multifaith organization that publishes the *Journal of Pastoral Care & Counseling* and accredits clinical pastoral education (CPE) programs; and the Association of Professional Chaplains, a membership society founded in 1998, with roots dating to the 1940s, which publishes the *Journal of Health Care Chaplaincy*.

At Texas Medical Center, in Houston, for example, the largest medical center in the world, there are six ACPE-accredited CPE centers, at Baylor St. Luke's Medical Center, Houston Methodist Hospital, Memorial Hermann Health System, the University of Texas MD Anderson Cancer Center, the Michael E. Debakey VA Medical Center, and Ben Taub Hospital. In all, according to the ACPE, there are nearly 450 accredited CPE centers in the U.S. that have trained in excess of 65,000 individuals. Almost every major faith tradition and Christian denomination are represented among credentialed healthcare chaplains (Handzo et al., 1999).

Parallel to this growth in the profession, a culture of evidence-based care is taking root (O'Connor, 2002), bolstered by innovative models of spiritual assessment (Shields et al., 2015), and evaluative and outcomes research has received strong support (Handzo et al., 2015). Since the start of the 21st century, this includes reports of collaborative research among healthcare chaplains and other professional providers (Flannelly et al., 2003), survey and qualitative data on the integration of chaplaincy into mental healthcare within military and veterans facilities (Nieuwsma et al., 2013), and case studies in various patient populations and clinical settings (Fitchett and Nolan, 2015).

2.4. Congregational health promotion and disease prevention

Religious congregations are familiar loci for community-based health promotion and disease prevention (HPDP) programs of many types (Bopp and Fallon, 2013). Congregation-based HPDP programs date back decades (see Campbell et al., 2007). This mode of public health delivery evolved from the pastoral care field in the 1950s and 1960s, inspired in part by Granger Westberg's "wholistic health centers" in Chicago churches in the 1970s (see Westberg, 1984).

Common emphases of congregational public health interventions include *risk reduction* (via screening, referral, and primary care delivery), *chronic diseases* (including hypertension, diabetes, HIV/AIDS, and prevention efforts related to community mental health and perinatal issues), and *underserved populations* (especially rural, urban, older adults, single mothers, and ethnic minorities).

African-American churches have been popular sites for intervention programs since the earliest days of congregational HPDP (Levin, 1984). This work was pioneered by the Health and Human Services Project of the General Baptist State Convention of North Carolina (Holmes and Hatch, 2007), and from the beginning has been oriented toward elimination of *health disparities* (Holmes, 2004). Contemporary efforts include programs addressing cardiovascular disease risk (Yanek et al., 2001), HIV/AIDS (Agate et al., 2005), and diabetes (Newlin et al., 2012).

2.5. Community-based outreach to special populations

Religious denominations and organizations have sponsored community-based organizations that coordinate outreach to special populations. Many of these faith-based organizations are national in scope. Outreach encompasses many types of programs and activities, often involving medical, healthcare, and communal service professionals, and taking place in various contexts and settings.

Examples include primary care clinics in underserved neighborhoods, faith community (parish) nursing located in congregational buildings, hospices and other services to the dying, patient education efforts sponsored by individual church congregations or denominational districts, and specialized programs operated by and/or within religious bodies: food banks, clothing banks, job programs, shelters (for the homeless, for abused women and their children). Partnerships between local health departments and faith-based organizations have been established in every region of the U.S., offering a collaborative means to provide for vulnerable populations using shared resources (Barnes and Curtis, 2009). Creative solutions have been proposed for navigating complex data management issues involved in evaluating such programs (Barnes et al., 2014).

Interfaith efforts exist in most communities throughout the U.S., coordinating activities among local congregations, across faith traditions, and targeting myriad special populations: older adults, mothers, children, homeless, hungry, unemployed, substance abusers, physically or cognitively challenged, and underserved older adults (e.g., Falck and Steele, 1994). An example of the latter is the Shepherd's Centers of America, founded in 1972 by Rev. Elbert Cole, a national network of interfaith community-based organizations serving older adults (Cole, 1981). In some communities, the work of interfaith organizations extends beyond provision of services to participation in coalitions involved in community organizing and health-directed social and political change agency (Meister and de Zapien, 2005), such as combating poverty or safeguarding the environment.

