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Jeffrey D. Robinson & Nussbaum Jon F.

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Grounding Research and Medical Education About Religion in Actual Physician–Patient Interaction: Church Attendance, Social Support, and Older Adults

Jeffrey D. Robinson and Jon F. Nussbaum
Department of Communication Arts & Sciences
The Pennsylvania State University

This article reviews the relation between social support and elder health, the social-support dimensions of religion, the relation between church attendance and elder health, the place of religion in the biopsychosocial model of medicine, and medical education’s position on physician–patient communication about religion. It then examines the emergence of the topic of religion in actual visits. Data are 71 videotaped and transcribed, chronic-routine visits between 12 internal medicine physicians and their older patients. Religion was raised as a topic in 9 visits (13%). In every case, the topic was initiated by patients. The most frequent topic was church attendance (7 of 9 topics), which patients typically used as a contextualizing framework to relate and describe somatic problems. In no cases did physicians make efforts to support or facilitate patients’ church attendance, as is advocated by medical education. Implications for medical education and the biopsychosocial model are discussed.

Roter (2000) identified the need for communication scholars to confront emerging ethical issues in medicine, such as decision making in end-of-life discussions. Although not as publicly visible as cloning and stem cell research, an equally controversial issue is religion (Mills, 2002). There is no scientific evidence that functional and organic disease can be healed by the solicitation of divine power alone (Levin, 1996). However, there is evidence that religious beliefs...
and behaviors are multifaceted health-protective factors, especially for older adults (Koenig, McCullough, & Larson, 2000). For medical educators and physicians, who have taken an oath to heal the sick, this presents a professional–ethical dilemma between prescribing behaviors and prescribing religion. It presents a similar dilemma for health care policymakers, who might consider, for example, granting frequent church attendees special health insurance rates (Koenig & Larson, 1998).

This article focuses on how religion—in particular, church attendance—emerges as a topic of discussion in visits where older adult patients are seeing internal medicine physicians for the purpose of dealing with chronic-routine problems. Regarding older adults, this article begins by briefly reviewing the relation between social support and health, how religion is a unique form of social support, and the relation between religion and health, with a focus on church attendance. It proceeds to review the place of religion in the biopsychosocial model of medicine and medical education’s position on physician–patient communication about religion. Finally, it grounds research and medical education about religion in actual physician–patient communication by analyzing the frequency, content, and process of discussing religious topics.

OLDER ADULTS AND SOCIAL SUPPORT

A complex relation exists among physical and mental health, social support, and aging. A general myth associated with the aging process is that, as persons grow older, they can expect a steady decline in both social activity and health. Although it is true that older adults suffer from more chronic or long-term illnesses than younger adults, and although older adults visit their physicians and utilize health care systems more frequently than younger adults (Beisecker & Thompson, 1995), it is nevertheless the case that each successive cohort of older adults maintains an active lifestyle and a positive health profile throughout the great majority of their lives (Nussbaum, Pecchioni, Robinson, & Thompson, 2000). Active and healthy aging can be attributed to various advances in medicine, technology, and public health policy. However, communication scholars have been searching for the social–interactional correlates and causes of activity and good health throughout the aging process.

Numerous researchers have concluded that active participation within a social network of family and friends, together with positive perceptions toward social interaction, are key determinants of successful aging (Baltes & Baltes, 1990). Krause (2001) highlighted the work of Barrera (1986) in an attempt to understand why older adults who are embedded within supportive social networks not only enjoy better physical and mental health, but also significantly increase their odds of having a longer life. Barrera advanced three dimensions of social support that ap-
pear to be related to good health as persons age: (a) social embeddedness (i.e., frequency of contact with others), (b) received support (i.e., the amount of help actually provided by others), and (c) perceived support (i.e., satisfaction with received support). Norris and Kaniasty (1996) found that positive feelings of perceived support is the most predictive characteristic of social support on health and well-being in later life. House, Landis, and Umberson (1988) reviewed a quarter century of research linking social support to health and concluded that individuals who are socially isolated, and who have not constructed a reasonably strong social network of supportive relationships, are more likely to be physically and psychologically less healthy and are more likely to die at a younger age. Levin (2001), a social epidemiologist, went so far as to conclude that a lack of social support is a fundamental cause of disease.

RELIGION AS A UNIQUE FORM OF SOCIAL SUPPORT FOR OLDER ADULTS

Sociologists (e.g., Durkheim, 1951) and psychologists (e.g., James, 1978) have long theorized that religious beliefs and practices involve social and psychological mechanisms that are associated with health and well-being (Levin, 1996; Vanderpool & Levin, 1990). Religious events (e.g., weekly mass, prayer groups, Bible school, church-related social functions, etc.) offer preexisting reservoirs of individuals and activities that constitute, and facilitate the maintenance of, social support networks (Krause, 2001). For example, other congregants can provide a sense of belonging, fellowship, and cohesiveness, as well as provide instrumental and emotional resources, such as monitoring others for illness and providing encouragement, hope, and aid (Koenig & Larson, 1998).

