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MAKING THE ROUNDS

IN HEALTH,
FAITH,
& ETHICS

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Disclosure vs. Confidentiality When Disaster Strikes

Introduction

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EARLY ONE FALL MORNING, IN A SUBURB northwest of Chicago, a commuter train traveling at high speed plowed into the rear of a school bus that could not clear the tracks. Horrified witnesses saw that there were students on board the bus.

A rapid disaster response ensued. Several victims were pronounced dead at the scene. The injured were transported to trauma centers and other hospitals nearby. The nearest community hospital, a church-affiliated facility, was informed that it would receive several victims. Under the hospital's "Operation Orange" disaster plan, staff members quickly went to assigned places and prepared to assume their designated roles. Among those deployed were public relations personnel and chaplains.

At first no information was available regarding fatalities at the scene or the condition of the injured who were being transported. This lack created a problem for public relations personnel and other staff members who had to respond to urgent media requests for information driven by the need to "scoop" the competition. Some media representatives attempted to enter areas that had been declared off-limits.

Then more became known about the condition of the patients. One patient had died in the emergency room, and others' injuries were severe enough to require transport to a Level I trauma center. What should be disclosed to the media? Reporters could argue that they were the primary source of the information needed by a community concerned to know the fate of its children. Given

the hospital's commitments to patient confidentiality and to the care of families who were in shock, overwhelmingly anxious, or grieving the sudden loss of a teen-aged child, what information could be shared?

Early on, the chaplains received an urgent request for information from a school representative. The representative had come to comfort students—classmates of the injured—who had gathered at the hospital. The distressed students wanted to know whether their friends were alive or dead. The school representative wanted to give them at least that much information, not only to ease their uncertainty but also to counteract rumors that had already begun to spread.

Releasing the information would be an act of compassionate care for these anguished young people—one in keeping with the hospital's faith-oriented commitment to serve its community. Yet the same act would violate hospital protocols about release of information. Moreover, some family members had not yet been reached with information about the accident or the condition of their loved ones. If family privacy and patient confidentiality were to be respected, what information could be shared with the school representative and students under such exceptional circumstances? How should this hospital balance its responsibilities to the patients, their family members, and the community?

(commentaries begin on page 3)

In the Trenches

Doctors are human

When his father died from the prescription of too large a dose of the anticoagulant coumadin, Alden Blodget flew to meet with the doctors involved in order to learn exactly what had happened. He writes of the encounter:

"[These doctors] were not gods or magicians. They were men—imperfect and fallible—frightened to appear so in a society that expects perfection and infallibility from its professionals, especially its doctors.

"These men were just like the rest of us. They'd spent years working hard to become competent in a field they care deeply about, a field that despite two or three thousand years of development is still a mixture of marvels and mystery. They hadn't been negligent or incompetent. They'd used the complex and dangerous tools of their craft as carefully as they could, guided by the knowledge and understanding based on previous use of the same tools. They had improvised as intelligently as they could when the results failed to conform to previous experience. They'd made mistakes that they could see only in hindsight, the perspective from which society makes its judgments. In hindsight everything is obvious.

"In this era of lawsuits and other lotteries, I am sure I could have become a millionaire by suing my father's doctors and the hospital. . . . But I didn't. . . . It wasn't that I wasn't angry with the doctors, that I didn't want revenge or someone to pay for my pain. . . . It was simply my realization that we expect too much from each other. We refuse to accept that we make mistakes, that even the best of us screw up.

"... To sue someone for failing to be the god we wanted," concludes Blodget, "strikes me as wrong."

(*Newsweek*, 1 April 1996)

Episcopal diocese supports assisted suicide

Suicide is morally acceptable for the terminally ill and those living with persistent physical pain, states a resolution adopted at the annual convention of the 40,000-member Episcopal Diocese of Newark, New Jersey. Despite the Episcopal Church's view that it is morally wrong to take a human life to relieve the suffering of the terminally ill, a majority of the 200 delegates to the diocesan convention voted in support of the resolution. The bishop of the diocese, John Spong, is an advocate of assisted suicide. According to news reports, the diocese hopes to encourage national debate in the church. The resolution will be presented at next year's national Episcopal Church convention.

