Religion and medicine

Sir—I agree with Richard Sloan and colleagues (Feb 20, p 664), 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, 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 is the only randomised clinical trial of prayer is incorrect. Sicher and colleagues have published a study 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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Sir—Richard Sloan and colleagues 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 (e.g., other physicians or surgeons, psychotherapists, 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 interventional. 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 and considered health-related quality of life. One study suggests that religious activity improves quality of life for elderly patients. It is within this domain where there is potential for intervention.

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