Older adults can have a particularly difficult time maintaining connections to social-support networks, and thus have the potential to rate low on social embeddedness, received support, and perceived support. Without endorsing the decrement model of aging, the aging process is associated with socially isolating changes in persons’ language skills, cognitive abilities, and competencies regarding relationships and communication (Nussbaum, Barringer, & Kundrat, 2002). As persons age, these factors, together with a host of others—such as the death of friends and family members, lesser mobility, stagnant finances, and forced relocation—can negatively affect the quantity and quality of social networks and support. For older adults, religion can be a unique source of social support. That is, as opposed to numerous social-support networks that are temporary across the life course (e.g., college associations, employment-related events, etc.), friend networks that shrink over the life course (e.g., due to relocation, friends’ deaths, etc.), and family networks that shrink when older adults are relocated, one enduring, social-support network is organized religion.
Older (vs. younger) adults are more likely to experience mobility limitations that are obstacles to maintaining active social lives (e.g., inability to walk or drive). However, unlike many other social support networks, religious organizations typically facilitate transportation to and from events. Philosophically, religion tends to encourage social-support-related behaviors, such as staying married (Levin, 1996). Theologically, religions offer coping strategies that secular institutions do not, such as providing a sense of control over one’s own actions (e.g., through prayer and ways of living), contextualizing stressful events in larger systems of meaning (e.g., fear of death), and ultimately turning over stressful events to a benevolent and concerned Other (e.g., God; Vanderpool & Levin, 1990). These latter aspects of “secondary control” are particularly helpful for older adults who, as a result, can spend more energy on positively interacting with others instead of negatively dwelling on their difficulties (Krause, Morgan, Chatters, & Meltzer, 2000).

Compared to middle-aged and younger adults, older adults are more likely to belong to formal religious organizations, pray, and attend church (McFadden, 1995). Unlike young and middle-aged adults, religiosity does increase with age among older adults (65+; Idler & Kasl, 1997). The normal development of the aging process, as well as health crises, foreground the meaning and purpose of one’s life (Erikson, Erikson, & Kivnick, 1986). Poor physical health (e.g., disability), especially having life-threatening diseases (e.g., malignant cancer), is positively associated with turning to religion for help with health problems (Idler, 1995).

**GENERAL HEALTH EFFECTS OF RELIGION ON OLDER ADULTS**

Egbert, Mickley, and Coeling (this issue) provide a detailed review of how religion has been measured. Among older adults (65+), intrinsic religiosity—such as religious coping, or the use of religion to manage stress induced by illness and hospitalization—has been found to be negatively associated with cognitive symptoms of depression (e.g., feeling hopeless, dropping interests and activities, avoiding social gatherings; Koenig et al., 1995). This finding heightens the importance of religion for older adults, because such symptoms are difficult to treat with conventional psychopharmacology (Reynolds, 1992). Among persons 75 and older, both intrinsic and extrinsic religiosity (e.g., church attendance) are significantly associated with increased morale (Koenig, Kvale, & Ferrel, 1988). Finally, both intrinsic and extrinsic religiosity have been found to reduce the risk of mortality among older adults (55+) who are in poor health (Oxman, Freeman, & Manheimer, 1995).
SPECIFIC EFFECTS OF EXTRINSIC RELIGIOSITY ON OLDER ADULTS

Among older adults (65+), church attendance has been positively associated with better health practices (e.g., gardening, exercising, maintaining a healthy diet, not drinking or smoking), increased social activity (e.g., leisure activities, social-network ties, holiday celebrations), and greater subjective well-being (the effect of which is pronounced among the disabled), and negatively associated with depression, somatic complaints, and interpersonal problems (Blazer & Palmore, 1976; Idler & Kasl, 1997; Koenig, Hays, et al., 1999). For persons 60 and older, religious attendance has been associated with a reduced likelihood of being hospitalized, fewer hospital admissions, and fewer days of hospitalization (Koenig & Larson, 1998). In a 6-year longitudinal study of almost 4,000 individuals, older adults (65+) who attended church frequently (vs. infrequently) were less likely to die (Koenig, Hays, et al., 1999).

A meta-analysis found that, compared to younger persons, there is a stronger relation between church attendance and subjective well-being for older (vs. younger) adults (Witter, Stock, Okun, & Haring, 1985). This is especially consequential when one considers that age is positively associated with disability (i.e., having difficulty, needing help, or not being able to do activities), and disability is negatively associated with church attendance (Idler & Kasl, 1997; Levin & Vanderpool, 1991). Compared to nondisabled older adults (65+), the positive associations between religious involvement and physical- and mental-health outcomes are more pronounced for disabled elderly (Idler & Kasl, 1997). Thus, the health-protective effects of church attendance tend to increase with age, yet advancing age tends to provide barriers to attending church.

RELIGION, THE BIOPSYCHOSOCIAL MODEL OF MEDICINE, AND PHYSICIAN–PATIENT COMMUNICATION

Mishler (1984) argued that patients’ communication is predominantly guided by Schutz’s (1962) “natural” attitude, which is similar to Habermas’s (1970) “symbolic” mode of consciousness. According to Mishler, in the natural attitude, “events are located and given significance with reference to one’s own biographical situation and location in the world … [E]vents take on relevance from their relationship to the acting subject’s interests, purposes, and plans” (p. 122). On the other hand, as a science, medicine and medical practice have been socially constructed so as to be predominantly guided by a biomedical model (Engel, 1977), which “assumes disease to be fully accounted for by deviations from the
norm of measurable biological (somatic) variables” (Engel, 1977, p. 130) and excludes social, psychological, environmental, and behavioral dimensions of illness. As such, continued Mishler, physicians’ communication is predominantly guided by Schutz’s “scientific” attitude, where the perspective is that of a “disinterested” observer: “[E]vents in the world are not viewed within subjective coordinates of space and time, but with reference to abstract, standard, and context-free coordinates of ‘objective’ space and time.” (p. 122).