2.6. Clinical and population-health research on religion and spirituality

Among the most well known, but most misconstrued, intersections of the faith-based and medical domains is the body of empirical research studies identifying religious and spiritual correlates and predictors of health and medical outcomes. Research on this subject actually dates to the 19th century and by now encompasses thousands of published studies and reviews (see Koenig et al., 2012). These include clinical, epidemiologic, biomedical, social, and behavioral research studies on almost every imaginable medical or health-related outcome, conducted among respondents, subjects, or patients in almost every one of the world's major religious traditions and denominations (Koenig et al., 2012; Levin, in press). Empirical results are mostly positive (i.e., in a salutary direction), depending upon the respective outcome under study, and have been found regardless of sociodemographic characteristics or religious affiliation.

The word misconstrued is used to characterize this literature because typically, in media reports, results of these studies are confused with results from a much smaller body of controversial clinical trials of distant healing prayer (Dossey and Hufford, 2005). Not all of the latter

studies can be easily dismissed; a minority are well designed and have obtained positive results (Roe et al., 2015). But, regardless, the thousands of published studies on religion and health are generally population-based or clinical studies that have nothing to do with experimental trials or therapies seeking to cure disease (see Levin, 2009). Rather, they are observational studies of mostly well populations conducted by social scientists, epidemiologists, and physician-researchers investigating how measures of religious identity, practice, or belief are associated with increases or decreases in risk of subsequent medical or psychiatric outcomes, often expressed in terms of population-wide rates of morbidity, mortality, or disability (see Koenig et al., 2012). Moreover, research findings on this subject are generally consistent with current understandings of the social determinants of population health (Idler, 2014).

2.7. Academic spirituality and health centers

As individual scientists focus their research on religion, spirituality, and health, and as programmatic research by established investigators continues to supplant a literature of one-off studies, formal academic institutes, centers, and programs have grown up at major universities and medical centers. The first such program was the Institute for Religion and Health (now the Institute for Spirituality and Health), established in 1955 at Texas Medical Center in Houston. It offered the first medical school course, "Religion and Medicine," taught by Granger Westberg at what was then known as the Baylor University College of Medicine (Nickell, 2012).

In the decades since, multifaceted programs dedicated to medical research and medical education have flourished at a variety of prominent universities. These include major academic centers located at Duke, Emory, Florida, George Washington, Chicago, Harvard, and Baylor. The most research-intensive of these is the Center for Spirituality, Theology and Health, at Duke University, directed by Harold G. Koenig. The Duke center, founded in 1998, sponsors an annual summer workshop in clinical research methods and is home to numerous ongoing clinical and population-based research projects (Koenig, 1999). The Institute for Public Health and Faith Collaborations, founded in 2002 as an initiative of Emory University's Interfaith Health Program, has become a global leader in mobilizing institutional faith-based and healthcare resources to create partnerships for addressing health disparities (Kegler et al., 2007). The George Washington Institute for Spirituality and Health, founded in 2001 by Christina M. Puchalski, has led the way in thoughtfully integrating spirituality into the clinical setting and patient care (Puchalski and Ferrell, 2010).

2.8. Religious medical ethics

Religious values, stated or unstated, explicitly or implicitly, have long influenced both the "healing transaction" and medical decision-making (Pellegrino and Thomasma, 1997). For the past half century, at least, theological scholars have systematically weighed in on procedures or courses of action that are *proscribed* (forbidden or discouraged) or *prescribed* (mandated or recommended) according to exegeses of sacred writings or interpretations or rulings made by religious or ecclesial authorities, as in the case of Roman Catholic moral theologians and Jewish *poskim* (rabbinic decisors) (Mackler, 2003).

Among the leading medical ethicists are well known contemporary Protestant (e.g., Hauerwas, 1990; Post, 2004), Catholic (e.g., Pellegrino and Thomasma, 1996), and Jewish (e.g., Dorff, 1998; Jakobovits, 1959) theological scholars. Among Jewish *poskim*, for example, *t'shuvot* (*responsa*) based on *halachah* (Jewish law) have been issued regarding abortion, stem cell research, euthanasia, test-tube babies, autopsy, transplantation, cloning, and other clinical matters (see Steinberg, 2003). There are also rapidly emerging bioethical traditions in the West among contemporary Hindu, Buddhist, Muslim, and Sikh scholars (Morgan and Lawton, 2007).

