Religion and medicine

Sir—I agree with Richard Sloan and colleagues (Feb 20, p 664),[1] who believe that it is premature to say that faith and religion have been proven to improve health, but I also think that they have not been completely fair in their review.

In their critique of a study of the effects of prayer on patients in a coronary-care unit,[2] they correctly point out that the prayer group had a significantly better outcome than the control group in only six of 29 outcome variables. They do not note, however, that the patients had a significantly lower overall severity score for their course in the hospital or that the p value of the multivariate analysis of outcome variables was less than 0·0001.

In addition, their statement that the Byrd study[2] is the only randomised clinical trial of prayer is incorrect. Sicher and colleagues[3] have published a study of distant healing, including prayer and psychic healing, for patients with advanced AIDS. They found that in comparing the treatment group with controls, the patients acquired significantly fewer new AIDS-defining illnesses, had lower illness severity, and required significantly fewer doctor visits, fewer hospitalisations, and fewer days in hospital. This was a small study of 40 patients, and it is certainly not definitive. Nonetheless, it is an important addition to the debate of the efficacy of prayer.

The ethical issues that the authors raise are important, particularly regarding the limits of medical interventions. A physician obviously would not prescribe marriage to an unmarried patient simply because it is associated with lower mortality, but one very well might, in psychiatry at least, address issues of social isolation if they are problematic for a patient. In the same way, a physician would not (or should not) prescribe a particular religion for a patient, but encouraging a patient to pursue work on spiritual issues would seem appropriate.

We should not prescribe our religious beliefs to our patients, but at the same time, as physicians, we should not ignore this potentially important aspect of mental and physical health. Given the great interest in spirituality in the general population, high quality research in this area should certainly be encouraged.

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1 Sloan RP, Bagiella E, Powell T. Religion, spirituality, and medicine. *Lancet* 1999; **353:** 664–67.

2 Byrd RC. Positive therapeutic effects of intercessory prayer in a coronary care unit population. *Southern Med J* 1988; **81:** 826–29.

3 Sicher F, Targ E, Moore D, Smith HS. A randomized double-blind study of the effect of distant healing in a population with advanced AIDS: report of a small scale study. *West J Med* 1998; **169:** 356–63.

Sir—Richard Sloan and colleagues[1] raise several ethical issues to stimulate discussion.

First, they question inquiries into a patient's spiritual life because a physician would be dabbling in areas in which they have no expertise. However, this argument fails to take into account the physician's role as a facilitator. There are many areas outside a doctor's expertise even within the sphere of medicine. In these situations doctors will recognise their limitations and refer the patient to the appropriate authority (eg, other physicians or surgeons, physiotherapists, social workers). There is no reason why a judicious question into a patient's spiritual life should not prompt a referral to experts, such as priests and rabbis.

Their second and third ethical points are linked. If a relation were established between religious factors and health, I agree that the religious variable would have to be taken into account in any analysis of health outcomes. In the real world I believe the physician's role would be supportive rather than interventive. I do not foresee physicians prescribing regular doses of religion to improve health. Therefore I feel the possibility of doing harm is overstated. In addition, many religious people already believe that their illness has been "decreed by God". Uncovering a clear link with health would only confirm what they have always suspected.

The focus of Sloan and colleagues' article has been on the physical. Many religious people are more concerned with achieving immortality of their soul, rather than the mortality of their physical body. Some people welcome death as an opportunity to be with their maker, a fact that is sometimes taken to extremes by certain cults. This may be another factor that confounds studies of mortality and religion.

Perhaps it is time physicians got beyond the physical[2] and considered health-related quality of life. One study suggests that religious activity improves quality of life for elderly patients.[3] It is within this domain where there is potential for intervention.

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1 Sloan RP, Bagiella E, Powell T. Religion, spirituality, and medicine. *Lancet* 1999; **353:** 664–67.

2 Sims A. Spirit as well as mind? *Br J Psychiatry* 1994; **165:** 441–46.

3 Reyes-Ortiz CA, Ayele H, Mulligan T. Religious activity improves quality of life for ill elderly. *Clin Geriatrics* 1996; **4:** 102–06.

Sir—Richard Sloan and colleagues[1] question the reliability of published data that suggest that for some individuals religion is a belief system that may have a beneficial effect on health. They think that studies showing a beneficial health effect of religion could be biased because individuals who are ill may have a decreased ability to participate in religious activities, leaving a disproportionate amount of healthy individuals doing so. They did not consider the converse, that a possible increased association of illness with religion may occur if, when faced with a catastrophic illness, an individual seeks out religious participation.

Sloan and colleagues suggest that religious beliefs may increase participation in behaviours that enhance health, which is indeed likely and should be regarded as a positive mechanism of religion promoting better health. A study of the health of Mormon men evaluated how closely they followed church teachings about the use of alcohol and tobacco.[2] Not all Mormons abstain from alcohol and tobacco use. However, those men who adhered to the church policy had significantly less risk of developing cancer of the lung, stomach, lip, oral cavity, pharynx, oesophagus, larynx, and bladder, and leukaemia and lymphoma.

A factor not considered by Sloan and colleagues[1] was the possibility that religious beliefs function as a buffer that prevents stress from altering the function of the immune system. Stressor-induced immune alteration may contribute to the onset of various immune-mediated diseases. A possible example of religion ameliorating a stressor-induced increase of immune system activation is provided in a study of the relation between plasma interleukin 6 and church attendance.[3] A raised plasma concentration of interleukin 6 was present in significantly fewer church-going individuals than individuals who did not attend church regularly. Because interleukin 6 has been reported to increase in plasma during stress[4,5] church-attending people may have had less of a psychological response to stress than did non-attenders. If religious beliefs or activities produce a state of central nervous system relaxation that is associated with a lowering of sympathetic nervous system activity and raised immune