The concern for medicine is the following: “In approaching a physician for help, a patient brings not only a physical problem but also a social context … A patient’s experience of physical problems is inseparable from the wider social context in which these problems occur” (Waitzkin, 1991, pp. 3–4). Numerous scholars have argued that health and illness are social facts as well as biological facts; that psychological, social, environmental, and behavioral aspects (e.g., work, economic security, gender, sexuality, family, marriage and partnership, the process of aging, and community) not only have interactive effects on biological (somatic) aspects, but have their own independent effects as well (Balint, 1957; Engel, 1977). Thus, effective medicine involves a biopsychosocial model of medicine (Engel, 1977), or treating “the pathology of the whole person” (Balint, 1957, p. 103). However, due to the biomedical model, combined with the physician-guided nature of medical activities (e.g., history taking) and asymmetries of power and knowledge between physicians and patients (for a review, see Robinson, 2001), a fundamental feature of physician–patient communication—a feature that is realized through myriad practices of questioning, answering, interrupting, examining, selective note taking, and so on—is the systematic inclusion of (or focus on) biomedical topics and exclusion of (or focus away from) their psycho-social contexts; this includes the process of isolating problems that emerge from psycho-sociocontexts and transforming (or medicalizing) them into technical biomedical problems (Mishler, 1984; Waitzkin, 1991).

Religion is akin to other psychosocial factors and falls squarely into the biopsychosocial model (Sloan, Bagiella, & Powell, 1999). The Diagnostic and Statistical Manual of Mental Disorders recognizes religion as a relevant source of emotional support or distress. In addition to affecting health, religion can shape how patients understand and enact medical directives and advice (Barnard, Dayringer, & Cassel, 1995), as well as how patients make medical decisions, especially as they pertain to chronic and terminal illness (Wennberg, 1989).

**MEDICAL EDUCATION ABOUT RELIGION AND PHYSICIAN–PATIENT COMMUNICATION**

The number of U.S. medical schools offering courses dealing with religion and health has increased from 4 in 1994 to almost 30 in 1997 (Levin, Larson, &
Puchalski, 1997) to over 65 in 2002 (Koenig et al., 2000). Medical education’s current stance on religion can be summarized by the following six positions. First, due to the positive effects of religion on health and differences in patients’ religious beliefs, needs, and attendance practices, physicians should at least be “familiar with the basic tenets regarding the meaning and purpose of human life in the major world religions as well as with religious interpretations of sickness, suffering, and death” (Barnard et al., 1995, p. 809).

Second, as advocated in contemporary textbooks on medical examination (Bates, Bickley, & Hoekelman, 1995), at least during intake histories, physicians should conduct a religious interview (Koenig, Idler, et al., 1999; McKee & Chappel, 1992; Oxman et al., 1995; Sloan et al., 1999), which involves taking account of patients’ religious values, beliefs, and practices. Physicians should not inquire into patients’ religious beliefs and practices to promote nonmedical agendas (Sloan et al., 1999).

Third, physicians should not “substitute [religious] beliefs or rituals for accepted diagnostic concepts or therapeutic practice” (McKee & Chappel, 1992, p. 206). The provision of prayer as a substitute for conventional medical therapy is almost universally discouraged (Post et al., 2000).

Fourth, although there may be times when it is appropriate for physicians to inquire into patients’ religious beliefs and practices (e.g., the “religious interview,” discussed earlier), educators tend to agree that physicians should not take any sort of lead in providing religious guidance to patients (e.g., advice regarding religious beliefs, values, and practices, including prayer; Koenig, Idler, et al., 1999). This is so even when such guidance is adjunctive to traditional medical treatments (Sloan et al., 1999). Along these lines, physicians’ offices have been considered public, secular spaces that should not contain signifiers of physicians’ (or any others’) religious beliefs (e.g., posters, relics, etc.; Graner, 2000). When patients ask physicians to pray with them, physicians should refer them to an identified religious leader, distinct from the patient’s medical team, who can provide more competent religious care (Dagi, 1995; Post et al., 2000).

Fifth, physicians should be aware of available clergy (e.g., ministers, rabbis, pastoral counselors, hospital chaplains) and their health care-related training. Physicians should be prepared to refer patients to such clergy (Barnard et al., 1995).

Sixth, although physicians should not volunteer religious guidance or encourage patients to further participate in religious communities beyond their current levels of engagement (Koenig & Larson, 1998), physicians have been encouraged to positively reinforce and facilitate patients’ extant religious behaviors (Oxman et al., 1995). This is especially true for church attendance among older adults, particularly for those who are disabled (Levin & Vanderpool, 1991).
Given the current medical stance associated with communication about religion within physician–patient interactions, little is known about the actual occurrence and content of religious talk in medical encounters. Thus, this research seeks to answer four research questions:

RQ1: With what frequency is religion raised as a topic of discussion?
RQ2: What aspects of religion are raised as topics of discussion?
RQ3: What proportion of religious topics are raised by physicians and patients?
RQ4: How do religious topics emerge in interactions with physicians and how do physicians deal with the topics?