2.9. Faith-based health policy advocacy

Concomitant to their involvement in medical ethics decision-making and their advocacy role in public policy (see Heclo, 2001), religious institutions and organizations often weigh in on medical and healthcare issues and legislation. This trend gained public visibility in the 1990s during that era's U.S. healthcare reform debate ("Hillarycare"), and accelerated a few years ago during debate over the Patient Protection and Affordable Care Act ("Obamacare"). These national discussions were informed and influenced by formal statements or white papers from the Catholic Bishops, the United Methodist Church, the Evangelical Lutheran Church in America, the Presbyterian Church (U.S.A.), the Episcopal Church, the United Church of Christ, the Southern Baptist Convention, the Islamic Society of North America, and many other religious and denominational groups. While these statements were in agreement on broad points, such as a need for healthcare reform, substantial differences emerged on particularly contentious issues (e.g., contraception, abortion).

Especially prolific, and influential, were a spate statements and documents advocating for or against features of healthcare reform originating from across Jewish denominations and organizations (Levin, 2012), and from individual Jewish academic bioethicists (e.g., Zoloth, 1999). For example, formal statements were issued by Reform, Conservative, and Orthodox groups, and from myriad organizations (e.g., Jewish Federations of North America, 2016). Again, while these documents mostly agreed about the broad strokes of healthcare reform legislation, differences did emerge and were communicated in respective reports.

These statements—including those of the other religious groups noted above—called for specific healthcare policies on the basis of what were perceived to be ethical or moral imperatives grounded in respective scriptural and faith traditions. This form of public advocacy was viewed as consistent with the prophetic role of these institutions—that is, their divinely mandated obligation to call the world out of complacency and sin and to right injustices and to act with compassion (Gibelman and Gelman, 2003)—whether grounded in *halachah*, Catholic social teaching, or some other sacred value system.

2.10. Federal faith-based initiatives

Many readers may recall the controversy surrounding establishment of a White House Office of Faith-Based and Community Initiatives, at the outset of the Bush Administration in 2001. Concerns were raised about the purpose and function of the Office (see Brooks and Koenig, 2002), such as whether public funds would be used to underwrite religious proselytizing. In actuality, the office served primarily as a clearinghouse, promoting "charitable choice" or the ability of faith-based organizations to compete alongside secular agencies for grants and contracts to provide human services, including healthcare. The supportive legislation was signed by President Clinton in 1996 (P.L. 104-193), five years before the office was formally established through executive order (E.O. 13198 and E.O. 13199) at the start of President Bush's first term, in 2001. The office was rebranded by President Obama (through E.O. 13498 and E.O. 13499) in 2009, and continues in operation today as the Office of Faith-Based and Neighborhood Partnerships (Hein, 2014; Levin and Hein, 2012).

Public reports have been issued during the past two administrations outlining program accomplishments (White House Office of Faith-Based and Community Initiatives, 2008; White House Office of Faith-Based and Neighborhood Partnerships, 2011) and describing legal and constitutional parameters and challenges that may arise in operating federal faith-based initiatives and partnerships (Rogers and Dionne, 2008). Faith-based offices also exist within nearly a dozen federal cabinet departments, including the U.S. Department of Health and Human Services (the DHHS Center for Faith-based and Neighborhood Partnerships; a.k.a. the Partnership Center). Current priorities include promoting patient awareness of the Affordable Care Act, the Let's Move program, and initiatives targeting fatherhood and mentoring. Perhaps the highest-profile

success has been the President's Emergency Plan for AIDS Relief (PEPFAR), which originated in the Bush Administration under the leadership of Mark Dybul and has become a centerpiece of the Obama Administration's Global Health Initiative (Goosby et al., 2012).

3. Questions that remain

The domains of religion and medicine have a history of encounter extending back a long time. This is not in doubt. But that is not to say that all or even most critical issues surrounding this encounter have been addressed and settled. To the contrary, important questions remain, especially regarding jurisdictional disputes. New questions, as well, emerge through public debate, such as the contentious matter of religious freedom arising out of the recent healthcare reform legislation (see Religious Freedom Project, 2012). Unpacking these issues in their entirety is beyond the scope of this paper, but prominent concerns are outlined here. Some of these questions have been broached by others. For some, answers have been proposed. But for the most part these are questions that still need resolving. They are offered to help frame the ongoing conversation on partnerships between the faith-based and medical sectors.