(*National and International Religion Report*, 5 February 1996)

Condoms approved by French bishops

A report of the French Bishops' Conference states that condom use is "necessary" to prevent the spread of AIDS. "The use of condoms is understandable in the case where sexual activity is already part of the person's behavior and there is a need to avoid a grave risk," the report continues. It also emphasizes faithfulness in sexual relations as a way to curb the spread of AIDS and, in spite of its approval of condoms, argues that sexual education for the young needs to do more than encourage condom use. The Vatican did not immediately comment on the report, which appears to contradict Vatican doctrine. (Pope John Paul II has maintained that the only morally acceptable means for preventing the sexual transmission of AIDS are abstinence outside marriage and faithfulness within it.) According to a spokesperson for the French Bishops' Conference, howev-

er, the report reflects the official policy of the Catholic Church in France.

(*World Population News Service PLINE*, January–February 1996)

Research and the link between abortion and breast cancer

The research supporting the claim that abortion can cause breast cancer needs to be carefully examined, argues the *Economist*. Because of the size of the samples in the study and the contradictory results in other studies, the *Economist* notes, the data need careful interpretation and replication. A particular difficulty in this area of research also needs to be acknowledged: "People lie, particularly about their sex lives, and particularly about procedures such as abortion that have a stigma attached to them. Studies have shown that they are more likely to lie if they are healthy. And, it seems, they particularly lie if asked orally rather than in writing." Information in the study supporting the abortion–breast cancer link was gathered in person.

One study analyzing the connection between abortion and breast cancer found its results "depended strongly on whether a woman's abortion took place before or after it was legal. The particular legal regime applying at any moment is unlikely, even with back-street abortionists, to influence a disease such as breast cancer.

"Women whose abortions were carried out before 1973 had a 35% increased risk. After 1973 this dropped to 12%. The most likely explanation of these results is that many of the healthy 'pre-1973ers' were lying about their lack of abortions—they had, after all, been guilty of a crime. Given which, it is plausible that the 'post-1973ers' were also lying, albeit less, over what was still an embarrassing, even if not an illegal, act."

(*Economist*, 2 March 1996)

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Giles Scofield

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ALTHOUGH ETHICISTS UNDERSTANDABLY TRY to turn every instance of personal upset, societal anguish, and conflicting demands into a dilemma demanding a professional response, sometimes a cigar is just a cigar. This is one of those times. Just as it doesn't take a rocket scientist to appreciate that acceding to the unreasonable demands of the media and others can only make a bad situation worse, it doesn't require an intimate knowledge of Aristotle to see that this case has more to do with etiquette than with ethics.

Dressing this case up as one with First Amendment implications for freedom of the press and the public's right to know makes a mountain out of a molehill. Just as time, place, and manner are relevant where the First Amendment is concerned, how we communicate is as important as what we communicate where the dissemination of information—especially tragic information—is concerned. However understandable the reporter's urge to get the scoop on who's dead and who's not, that does not render the urge any less regrettable or more excusable; nor does it give a reporter priority over others in needing to know first or in getting to the source first. Last time I checked the books, the laws prohibiting trespass on private property apply as much to reporters as to anyone else. Since when does media misbehavior warrant premature disclosure of sensitive information?

Similarly, while others need to have concerns assuaged and rumors quashed, that does not relieve the hospital of its obligation to disseminate reliable information in a timely manner. Even though one cannot control rumors, one need not succumb to the behavior they create. People need simply to be informed that they will be told everything as soon as it is known and as soon as it is proper for this information to be disclosed. If these people truly are concerned for the emotional well-being of everyone caught up in this tragedy, they should appreciate that the families who have suffered a real loss are entitled to greater respect than those who only imagine that they have suffered a loss. Or would those families rather hear through the grapevine or over the airwaves that their son or daughter died on the way to school?