METHOD

Participants

Participants were drawn from the Geisinger Health System, a large multispecialty group practice that provides health care for more than 2 million people in 31 counties in rural Pennsylvania. Data were collected from one county and its two hospital-based internal medicine clinics. Internal medicine physicians were targeted because as compared to family practice physicians, they tend to be less intrinsically and extrinsically religious (Koenig et al., 2000) and their patients tend to be older. Seventeen internal medicine physicians were offered $50 to participate and 12 agreed (71%). Physicians were eligible if they were an MD with a specialty in internal medicine. Patients were eligible if they were (a) an adult, (b) meeting with an internal medicine physician, (c) established with (vs. new to) the practice, and (d) visiting to deal with the routine monitoring of one or more chronic problems (e.g., hypertension, diabetes, etc.; not acute, follow-up, or physical examination visits). For each participating physician, 5 to 7 ($M = 5.8; SD = 2.2$) randomly selected patients were offered $20 to participate and 73 out of 100 patients agreed (73%). Two patients, a nun and a pastor, were omitted because their public occupation provided differential grounds for discussing religion-related topics (resulting in a total of 71 patients).

Procedure

This study was approved by the Human-Subjects Protection Committee of both The Pennsylvania State University and Geisinger Health System. Nurses admitted all eligible patients (beginning with the first patient of the day) and escorted them to a private room where a researcher explained the study and, if patients agreed to participate, secured their written consent. Participating patients then filled out a
previsit survey, after which they were escorted to a visit room and seen by a physician. Physicians and patients interacted naturally and researchers were not present during visits. Visits were videotaped with small cameras that were positioned in ceiling corners such that their view could be obstructed by an examination curtain, which was drawn when patients dressed or underwent especially private examinations. Additionally, visits were separately audiotaped with small wireless microphones. After their visit, patients were escorted to the waiting room, filled out a postvisit questionnaire, and finally were thanked and paid $20 for their participation. All data for this article were transcribed by Jeffrey D. Robinson according to Jefferson’s (Atkinson & Heritage, 1984) notation system.

RESULTS

Regarding RQ1, religion was raised as a topic of discussion in 9 out of 71 visits (13%). Regarding RQ2, topics dealt with were as follows: prayer (one case), God’s will (one case), and church attendance (seven cases). Regarding RQ3, in all nine cases, religious topics were initiated by patients. RQ4 is addressed through a detailed examination and analysis of specific cases.

Prayer (One Case)

Extract 1 comes from a routine checkup for a 60-year-old, high school educated, White woman who suffers from chronic back pain and depression. The patient’s 35-year-old son recently died in a car accident, but is survived by his girlfriend and their 10-month-old baby. At line 1, the patient initiates a telling about the girlfriend who, during the patient’s grief over her son’s death, is “thuh only one thet’s bein’ r:otten” (line 4).

Extract 1: [P3:88–14]

01 PAT: [[My son’s]] Girlfrienď had a baby in december [last dec]ember.  
02 DOC: [I see. ]  
03 (2.2)  
04 PAT: She’s thuh only one thet’s bein’ r:otten.  
05 (0.2)  
06 DOC: .tch ↑Oh↓:. ((disappointed/sympathetic voice))  
07 (1.2)  
08 DOC: Rotten to:_  
09 PAT: .hh Sh:ġ [asked me mond]ay fer: uh:m (1.1) death certificate  
10 DOC: [ To you:, ( ) ]  
11 PAT: >to go to thuh< socia’ s’curity (.) °office.°  
12 (.)
At line 19, the physician produces a summative, empathetic assessment of the patient’s telling as embodying a hardship: “>W’ll that< soundsº like a very difficult_ (.) situation.” As part of her response, the patient says, “We’ll get >through it.<” (line 22), which claims that she (and presumably her husband, and possibly even her daughter-in-law) will recover from the hardship. At line 25, the patient extends her response by providing evidence for her previous claim: “Thuh lord ’ll help us.” By citing the “lord” as an example of the type of help she expects, the patient displays an understanding that other more concrete, or proximate, forms of help will not be efficacious. This is understood by the physician, who immediately offers to help the patient by asking: “ºIs thereº anything I can do to h:elp you with it?” With the word “anything,” which is a negative polarity item (Horn, 1989), the physician builds the question with a preference for a “no”-type answer, and thus a presumption of her inability to help. By stressing the word “I” (denoted by the underline), which is hearably contrastive with “Thuh lord,” the physician can be heard to be offering medical, versus theological, assistance. In response, the patient explicitly produces prayer as a possible form of assistance: “º(J’st pra:yers,” (line 29). Although the physician claims to accept the patient’s answer with “º(O)okay,” (line 31), she ultimately moves on to other matters. Neither here, nor during the rest of the visit, does the physician pray with the patient or refer her to religious counseling.

There is evidence that the patient is religious. Note that the patient’s “Thuh lord ’ll help us.” (line 25) is not a colloquial expression, such as an idiomatic expression
(e.g., “Lord help us”) or a response cry (Goffman, 1976) of surprise or disappointment (e.g., “Oh my Lord”), both of which might be more readily uttered by nonreligious persons. Furthermore, the patient specifically requests “prayers” (line 29) as a form of help. Not only is this evidence initiated and volunteered by the patient, but “prayers” are specifically requested in the face of a medical (vs. religious) offer (line 27).

God’s Will (One Case)

Extract 2 comes from a routine checkup for a 68-year-old, Italian woman who suffers from chronic knee pain. During this visit, the patient claims that she is depressed from the recent death of her closest friend, who died of cancer. A discussion ensues, and at line 1, the patient is describing her late friend’s generosity.