3.1. Legal/constitutional

Federal funding of religion-health research, congregation-based public health interventions, and especially large-scale faith-based initiatives and partnerships remains a subject of debate, despite efforts to delineate precisely what is and is not permitted and concomitant judicial vetting during the Clinton, Bush, and Obama administrations (Levin, 2013). The charitable choice doctrine and federal funding of faith-based programs—which predates by decades the creation of a White House office—create administrative, legal, and ethical challenges that persist, despite efforts to clarify what is and is not acceptable (Kennedy and Bielefeld, 2002). The public visibility and contentiousness of these disputes have died down, but key questions remain:

What are or should be the parameters surrounding federal funding of faith-based initiatives/partnerships?

Who defines what is and is not acceptable behavior—of a religiously partisan nature—on the part of funding recipients?

How are assurances regulated and enforced regarding: Potential misuse of federal funds by faith-based organizations in ways that violate church-state separation? Potential federal violations of the religious freedom of faith-based organizations?

3.2. Political/policy

Faith-based institutions and organizations have a long history of medical and health-directed work, as this review describes. Relationships have been developed and nurtured that can be drawn upon to meet strategic population-health needs (Bennett and Hale, 2009). This much is widely appreciated (Gunderson and Cochrane, 2012). But the "how" of such strategic relationships, especially globally (World Faiths Development Dialogue, 2012), is still a work in progress and parameters of this conversation require thinking through important questions, including:

How can the public health sector work with faith-based organizations to reduce health disparities?

What opportunities are there for DHHS agencies (e.g., CDC, HRSA) and Public Health Service offices (e.g., ODPHP, OGHA, OSG) to work in conjunction with the faith-based sector to meet national objectives?

How can state and local governments partner with religious denominations and congregations for community health development? Are there existing models that outline how such partnerships can come together and function harmoniously?

3.3. Professional/jurisdictional

Especially in clinical settings, professionally trained practitioners in medical, healthcare, and faith-based occupations are in regular contact and interaction in the care of patients. Sometimes these relationships are ongoing; sometimes they are transient. Their dynamics, in turn, may be reinforced by institutional guidelines and by unstated parameters related to professional jurisdiction, tacit decision-making authority, and other turf-related issues (Post et al., 2000). In interactions among medical/healthcare and faith-based personnel and professionals:

Which sector or profession has decision-making authority? Does it depend on the context/issue? Does it matter? If there is such a thing as a "healthcare team," are some partners more equal than others? Are there particular clinical endpoints (cure, recovery, discharge) that take precedence over others (well-being, patient satisfaction, pain-free status) and that are the domain of respective professions?

How are misperceptions of the mission of the other sector handled? How are vision or values conflicts negotiated? How are turf conflicts adjudicated? Does this always result in the "right" decision?

Is there a role for clinical pastoral professionals in the training of medical care professionals, and vice versa?

How can medical practitioners best be made aware of faith-based resources that may impact on health care or health status, for better or worse? Should practitioners even concern themselves with such things, much less patient spirituality and beliefs, even if evidence suggests a positive impact on mental or physical health?

3.4. Ethical

Aside from ethical concerns implicit in issues touched on above related to faith-based organizations, federal sponsorship, institutional partnerships, and health-directed programming, ethical challenges also exist in the clinical encounter between religion and medicine. Conflicts may arise, for example, related to spiritual assessment, referral to pastoral care providers, end-of-life decision-making, prayer with patients, and delivery of spiritual care (Puchalski and Ferrell, 2010). Spiritual beliefs of physicians add another factor of complexity to difficult clinical decisions that may be perceived as morally compromising (Curlin et al., 2007). Yet these challenges must be negotiated, in order to foster practice of "compassionate medicine" (Puchalski, 2001), meaning "to do what is best for the patient" (Puchalski, 2001, p. 35). Efforts to sort through these issues are ongoing, part of a larger mission focused on what has been referred to, in explicitly religious terms, as "redeeming medicine" (Meador, 2007). A sampling of questions that arise, clinical as well as institutional:

Is it ever appropriate for medical caregivers to pray with patients? Under what conditions? Who decides? Who initiates it?