Even though the most difficult task is to keep one's head when others have lost theirs, it is necessary to do so—especially when others cannot or will not. Whether this insight requires possessing the esoteric knowledge and skills that ethicists supposedly have is a doubtful proposition. One need only see how everyone has behaved during the recent shootings in Scotland to understand that it is possible and desirable for all concerned to behave reasonably in the face of tragedy. Why we cannot or will not do so is an individual, professional, and societal problem—but hardly an ethical one.

Tom Koch

Author of The News as Myth: Fact and Context in Journalism, Toronto, Ontario, Canada

IMPLICIT IN THIS STORY OF A MAJOR DISASTER is the irresponsibility of media representatives seeking data on the names of those who had been injured or killed in the train-school bus collision. Urgent media requests, however, are not necessarily driven by the need to "scoop" the competition." In the case of a disaster, that priority becomes secondary.

To the extent that the media serve as "the Fourth Estate," their role is to disseminate public data as widely as possible. The names of the injured and dead are of critical importance not only to immediate family members but also to the community at large. Friends, neighbors, and coworkers will want to know about the tragedy of the survivors and will want to offer support, condolences, and assistance.

The service offered by public dissemination of accident information can be real. In most jurisdictions, disaster protocols state that the names and addresses of those fatally or even seriously injured are not released until immediate relatives have been notified. It is a protocol that most journalists understand. Nobody wants the first notice of a personal tragedy to come in a newsbreak, although many people will want the community support that a public report can offer.

It seems, from this report, that the disaster plan protocols did not consider the legitimate concerns of the community for information—and in law and history the news media stand as a surrogate for the community—along with the immediate need to withhold data pending notification of next-of-kin and to verify data.

It would make sense to update the "Operation Orange" plan in this area. The hospital should invite staff from local newspapers, radio stations, and TV newsrooms to a meeting. The question of when and how to release disaster data in the future should be discussed. Journalists are not unmindful of tragedy's effect. They are, however, constrained by deadlines and by priorities unique to their profession.

A plan jointly created by the hospital and journalistic representatives would assure evenhanded treatment to all media representatives, protect the privacy of newly grief-stricken relatives, and assure that the hospital's primary function—care of the injured and ill—is only minimally disrupted. By inviting journalists to participate in setting rules and guidelines for releasing information in future disasters, they make the journalists equally responsible for the adherence to those guidelines. Thus compliance is more likely.

Stephen E. Lammers

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THIS IS ONE OF THOSE SITUATIONS in which we are tempted to undertake more good than it is possible to do. What we sometimes fail to remember is that what our institutions are, and who we are as professionals and hospital personnel, limits the amount of good that can be done.

In this instance, the primary goods are the restoration of the health of the body to those who will be well again and assistance to those who are dying. It is to these that we owe our primary allegiance, even as administrators and staff members of a faith-oriented hospital. Secondly, we ought to comfort the patients' families and their friends. By doing these things, we serve the community.

The media know and need to be reminded of the hospital's obligation to inform families before informing the media. Media representatives might be given numbers of dead and injured, but no names should be released until families have been notified.

Unfortunately, the same must be said to the school representative. Here, however, more can be done. Chaplains can meet with the students at the hospital. If there are psychotherapists on staff, they too can meet with the students and be with them in their grief.

Imagination is needed to direct these young people toward activities through which they can assist others. The students should be led to see that, terrible as their own grief is, it is still possible and important to reach out to others. Times like these challenge those in faith-based institutions to act on their belief that they are committed to others in a distinctive way.

Glenn McGee

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IN THE SEA OF TRAGEDY, INFORMATION IS A LIFEBOAT. Without it, we vacillate between despair and hope. The hospital holds the key to reconnecting families and putting community members at ease. The school has become a crowd of scared children who need to know what has happened; the school officials also look to the hospital for help. The entire community, represented by the reporters, waits to hear the fate of its young members.

All of these demands for information, even those of the news team, are legitimate. We must be careful not to overextend the right to confidentiality. Where students have died in the tragedy, it is indeed appropriate to identify them to the schools and the media after an attempt has been made to contact the families. While it would be better to notify family members individually of the death of their loved one, the concomitant need of the schools and the community outweighs the needs of families for privacy in the time of death. Put another way, we have to begin to recognize that it is in the nature of a communal tragedy that the right to privacy is trumped by the community's need to know. While there are examples of institutional efforts to maintain privacy in death (the most notable is the military's house-by-house notifications of families about deceased service members), equally notable are the efforts of other social institutions (such as the church) to make of death a more public event.