Extract 2 [P3:]

01 PAT: <She gave money> away like it was unbelievable.
02 (0.4)
03 PAT: I [kept telIin’ her Rosa:nnna I mean: why are you doing this.
04 DOC: [(Mm)]
05 PAT: I meant you should worry about yourse:lf.
06 DOC: [(Mm hm, ]
07 DOC: [Mm hm.]
08 PAT: [.hhh ] She=says I don’ have ta worry. There’s plenty. she says. (.) you [know.]
09 DOC: [Mm hm]m. Mm hm.=
10 PAT: =There’s [plenti y for everybody.
11 DOC: [(Mm)]
12 DOC: .tch Oh that’s nice,
13 ()
14 15 DOC: That’s a that’s a very generous heart the[re.]
16 PAT: [S]o- should- (.) if
17 th[ere is a ] God in th[is world ]=eh should ’e have let that
18 DOC: [Mm hm. ] [Mm hm. ]
19 PAT: happ[en?]
20 DOC: [We:]ll, you kno::w_ (0.2)
21 PAT: [Uhhh ] ((laughter))
22 DOC: [Maybe] in a way he was giving it to someone that he knew
23 would (. ) gain plleasure by giving it [to other people.]
24 PAT: [I guess::. ] I guess.:

Following the physician’s description of the patient’s late friend as “a very generous heart” (line 15), the patient initiates an explicit question, one that pursues the
physician’s opinion on a matter of religion: “So- should- (. ) if there is a God in this world=eh should ’e have let that happen?” (lines 16–19). The patient is not smiling or laughing while asking her question, and in this sense it is asked seriously.

The patient’s question—whose generic form is something along the lines of, “If God is a benevolent, omnipotent deity, why does He allow good, innocent, and virtuous people to die premature deaths”—is a common, and theologically serious, question. Although the physician’s answer at lines 20 to 23 might be characterized as harmless speculation, note that it does not address the patient’s question; rather, it addresses the late friend’s extreme generosity. (In the physician’s answer, “he” refers to God and “it” refers to money.) Neither here, nor during the rest of the visit, does the physician refer the patient to religious counseling.

Church Attendance (Seven Cases)

The remainder of the cases involved church attendance. Five themes emerged. First, as in extracts 1 and 2, patients (vs. physicians) initiate the topic. Second, patients raise the topic not for its own sake, but as a contextualizing framework in which to relate and describe somatic problems. Third, in raising the topic, patients display that church attendance is an important, extant behavior in their lives. (A parallel theme can be found in extracts 1 and 2, where patients reveal that religion or religious issues are important.) Fourth, in each case, an argument can be made that the patients’ somatic problems threaten to interfere with their attending church. Fifth, in no cases did physicians make efforts to support and facilitate patients’ church attendance.

Patients raised the topic of church attendance in one of two general ways. First, it was raised as part of an answer to physicians’ inquiries regarding somatic problems. For example, extract 3 comes from a routine checkup for a 66-year-old, high school educated, White, female, breast cancer survivor who suffers from depression and osteoarthritis in her knees. At line 1, the physician refers to Viox, a prescription medication being used to treat the patient’s arthritis.

Extract 3 [P3:95-15]

01 DOC: (H)as ’at been helping at all? ((referring to Viox))
02 PAT: Oh a little, not_ (0.7) not all <that much.>
03 DOC: Are you stiff when you first go da get up outta thuh chair,
04 an’ things,
05 DOC: Ye:ah,
06 (0.5)
07 DOC: Ooh::: ((sympathetic voice))
08 (0.4)
09 PAT: I have ta (0.2) I have ta get up_ (. ) with bgth a my ha:nds o:n
10 thuh chair. Even in [church.]
When I’m in church even ta stand up at church I’ve ta pull.

Pull my self up.

I can’t get up_

Okay,

Can’t carry anything up thuh stairs any more,

Have ya tried takin’ one of thuh vi:ox.

At line 2, the patient communicates that her current dosage of Viox is not providing sufficient relief. At lines 3 to 4, perhaps to more fully understand the patient’s answer and condition, the physician pursues his initial question by asking the patient to confirm or disconfirm a generic scenario: “Are you stiff when you first go da get up outta thuh chair, an’ things.” Simultaneous with the word “chair,” the patient begins a confirmatory head nod; from this point through line 6, the patient produces two nods in one continuous motion. After the patient’s initial head nod, the physician pursues confirmation with “Ye:ah,” to which he receives another head nod. At line 7, the physician sympathetically and negatively assesses the patient’s condition with “Ooh::.” The physician’s assessment possibly closes the question–answer sequence at lines 1 to 6 (Schegloff, 1995). During the silence at line 8, the physician returns his gaze to the patient’s medical records. At line 9, the patient initiates a turn of talk wherein she continues to answer the physician’s question at lines 3 to 4—here, she upgrades the severity of her condition by moving from a simple confirmation of the physician’s medical description “stiff” to the provision of a more severe description: “[I have ta get up_ (. ) with both a my ha:nds o:n thuh chair” (lines 9–10). The patient immediately continues to extend her explanation of the severity of her condition by adding the following: “Even in church” (line 10). At lines 10 to 17, the patient moves beyond the physician’s generic scenario and contextualizes her arthritic condition—specifically, her problem with standing from a sitting position—within the activity of church attendance. After passing on at least four interactional places where it would have been relevant to acknowledge, or otherwise respond to, the patient’s church scenario (i.e., lines 12, 14, 16, and 19), the physician finally does so with “Okay,” (line 20). The physician maintains his previous biomedical agenda by proceeding to ask an-
other question: “Have ya tried takin’ ↑two of thuh vi:↓ox” (line 24). Neither here, nor during the rest of the visit, does the physician deal with church attendance.