Can particular religious ideations be psychopathological? Who decides? Who treats?

How do denomination-sponsored healthcare institutions respond to federal mandates that violate their values?

What responsibilities does the federal government have to its "shareholders" (i.e., the American public) to enforce healthcare regulations in the face of resistant private faith-based entities?

3.5. Research and evaluation

Research on religion and health has been of several types, including clinical, population-based, biomedical, behavioral, and evaluative. Of these, the latter has received the least attention, yet is the most critical for program planning in prevention. Questions that arise here are

simple, yet, to now, underexplored. So much energy has been expended on vetting legal issues—such as the constitutionality of federal faith-based initiatives—that more fundamental and just as important questions regarding efficacy and applications have been relatively ignored (Johnson, 2002). For example:

> What works and what does not work? Is there evidence that faith-based interventions measurably improve population-health outcomes and not just near-term impacts?
>
> How can medical care institutions and public health agencies more effectively make use of faith-based resources, both human and organizational?
>
> How should the health-directed work of faith-based organizations inform policy deliberations about public-private partnerships regarding distribution of scarce public resources related to healthcare? What are the barriers to evidence-based evaluations being used formatively by government decision-makers?

4. Conclusions

To restate the take-home point from earlier in this paper: *The intersections of the faith-based and medical sectors are multifaceted and of long standing.* The idea that religion and of medicine can partner in ways to promote well-being and relieve suffering is a very old one. The Bible, for one, and other sacred Jewish and Christian texts have far more to say about health, healing, healthcare, medicine, and even the human body and pathophysiology than most people may be aware (see Preuss, 1993).

The intersection of religion and medicine is not a novel concept, nor one that implicitly connotes whatever disreputable images may be conjured by activities of religious fundamentalists or new-agers, images that many within the mainstream of scientific medicine may find distasteful. Religious people, organizations, and institutions have worked hand in hand with medical and healthcare practitioners, organizations, and institutions for hundreds of years, especially since the mid 20th century, creating fields of academic study, professional practice, community intervention, and human caregiving that buttress the work of those laboring to advance the cause of preventive medicine and public health.

Former U.S. Surgeon General David Satcher, a widely revered public health leader, has made this very point: "Through partnership with faith organizations and the use of health promotion and disease prevention sciences, we can form a mighty alliance to build strong, healthy, and productive communities" (Satcher, 1999). There is historical precedent for such an alliance, and, informed by science and scholarship, it is in our best interest for this to continue and to flourish.

Conflict of interest statement

The author declares that there are no conflicts of interest.

Transparency document

The Transparency document associated with this article can be found in the online version.

Acknowledgment

A version of this paper was presented as a Spirituality, Theology, and Health Research Seminar at the Duke University School of Medicine, on July 20, 2016.