In part, our reluctance to release information to the media is attributable to the repugnance of their tactics, which reflect and respond to the voyeuristic tendency in contemporary urban culture. But it is too easy to dismiss reporters as vultures circling the hospital. Their desire to get information on the air quickly is an instrument of the community's need to know. What for reporters is a "scoop" is for members of the community an opportunity to understand the tragedy as it unfolds.

Whether voyeurism or compassion motivates the media, the fact is that information about death and tragedy is not poison. It is just information. The goal of responsible media treatment of a disaster is better accomplished when the media are talking in real, human terms, rather than at a distance. Here, the news media will either show film footage of the train and the bus from a helicopter or talk specifically about those who are imperiled as a result of the collision. Which treatment is more likely to elicit reforms—school bus-driving licensure, drug-testing of train engineers, requiring the use of seatbelts on buses—to reduce the chances of such accidents occurring in the future? The benefits of disclosure almost always outweigh the risks (if an attempt to contact the closest relatives is made first).

Critically ill children, however, should remain unnamed until an appropriate surrogate decision maker can be identified. The hospital may have to play this role if parents cannot be located, and at that point disclosure may be

part of a strategy designed to contact the parents. The protection of confidentiality is nonetheless a proper mantle on which to hang refusal to disclose the identities of those about whom important medical decisions are being made. Suppose, for example, that one of the critically ill is a young Jehovah's Witness, whose parents are out of town but whose pastor is watching the news. If the pastor finds out about the child's status, he might attempt inappropriately to intervene before the parents return. This kind of situation calls for careful monitoring of the press's conduct. While the public has an interest in determining who is ill, the media and the school should be used only instrumentally by the hospital (to determine who the parents are) until parents are notified. Where lives are still in the balance, the information lifeboat is a means, not a moral end-in-itself.

Summary and Conclusion

David B. McCurdy

THIS TRAGEDY IS A SITUATION in which compassionate people may be inclined both to attempt more good for needier others than can be achieved (Lammers) and to shelter those who are most drastically affected and vulnerable from the pressure of others' felt needs (Scofield).

If Scofield's "behaving reasonably in the face of tragedy" is the baseline of both etiquette and ethics for all parties with responsible roles to fulfill, the commentaries display divergent understandings of what is "reasonable" in such a situation.

Reasonableness can mean abiding by protocols that reflect widely accepted values and have withstood the test of painful community experience. Reasonableness can also mean recognizing the health care facility's and staff's primary responsibility to care for the health and well-being of patients (first) and families (second).

On the other hand, reasonableness must recognize the legitimate interests of communities when tragedy occurs, because tragedy has such communal impact. What reasonable recognition of those interests entails is a more contentious question. Lammers reminds us that the care of individual patients and specific families is itself a substantial community interest. Koch and McGee suggest that there is more here than often meets the eye. If information is the vehicle of community solidarity, and the media serve as the community's representatives, might their surrogate claim on information carry greater moral weight than many of us have been inclined to acknowledge?

In the end Koch recommends that all involved follow established protocols during the crisis, although those responsible for releasing information should remember the legitimate role of the media (despite some of their tactics). McGee is more inclined to see the community's interests in obtaining specific information as overriding, once initial efforts to contact families of tragedy victims have

been made. At this point, in most cases, the need to benefit greater numbers of people with identifiable needs becomes primary.

Koch adds, however, that after the tragedy there is constructive work to be done. Health care and media representatives can meet and work collaboratively to create a better procedure. In effect, Koch reminds health care professionals of their much-advertised

commitment in recent years to work together with various "customers," including community customers, to improve the quality of their service and their processes.