For a second example, see extract 4, which comes from a routine checkup for an 83-year-old, 10th-grade-educated, White man who suffers from irritable bowel syndrome, degenerative back disease, coronary artery disease, and anxiety.

**Extract 4 [P3:011-03]**

01 DOC: Okay bo:wels >that was thee other< thing we fo llow is that
02 irritable bowel (h)as that been doin’ _ (0.2) okay er
03 PAT: d-=Oh::: yes sir. ( ) (. ) {is better} 
04 PAT: B’t sunday is ba:d. I(h) d(h)on’t k(h)now why sunday, I
05 [said I’m ] going ta church- sunday school if it (k)- if I gotta
06 DOC: [Oh yeah,]
07 PAT: go on my hands an’ knees. I: went .hh an’ (nen) then: I: uh:
08 felt a little better, an’ [hh]
09 DOC: [N ]k[a:y. ]
10 PAT: ["b’t"] it- it- (0.2) gr-=I: I
11 ’ave good da:ys an’ ba:d days. that’s all I can say.
12 DOC: A’right;

In response to the physician’s question regarding the irritable bowel, “(h)as that been doin’ _ (0.2) okay” (line 2), the patient responds affirmatively, “yes sir.” (line 3). Following some unintelligible talk (line 3, denoted by the parentheses), the patient continues his turn by hedging his previously unproblematic assessment with a piece of contrasting evidence: “B’t sunday is ba:d.” (line 4). The patient continues to explicate his assessment “ba:d” by reporting his response to the pain, a response that is grounded in a concrete event (i.e., church attendance): “I said I’m going ta church- sunday school if it (k)- if I gotta go on my hands an’ knees” (lines 4–7). The patient’s response simultaneously displays his perception of the importance of church and of the threat his medical condition poses to such attendance.

A third example, seen in extract 5, comes from a routine checkup for a 46-year-old, high school educated, White, female secretary who suffers from diabetes and, recently, knee pain.

**Extract 5 [P3:060-10]**

01 DOC: You’re ha:ving knee problems since (. ) Ju:ne.
02 PAT: Yes.

.. ((physician takes history of knee; six questions omitted))

03 DOC: .hhh It does not restrict your <physical_> (. ) capabilities.
04 you’re sti:ll able to do: >whatever you< normally feel like.
PAT: The only thing I can’t do I can’t get down=on=my knee to scrub my floor anymore.

DOC: Okay,

PAT: An’ I can’t kneel in church anymore.

DOC: Okay;

DOC: Ah=have you noticed any swelling in thuh joint,

As part of a series of questions about the patient’s “knee problems” (line 1), the physician addresses its effects on her “<physical_>(.) capabilities” (line 3), and requests confirmation that: “you’re still able to do: >whatever you< normally feel like” (line 4). This question specifically addresses the relation between the medical problem and what Engel (1977) termed “problems of living,” and the patient responds by relating that her knee problems interfere with her ability to do housework (lines 5–6). The physician acknowledges the patient’s answer with “Okay” (line 7). Insofar as the patient communicated that this was “The only thing” (line 5), the physician’s “Okay” (line 7) possibly closes the question–answer sequence and projects a shift to a new question or action (Beach, 1995). However, the patient continues to produce a second restriction: “An’ I can’t kneel in church anymore” (line 8). This is also acknowledged by the physician and, after a long silence (line 11), the physician reasserts his biomedical agenda (begun at line 1) by asking a new question about the patient’s knee (line 12).

Patients do not have to capitalize on physicians’ questions to raise the topic of church attendance. In two cases, patients simply initiate a complaint that implicates church attendance. For example, see extract 6, which comes from a routine checkup for a 76-year-old, high school educated, retired, White man who suffers from back pain, high blood pressure, diabetes, and coronary heart disease.

Extract 6 [P3:169-26]

DOC: How’s your breathing.

PAT: Good.

DOC: (N)ka(y)

PAT: Good.

DOC: Mm hm::,

PAT: Okay, (.).

PAT: How should I= tell ya this. .hh When I go da church_ (0.2) say I’m in church.

DOC: Okay, (.).

PAT: ‘f I’m settin’ there. (1.2) an’ all of a sudden_ (.
13 we have ta get up.
14 (.)
15 DOC: Mm hm[: ;] [You kn]ow
16 PAT: [I::] [get] dizzy
17 (0.4)
18 DOC: You feel a little light headed [when you get [up.]
19 PAT: [I::] [I::]
20 a[shel ]l.
21 DOC: [(Mm:)]
22 (.)
23 ???: :hhh
24 DOC: You [have to get up] s[l o : : ]w.
25 PAT: [So::] [w] [what (I)]
26 PAT: W- Yeah, well what I do I (.) le[gan on thuh (0.2) on thuh pgw
27 next_ (0.4) in fron’ a me.
28 (0.7)
29 PAT: A:n’ (-0.2) <until> it_ (.) goes awa:y. which is a couple a .hh
30 ’bout h alf a minute or so maybe,
31 (3.0)
32 PAT: But duh=hh (1.8) I guess that’s normal, I don’t know.
33 (0.4)
34 DOC: We::ll (.) unfortunately that’s (.) probably:=uh:m (.) part of
35 your diabetes.