References

Agate, L.L., Cato-Watson, D., Mullins, J.M., et al., 2005. Churches United to Stop HIV (CUSH): a faith-based HIV prevention initiative. J. Natl. Med. Assoc. 97 (Suppl. 7), 60S–63S.
Barnes, P.A., Curtis, A.B., 2009. A national examination of partnerships among local health departments and faith communities in the United States. J. Public Health Manag. Pract. 15, 253–263.
Barnes, P.A., Cutts, T., Dickinson, S., et al., 2014. Methods for managing and analyzing electronic medical records: a formative examination of a hospital-congregation-based intervention. Popul. Health Manag. 17, 279–286.
Bennett, R.G., Hale, W.D., 2009. Building Healthy Communities through Medical-Religious Partnerships. second ed. Johns Hopkins University Press, Baltimore.
Berger, N. (Ed.), 1995. Jews and Medicine: Religion, Culture, Science. Jewish Publication Society, Philadelphia.
Bopp, M., Fallon, E.A., 2013. Health and wellness programming in faith-based organizations: a description of a nationwide sample. Health Promot. Pract. 14, 122–131.
Brooks, R.G., Koenig, H.G., 2002. Crossing the secular divide: government and faith-based organizations as partners in health. Int. J. Psychiatry Med. 32, 223–234.
Cadge, W., 2012. Paging God: Religion in the Halls of Medicine. University of Chicago Press, Chicago.
Campbell, M.K., Hudson, M.A., Resnicow, K., Blakeney, N., Paxton, A., Baskin, M., 2007. Church-based health promotion interventions: evidence and lessons learned. Annu. Rev. Public Health 28, 213–234.
Chapman, E., 2003. Radical Loving Care: Building the Healing Hospital in America. Baptist Healing Hospital Trust, Nashville.
Cole, E.C., 1981. Lay ministries with older adults. In: Clements, W.C. (Ed.), Ministry with the Aging. Harper and Row, San Francisco, pp. 250–265.
Curlin, F.A., Lawrence, R.E., Chin, M.H., Lantos, J.D., 2007. Religion, conscience, and controversial practices. N. Engl. J. Med. 356, 593–600.
Dorff, E.N., 1998. Matters of Life and Death: A Jewish Approach to Modern Medical Ethics. Jewish Publication Society, Philadelphia.
Dossey, L., Hufford, D.J., 2005. Are prayer experiments legitimate?: twenty questions. Explore (NY) 1, 109–117.
Falck, V.T., Steele, L., 1994. Promoting the health of aging adults in the community. J. Community Health 19, 389–393.
Fitchett, G., Nolan, S. (Eds.), 2015. Spiritual Care in Practice: Case Studies in Healthcare Chaplaincy. Jessica Kingsley, Philadelphia.
Flannelly, K.J., Weaver, A.J., Smith, W.J., Handzo, G.F., 2003. Psychologists and health care chaplains doing research together. J. Psychol. Christ. 22, 327–332.
Gibelman, M., Gelman, S.R., 2003. The promise of faith-based social services: perception versus reality. Soc. Thought 22, 5–23.
Good, C.M., 1991. Pioneer medical missions in colonial Africa. Soc. Sci. Med. 32, 1–10.
Goosby, E., Dybul, M., Fauci, A.S., et al., 2012. The United States President's Emergency Plan for AIDS Relief: a story of partnerships and smart investments to turn the tide of the global AIDS pandemic. J. Acquir. Immune Defic. Syndr. 60 (Suppl. 3), S51–S56.
Gunderson, G.R., Cochrane, J.R., 2012. Religion and the Health of the Public: Shifting the Paradigm. Palgrave Macmillan, New York.
Handzo, G.F., Smith, W.J., Twiname, J., Twiname, C., Weiss, W.M., 1999. The HealthCare Chaplaincy, Inc., New York, New York. J. Health Care Chaplain. 9 (1/2), 29–42.
Handzo, G.F., Cobb, M., Holmes, C., Kelly, E., Sinclair, S., 2015. Outcomes for professional health care chaplaincy: an international call to action. J. Health Care Chaplain. 20 (2), 43–53.
Hauerwas, S., 1990. God, Medicine, and Suffering. Wm. B. Eerdmans, Grand Rapids, MI.
Heclo, H., 2001. Religion and public policy: an introduction. J. Policy Hist. 13, 1–18.
Hein, J., 2014. The Quiet Revolution: An Active Faith that Transforms Lives and Communities. Waterfall Press, U.S.
Holman, S.R., 2015. Beholden: Religion, Global Health, and Human Rights. Oxford University Press, New York.
Holmes, M.A.P., 2004. Health disparities, the faith agenda, and health promotion/disease prevention: the General Baptist State Convention of North Carolina model. N.C. Med. J. 65, 373–376.
Holmes, M.A.P., Hatch, J., 2007. Health promotion and African-American Baptist churches in North Carolina. N. C. Med. J. 68, 376.
Idler, E.L. (Ed.), 2014. Religion as a Social Determinant of Public Health. Oxford University Press, New York.
Jakobovits, I., 1959. Jewish Medical Ethics: A Comparative and Historical Study of the Jewish Religious Attitude to Medicine and its Practice. Bloch Pub. Co., New York.
Jewish Federations of North America, 2016. Health & long-term care resource center. Retrieved June 10, 2016 from http://jewishfederations.org/about-jfna/washington-office/health-long-term-care-resource-center.
Johnson, B.R., 2002. Objective hope: assessing the effectiveness of faith-based organizations: a review of the literature. Center for Research on Religion and Urban Civil Society (CRRUCS) Report. University of Pennsylvania, Philadelphia.
Katz, R.A., 2010. Paging Dr. Shylock!: Jewish hospitals and the prudent reinvestment of Jewish philanthropy. In: Smith, D.H. (Ed.), Religious Giving: For the Love of God. Indiana University Press, Bloomington, IN, pp. 162–184.
Kegler, M.C., Kiser, M., Hall, S.M., 2007. Evaluation findings from the Institute for Public Health and Faith Collaborations. Public Health Rep. 122, 793–802.
Kennedy, S.S., Bielefeld, W., 2002. Government shekels without government shackles?: the administrative challenges of charitable choice. Public Adm. Rev. 62, 4–11.
Koenig, H.G., 1999. The Healing Power of Faith: Science Explores Medicine's Last Great Frontier. Simon and Schuster, New York.
Koenig, H.G., King, D.E., Carson, V.B., 2012. Handbook of Religion and Health. second ed. Oxford University Press, New York.