What role, if any should the "faith-based" (Christian) orientation of the hospital play in assessing its responsibilities to provide information in this tragic time? Lammers observes that the primary situational task of restoring health, caring for the dying, and supporting those closest to patients is in

keeping with the traditional health-focused mission of most such facilities. His suggestion that hospital personnel seek ways to help the anxious students support others, even if impracticable at this point in the tragedy, is reminiscent of a prayer which asks that "those absorbed in their own grief . . . may be raised to share the sorrows of others" (*Hymnal of the United Church of Christ* 1974).

As to the possibility that, because of its mission, the faith-based hospital has additional or more specific responsibilities to its wider community, it appears that the mission alone will provide little specific guidance on this score. To the extent that such facilities espouse a commitment to the value of community itself and to the society which provides the context of health care, they share that commitment with all health care facilities. Nonetheless, a faith-based institution's commitment to community and compassionate solidarity with those who suffer may be understood to flow from the solidarity of persons created in the image of God and redeemed in a shared salvation. □

**If information is the vehicle of
community solidarity, and the media
serve as the community's representatives,
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have been inclined to acknowledge?**

Religion, Health, and Aging

Deborah Harris-Abbott

Idler, Ellen L. "Religion, Health, and Nonphysical Senses of Self." *Social Forces* 74, no. 2 (December 1995): 683-704.

Koenig, Harold G. "Religion and Hope for the Disabled Elder." In *Religion in Aging and Health: Theoretical Foundations and Methodological Frontiers*, ed. Jeffrey S. Levin. Thousand Oaks, Calif.: Sage, 1994.

Pargament, Kenneth I., Kimberly S. Van Haitsma, and David S. Ensing. "Religion and Coping." In *Aging, Spirituality, and Religion: A Handbook*, ed. Melvin A. Kimble et al. Minneapolis: Fortress, 1995.

In an exploration of how people's beliefs about the origins of their illnesses are incorporated into a larger interpretive framework, researcher Gareth Williams described his interaction with a woman in her early sixties suffering from arthritis:

The interview with Betty was a particularly difficult one to conduct because my sociological questions appeared insignificant and redundant in the face of the teleological certainty of her beliefs. When interviewing someone with such a profound sense of meaning, it seemed almost meaningless to ask whether the illness had damaged her sense of self worth or whatever. For Betty, most people live their lives in the immediacy of personal and material interests. Their lives follow a narrative thread defined by everyday events and happenings and routines, and when major problems occur in their social world their identity is bound to be threatened and it is not surprising that they should become lost and depressed. But for her "there is an end in it" and all analytic puzzlement and personal doubt evaporate in the glare of God's purpose. (1984:195-96).

This may explain, in part, why religion has been ghettoized in the social scientific literature. For many clergy, chaplains, and people of faith, Betty's outlook is not unusual and therefore not remarkable. The literature on religion and the difficulties of illness, pain, and aging reach back thousands of years—the book of Job being the most obvious example. In the past few decades, a rapidly expanding body of empirical, mostly quantitative, research on religion, aging, and health has been published; Jeffrey Levin and Harold Koenig have been two of the most prolific authors. In the introduction to *Religion in Aging and Health*, Levin explores some of the failings of this recent work, much of which links measures of religiosity to health outcomes and various measures of well-being. "There are other reasons for the persistent marginality of research on religion, aging, and health, and these reasons suggest that it is

inappropriate to place blame solely with some amorphous 'scientific worldview.' . . . With notable exceptions, this empirical work has been mediocre, even dreadful. . . and, worse, has failed to engage midrange theoretical issues" (p. xviii). His edited volume represents an essential advance toward integration of theoretical and methodological issues.

The third piece to the puzzle of literature on religion, health, and aging is the excellent qualitative work done in recent years on the experience of illness—excellent, that is, except for its remarkable ignorance of the importance of religion in shaping people's attitudes toward loss and difficulty. (For a helpful review of this literature, see Conrad 1987.) I locate this literature within the corpus on religion, health, and aging because "nothing so concentrates experience and clarifies the central conditions of living as serious illness" (Kleinman 1988:xiii), and, frequently, nothing so undergirds individuals in their struggles as religious beliefs, practices, and understandings. The absence of religious themes may be rooted in the fact, alluded to in Williams's discussion of Betty, that the minds of those who think in terms of self-image and the minds of those who think in terms of the image of God may easily pass like ships in the night. If the person defining the terms of the discussion is concerned primarily with self-image, is it any wonder that the image of God remains unspoken or unheard?