At line 1, the physician asks for an assessment of one of the patient’s chronic problems, “How’s your breath thing” (line 1), to which the patient responds positively: “Good. (0.2) goo:d.” (line 3). The physician’s subsequent “(N)ka(y)” (line 4) acknowledges the patient’s answer, possibly closes the question–answer sequence, and projects a shift to new matters (Beach, 1995). However, the patient continues to reiterate his positive assessment, “Good” (line 6) and, after a brief silence (line 7), initiates a new topic dealing with a different problem: lightheadedness when standing up (which is likely caused by his diabetes, although the patient does not realize this). The patient initially, and explicitly, struggles with how to describe his problem: “How should I= s tell ya this” (line 9). The patient’s solution is to contextualize his problem in the activity of church attendance: “When I go da church_ (0.2) say I’m in church.” (lines 9–10). In overlap with the physician’s remedy, “You have to get up slo::w.” (line 24), the patient begins to describe his solution, “So:: what (I) …” (line 25), which he completes at line 30. During the long silence at line 31, the physician reads the patient’s medical records. If the patient orients to his lightheadedness as a relatively new problem, then his presentation of the problem may have made relevant some sort of diagnosis by the physician (Robinson, 2003), which is absent during the silence at line 31.
This argument is supported by the fact that the patient continues to pursue a diagnosis, “But duh=hh (1.8) I guess that’s normal, I don’t know.” (line 32; Robinson, 2001), and the physician responds by providing one: “that’s (.) probably:=uh:m () part of your diabetes” (lines 33–34).

For a second example, see extract 7, which comes from a routine checkup for an 87-year-old, seventh-grade-educated, retired, White woman who suffers from incontinence and chronic back pain. The patient is homebound by her medical conditions and assisted by a part-time nurse. During the following extract, the physician is physically examining the patient, who is sitting on the exam table. (The patient’s daughter, “DAU,” is also in the room.)

Extract 7 [P3:056-10]

01 DOC: (Gunna) look in your e:ars.
02 (6.0)
03 PAT: They itch so.
04 (4.0)
05 DOC: Well you got some wax buildup on this si:de,
06 (4.0)
07 PAT: (Then) my ey:es itch too:. 
08 (15.0)
09 PAT: (Then) my <’fridgeator> wen’ o:ut.
10 DAU: Huh heh (. ) heh heh,
11 PAT: Huh
12 (. )
13 PAT: (That’s it.)
14 (0.2)
15 DOC: Not=a been=a good week for you.
16 PAT: u=N:o en=eh (. ) good two da::ys. º(huh)º
17 (7.0)
18 PAT: My priest ca:led ta bring communion.
19 (. )
20 PAT: I said £oh: no:.£
21 (1.4)
22 PAT: Tomarrah, (1.1) (s)o he’s commin’ ’omorrow[w.] 
23 DOC: [ U]h huh,
24 (0.2)
25 DOC: ºUkayº,
26 DOC: Let me listen to your hgart here,

At lines 3 and 7, the patient produces two complaints regarding physical symptoms (i.e. her ears and eyes itch). After 15 sec of silent examination (line 8), the patient produces another complaint, this time shifting from the realm of physical
symptoms to that of daily living: “(Then) my ‘fridge’ wen’ out.” (line 9). Although the physician does not cease his examination, he does sympathize with the patient—at line 15, he formulates an upshot of at least the patient’s complaint about her refrigerator (and perhaps about the patient’s multiple complaints) by characterizing her as having had a bad week, to which the patient agrees. Line 17 constitutes another 7 sec of silent examination. Out of this silence, the patient initiates a second complaint in the realm of daily living: “My priest ca:led ta bring communion” (line 18). This homebound patient’s priest had called to schedule a time for communion that conflicted with her present appointment with the physician. There is evidence that the patient orients to this as a complaint in her report of how she responded to the potential conflict: “I said ‘oh: no:’” (line 20). The patient’s “oh:” displays that she had not anticipated the conflict (Heritage, 1984), and the rejection component “no:” displays her understanding of the conflict as being undesirable. This is further supported by the fact that the patient reports rescheduling the visit for “Tomarrah” (line 22). This is acknowledged by the physician with “Uh huh” (line 23), who then proceeds to project a shift to a new examination, “‘Okay’,” (Beach, 1995), which he does at line 26.

DISCUSSION

Church attendance is a unique and prevalent aspect of social support, especially for older adults, and is associated with myriad positive health outcomes. Despite this, there are several reasons why it can be ethically and practically inappropriate for physicians to initiate and provide religious “guidance” to patients, including praying with patients and advising patients to practice previously nonpracticed religious behaviors (e.g., church attendance). The primary reason is that, due to physicians’ role or relationship with patients—that is, the asymmetrical power, status, and emotional- and physical-needs relationship (Parsons, 1975)—physicians’ religious guidance can be unduly influential (McKee & Chappel, 1992; Oxman et al., 1995). This is complicated by the religious gap between physicians and patients, with physicians being less intrinsically and extrinsically religious than the general population (Maugans & Wadland, 1991). Another reason is that many physicians are not professionally competent in the provision of religious care and advice. Finally, despite their enormous benefits, intrinsic and extrinsic religiosity have also been associated with negative health outcomes (Ellison & Levin, 1998).