Levin, J.S., 1984. The role of the Black church in community medicine. J. Natl. Med. Assoc. 76, 477–483.
Levin, J., 2001. God, Faith, and Health: Exploring the Spirituality-Healing Connection. John Wiley and Sons, New York.
Levin, J., 2009. "And let us make us a name": reflections on the future of the religion and health field. J. Relig. Health 48, 125–145.
Levin, J., 2012. Jewish ethical themes that should inform the national healthcare discussion: a prolegomenon. J. Relig. Health 51, 581–600.
Levin, J., 2013. Engaging the faith community for public health advocacy: an agenda for the Surgeon General. J. Relig. Health 52, 368–385.
Levin, J., 2014a. Faith-based initiatives in health promotion: history, challenges, and current partnerships. Am. J. Health Promot. 28, 139–141.
Levin, J., 2014b. Faith-based partnerships for population health: challenges, initiatives, and prospects. Public Health Rep. 129, 127–129.
Levin, J., 2016. The epidemiology of religion. In: Levin, J. (Ed.), Religion and the Social Sciences: Basic and Applied Research Perspectives. Templeton Press, West Conshohocken, PA (in press).
Levin, J., Hein, J., 2012. A faith-based prescription for the Surgeon General: challenges and recommendations. J. Relig. Health 51, 57–71.
Mackler, A.L., 2003. Introduction to Jewish and Catholic Bioethics: A Comparative Analysis. Georgetown University Press, Washington, DC.
Marty, M.E., Vaux, K.L. (Eds.), 1982. Health/Medicine and the Faith Traditions: An Inquiry into Religion and Medicine. Fortress Press, Philadelphia.
Meador, K.G., 2007. Redeeming Medicine, in Christian Reflection: A Series in Faith and Ethics, 22: Health. Baylor University Center for Christian Ethics, Waco, TX, pp. 81–86.
Meister, J.S., de Zapien, J.G., 2005. Bringing health policy issues front and center in the community: expanding the role of community health coalitions. Prev. Chronic Dis. 2 (1), 1–7.
Morgan, P., Lawton, C.A., 2007. Ethical Issues in Six Religious Traditions. second ed. Edinburgh University Press, Edinburgh, U.K.
Newlin, K., Dyess, S.M., Allard, E., Chase, S., Melkus, G.D., 2012. A methodological review of faith-based health promotion literature: advancing the science to expand delivery of diabetes education to Black Americans. J. Relig. Health 51, 1075–1097.
Nickell, C.G., 2012. Uniting Faith, Medicine and Healthcare: A 57-Year History of the Institute for Spirituality and Health at the Texas Medical Center. Lightning Source, La Vergne, TN.
Nieuwsma, J.A., Rhodes, J.E., Jackson, G.L., et al., 2013. Chaplaincy and mental health in the Department of Veterans Affairs and the Department of Defense. J. Health Care Chaplain. 19, 3–21.
Numbers, R.L., Amundsen, D.W. (Eds.), 1986. Caring and Curing: Health and Medicine in the Western Religious Traditions. Macmillan, New York.
O'Connor, T.StJ., 2002. The search for truth: the case for evidence based chaplaincy. J. Health Care Chaplain 13, 185–194.
Pellegrino, E.D., Thomasma, D.C., 1996. The Christian Virtues in Medical Practice. Georgetown University Press, Washington, DC.
Pellegrino, E.D., Thomasma, D.C., 1997. Helping and Healing: Religious Commitment in Health Care. Georgetown University Press, Washington, DC.
Post, S.G., 2004. Encyclopedia of Bioethics. third ed. Macmillan Reference USA, New York.