Pargament et al. touch on this subject in their chapter on religion and coping:

How can one make sense of the myriad and at times puzzling ways people cope—religiously or non-religiously—with adversity? For example, how can one understand the nursing home resident who spends most of her day rocking in her chair, refusing to take part in the social activities of the home? As long as personal definitions of significance and coping are projected on others, the picture is cloudy. But with a different assumption—that people seek diverse ends in diverse ways—the picture becomes clearer. The nursing home resident may spend her time in the rocker reminiscing. Social activities simply get in the way of her coping, as expressed in this excerpt from a poem [MacLay 1990:42]:

Preserve me from the occupational therapist, God,
She means well, but I'm too busy to make baskets.
I want to relive a day in July
When Sam and I went berrying.

In the introduction to her article on nonphysical senses of self, Idler suggests additional, albeit less poetic, reasons that social scientists on the whole have been indifferent to the interplay of religion and health, including the complexity of both religion and health (and therefore the difficulty in effectively characterizing each), the complexity of the relationship between the two, the dearth of follow-up studies necessary to determine causal direction, the dependence of researchers on federal funding (which tends to be awarded for secular research), and a simple lack of interest.

Pargament et al. take a psychological perspective on religion as a method of coping with the difficulties of later life. What they

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write is important not because of its originality but because—while they speak of coping, efficacy, negative events, and positive outcomes—they insist on broadening the social scientific understanding of the role of religion in coping. They clearly outline their basic assumptions: that critical life events are constructed with significance in mind, that people do not come to coping empty-handed, and that religion is not simply a method of coping. One notable assumption is that religion comes to life in concrete situations. They criticize much of the psychological research that has focused on religion solely as a general orientation, rather than seeking to understand how people translate their religious disposition into action.

Data from the authors' Project on Religion and Coping show an important difference in the methods of coping used by the intrinsically and extrinsically religious. The intrinsically religious, those whose primary motivation in life is their religion, are more likely to understand events as opportunities to grow, to use spiritually based coping efforts, to solve problems actively, to use nonavoidant coping, and to seek closeness with God rather than self-development through religion. The extrinsically religious, those with a more superficial understanding of faith who find religion useful for such things as solace or social support, tend to have more defensive coping strategies, to emphasize the personal threat inherent in an event, to believe in individual impotence, to focus on the positive and the possibility of miracles, to engage in nonreligious avoidance, and to seek instrumental ends from religion, such as self-development or personal restraint. Pargament et al. then outline how religion can help people cope with four major challenges of aging (which are also relevant to persons of any age who face illness): maintaining and integrating the self, navigating a changing environment, facing life's finitude, and realizing intimacy with others. They conclude with a call for further research into the ways that religion "comes to life" as particular people cope with particular problems of aging, illness, and death.

Koenig touches on some similar themes, but he uses the Hebrew Bible and New Testament as his foundation. He outlines 11 themes found in Judeo-Christian religions that can offer hope to people facing the difficulties of aging, including emphases on interpersonal relations and on seeking and offering forgiveness, hope for healing and change, a paradigm and role models for suffering, the promise of life after death, and provision of a supportive community. Again, these themes are relevant to people other than the aged. Using Scripture, he shows how faith can help convey a sense of self-worth, independent of functional ability, and how it is never too late to start anew or reinterpret difficult circumstances in a new light. Koenig also argues that although religious persons may appear to be relying on an external source of control (God), belief in a loving God may obviate the need to rely on other external sources of control, thus providing indirect inter-

nal control. He emphasizes that the strength, comfort, and meaning provided through religious faith are potentially available to everyone, regardless of their other resources (money, power, education, or mental health).