There are at least two types of evidence that researchers, educators, and physicians have used to justify initiating and discussing religious issues. First, according to national statistics, a significant majority of the U.S. population reports a belief in God (96%), and a large minority (42%) report that they attend regular religious services. Second, a number of studies have revealed that a majority (80%–93%) of patients report that primary-care physicians should “con-
sider” patients’ religious needs (King & Bushwick, 1994; King, Sobal, Haggerty, Dent, & Patton, 1992). Ethically, however, neither reason warrants physicians initiating and discussing religious issues. National rates of belief in God and church attendance vary dramatically by geographic location. Furthermore, research has found that a majority of patients (79%) disagree that physicians have the “responsibility” to make religious inquiries, and that only a minority of patients (albeit a large minority; 40%–48%) report that they would like their physicians to address or discuss religious issues (Maugans & Wadland, 1991), pray with them (King & Bushwick, 1994), or discuss personal religious beliefs more (King & Bushwick, 1994). Overall, there are numerous ethical hazards associated with initiating and providing religious guidance that dissuade physicians from making inquiries.

In light of these ethical hazards, medical education encourages physicians to reinforce or facilitate patients’ “extant” religious behaviors, particularly church attendance. One barrier to enacting this pedagogy is that physicians rarely know about patients’ “extant” religious behaviors. As such, physicians are encouraged to ask about such behaviors in a “religious interview.” However, this rarely happens (Maugans & Wadland, 1991), and when it does, it typically occurs during an intake interview and in a manner that is divorced from particular medical problems or concerns (e.g., “Do you attend church?” “How frequently?”). Without results from a religious interview, the biomedical model biases physicians (psychologically and interactionally) away from addressing, and perhaps even considering, psychosocial aspects of patients’ somatic concerns, including religion. Indeed, a majority of physicians (51%), report that patients rarely or never mention religion (Koenig, Bearon, & Dayringer, 1989), and it has been speculated that “[u]nless a physician overtly or tacitly invites comments about spiritual and religious interests, patients may seldom mention them” (Koenig, Moberg, & Kvale, 1988, p. 363). Importantly, but perhaps not surprisingly, given more recent research on ways in which patients solicit information and initiate topics (Robinson, 2001), the aforementioned research, reports, and speculations are contraindicated by the present findings.

In this data, the topic of religion was raised in 13% of the visits, and in every single one of these cases, the topic of religion was volunteered by patients. Thirteen percent of visits may seem low compared to prior findings regarding the frequency of discussing other so-called lifestyle topics, such as smoking (43%–81%), drinking (19%–69%), exercise (40%–56%), and nutrition (26%–56%; Bertakis & Callahan, 1992; Johanson, Larsson, Saljo, & Svardsudd, 1995). However, these topics are relatively closely tied to biomedical aspects of health, whereas topics with more distant ties such as housing arrangements (7%), stress (5%), and sexual habits (7%) are discussed much less frequently (Johanson et al., 1995). Thus, in comparison to these latter lifestyle topics, religion (13%) appears to be a relatively common topic in physician–patient communication.
In cases 1 to 5 of this study, patients raised the topic or religion as part of a response to a physician-initiated utterance that made a response relevant. In cases 6 to 7, patients voluntarily initiated utterances that contained topics related to church attendance. In each case, however, patients used an aspect of religion to ground, or contextualize, relatively abstract problems in concrete, lived aspects of their social lives. In cases 1 and 3 to 5, patients literally worked interactively to transition from a purely biomedical frame to one with psychosocial implications. That is, physicians’ questions were addressed to patients’ somatic or medical–psychological problems (e.g., knee pain or depression), and patients’ initial answers responded to, and within, the biomedical frames of the questions. However, patients continued to expand their initial answers, beyond places where physicians were interactionally within their rights to take the floor, to ground their initial answers in a religious aspect of their social lives. All of these observations support a basic tenet of the biopsychosocial model of medicine, which is that patients’ physical problems are inseparable from their social contexts. These observations also highlight Balint’s early observation: “[I]f the doctor asks questions in the manner of medical history-taking, he will always get answers—but hardly anything more. Before he can arrive at what we called ‘deeper’ diagnosis, he has to learn to listen” (Balint, 1957, p. 121, emphasis deleted). Du Pre (2002) argued that patients often gauge how sick they are by the affect of their illness on their social activities. When patients contextualize their problems in aspects of their religious lives—and especially when patients explicitly orient to the personal importance of religious activities, such as church attendance—patients’ revelations solve the predicament of pedagogy mentioned earlier. That is, patients themselves reveal their “extant” religious behaviors. Furthermore, the “validity” of such revelations are high insofar as they are not abstract answers to decontextualized religious-interview questions, but rather utterances that are concretely and intimately linked to lived moments in patients’ lives.

CONCLUSIONS

In sum, there are numerous pressures working against physician-initiated inquiries into patients’ religious behaviors, and without such information, physicians are practically unable, and ethically ill advised, to facilitate or reinforce such behaviors. This ethical and practical predicament of pedagogy is resolved, at least in part, if patients themselves reveal their extant religious behaviors or beliefs, and thus indirectly (or directly) reveal their commitment to such behaviors or beliefs. In other words, if patients initiate a topic that reveals their commitment or desire to attend church, as 13% of participants did in this study, they metaphorically open the ethical and topical door for physicians to facilitate and reinforce such attendance. Future research should strive to further inform our understanding of the biopsychosocial
model of medicine and should provide solutions to the practical and ethical bias posed by medical education in terms of physicians addressing religion.

REFERENCES