Post, S.G., Puchalski, C.M., Larson, D.B., 2000. Physicians and patient spirituality: professional boundaries, competency, and ethics. Ann. Intern. Med. 132, 578–583.
Preuss, J. 1993. Biblical and Talmudic Medicine [1911]. Rosner, F. (Trans.). Jason Aronson, Northvale, NJ.
Puchalski, C.M., 2001. Spirituality and heath: the art of compassionate medicine. Hosp. Physician 37 (3), 30–36.
Puchalski, C.M., Ferrell, B., 2010. Making Health Care Whole: Integrating Spirituality into Patient Care. Templeton Press, West Conshohocken, PA.
Religious Freedom Project, 2012. Report of the Georgetown Symposium on Religious Freedom and Healthcare Reform, March 22, 2012. Georgetown University, Berkley Center, Washington, DC.
Roe, C.A., Sonnex, C., Roxburgh, E.C., 2015. Two meta-analyses of noncontact healing studies. Explore (NY) 11, 11–23.
Rogers, M., Dionne Jr., E.J., 2008. Serving People in Need, Safeguarding Religious Freedom: Recommendations for the New Administration on Partnerships with Faith-Based Organizations. Brookings Institution, Washington, DC.
Satcher, D., 1999. Opening address. CDC/ATSDR Forum: Engaging Faith Communities as Partners in Improving Community Health (pp. 2–3). Centers for Disease Control and Prevention, Public Health Practice Program Office, Atlanta.
Shields, M., Kestenbaum, A., Dunn, L.B., 2015. Spiritual AIM and the work of the chaplain: a model for assessing spiritual needs and outcomes in relationship. Palliat. Support. Care 13, 75–89.
Steinberg, A. 2003. Encyclopedia of Jewish Medical Ethics: A Compilation of Jewish Medical Law on All Topics of Medical Interest, from the Most Ancient Sources to the Most Current Deliberations and Decisions, with a Concise Medical and Historical Background, and a Comprehensively Comparative Analysis of Relevant General Ethical Approaches. Rosner, F. (Trans.). Feldheim Publishers, Jerusalem.
Stempsey, W.E., 2001. Institutional identity and Roman Catholic hospitals. Christ. Bioeth. 7, 3–14.
Sullivan, L.E., 1989. Healing and Restoring: Health and Medicine in the World's Religious Traditions. Macmillan, New York.
Tobin, D., Tobin, G.A., Rubin, S., 2005. In Every Tongue: The Racial and Ethnic Diversity of the Jewish People. Institute for Jewish and Community Research, San Francisco.
Vaux, K., 1976. Religion and health. Prev. Med. 5, 522–536.
Westberg, G.F., 1984. Churches are joining the health care team. Urban Health 13 (9), 34–36.
White House Office of Faith-Based and Community Initiatives, 2008. Innovations in Compassion: The Faith-Based and Community Initiative: A Final Report to the Armies of Compassion. The White House, Washington, DC.
White House Office of Faith-Based and Neighborhood Partnerships, 2011. Partnerships for the Common Good: A Partnership Guide for Faith-Based and Neighborhood Organizations. The White House, Washington, DC.
World Faiths Development Dialogue, 2012. Global Health and Africa: Assessing Faith Work and Research Priorities: Full Report. Georgetown University, Berkley Center, Washington, DC.
Yanek, L.R., Becker, D.M., Moy, T.F., Gittelsohn, J., Koffman, D.M., 2001. Project Joy: cardiovascular health promotion for African American women. Public Health Rep. 116 (Suppl. 1), 68–81.
Zoloth, L., 1999. Health Care and the Ethics of Encounter: A Jewish Discussion of Social Justice. University of North Carolina Press, Chapel Hill, NC.