Like the chapter by Pargament et al., Koenig's chapter is not remarkable so much for what it says as for what it represents—a framework in the social scientific literature for understanding religion as a way of coping with the difficulties of aging and illness. Writings on this subject are so widely dispersed throughout religious, literary, philosophical, and other spheres and across time that, in this great information age, they seem to have been lost to many a social scientist. Even Pargament et al. write, "The weight of the evidence seems to suggest that religious commitment, beliefs, and practices can assist people in troubled times. However, this

area of research is still in its infancy" (p. 55). Although this may be true for social scientific research, the idea that exploring how people rely on religious faith and practice to deal with adversity is in any way a new undertaking is simply incredible. Perhaps these two recently published, very accessible theoretical frameworks will help modern scholars to understand more clearly the actual and poten-

tial roles of religion in aging and health and encourage them to broaden their research to include consideration of religion.

Idler's article is an important addition to the literature on religion and health because it includes *qualitative* data about people's understandings of how their religious beliefs help them with their health problems. She argues, rightly, that religion and health are naturally interwoven, and, rather than trying to untangle the two, she explores various ways one can view the "knot." The first is an instrumental, Durkheimian view of religion as a stabilizing, supportive force that has a positive effect on health; in the causal chain, religion precedes health. The second view is that people often turn to their religious faith and communities in times of poor health for prayer, support, and meaning, as Pargament et al. and Koenig have illustrated so well; in this view, health precedes religion. The third view is a much more complicated one that depends on the individual's subjective understanding of health. When people assess their own health, they tend to take into account much more than simply disease status—they often include such things as stress, past health, the health of others, interpersonal relationships, and health habits (see Charmaz 1987). Thus, a person with a severe debilitating disease may consider her health to be excellent. Those who understand themselves as having integrity apart from their bodies tend to rate their health more positively than their physical health would justify. Thus, the identities of those who have a strong religious or spiritual sense of self are less likely to be threatened by disease or disability than the identities of those lacking a spiritual sense of self. This third view is like the first in that religion precedes health in the causal chain, but in this view health is understood in a more holistic, subjective way.

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In a study of 146 subjects, Idler tested two hypotheses, based on views two and three, that (1) those with poorer health are more likely to have sought help from their religion and (2) those with a strong religious identity and positive subjective ratings of health will have a strong nonphysical sense of self. Her quantitative analysis supports both hypotheses. But she does not stop there, as too many researchers do. She explores qualitatively the answers of the 62 percent of participants who responded positively to the questions, "Do your religious beliefs help you at all with your health problems? Can you tell me in what way, or give me any specific examples of help that you received?" She gives examples of people who experienced spiritual growth concurrently with or as a direct result of their diminished physical health or abilities; people who experienced a heightened sense of God's purpose for their lives, often as a result of coming close to death; people who experienced the healing power of God, either through physical healing or a sense of peace or strength; and people who, although they may have been frustrated or angry like Job, believed that their suffering must have religious significance. All of these examples point to the complex interaction between religion and health and call for further exploration of what Idler calls the nonphysical senses of self that transcend physical illness and disability. A consistent theme in

participants' responses was that religion offered them a way to transcend or put into perspective their present difficulties.

In the past few years, several scholars have sought to integrate the theoretical and empirical, mostly quantitative, components of research into the interrelationships among religion, health, and aging. Through their respective chapters, Koenig and Pargament et al. have made important contributions to this literature. Idler reaches one step beyond to engage qualitative data—an exciting new development. The social scientific corpus on religion, aging, and health seems to be coming of age itself. □

REFERENCES

- Charmaz, Kathy. 1987. "Struggling for a Self: Identity Levels of the Chronically Ill." *Research in the Sociology of Health Care* 6:283-321.
- Conrad, Peter. 1987. "The Experience of Illness: Recent and New Directions." In *Research in the Sociology of Health Care: A Research Annual* 6:1-31.
- Kleinman, Arthur. 1988. *The Illness Narratives*. New York: Basic Books.
- Maclay, E. 1990. *Green Winter: Celebrations of Later Life*. New York: Holt.
- Williams, Gareth. 1984. "The Genesis of Chronic Illness: Narrative Reconstruction." *Sociology of Health and Illness* 6:175-200.