The New England Journal of Medicine



SOUNDING BOARD

Volume 342:1913-1916 June 22, 2000 Number 25

# Should Physicians Prescribe Religious Activities?

ARTICLE
- Table of Contents
- Editors' Summaries
- Related Letters to the Editor
- Find Similar Articles in the Journal
- Articles citing this article

SERVICES
- Add to Personal Archive
- Download to Citation Manager
- Alert me when this article is cited

MEDLINE
- Related Articles in Medline

Articles in Medline by Author:
- Sloan, R. P.
- Poulos, P.

- Medline Citation

There is increasing interest among the general public and the medical community in the role of religion in medicine. Polls indicate that the U.S. population is highly religious; most people believe in heaven and hell,[1] the healing power of prayer,[2] and the capacity of faith to aid in the recovery from disease.[3] The popular press has published many articles in which religious faith and practice have been said to promote comfort, healing, or both. A report that 77 percent of hospitalized patients wanted physicians to consider their spiritual needs is consistent with this trend.[4]

Interest in the connection between religion and health has also emerged in the medical community.[5,6] The National Institute for Healthcare Research, a privately funded, nonprofit advocacy organization, has published extensive literature reviews suggesting that religious faith and practice are positively associated with health status. The organization's World Wide Web site encourages physicians to pay more attention to religious matters and recommends that they take a spiritual history at the time of each complete physical examination, with any concerns raised by patients addressed during follow-up visits. In addition, the National Institute on Aging and Harvard Medical School sponsor meetings on the integration of spirituality and medical practice.[7] A survey of family physicians found that they strongly support the notion that religious beliefs can promote healing.[8] Some physicians believe that going to church promotes health,[9] argue for spiritual and religious interventions in medical practice, hope that the wall between medicine and religion will be torn down,[10] and assert that "the medicine of the future is going to be prayer and Prozac."[11]

Nearly 30 U.S. medical schools now offer courses on religion, spirituality, and health.[12] The American Association of Medical Colleges has cosponsored a conference entitled "Spirituality and Medicine: Curricular Development" for the past three years, and each year it has attracted more than 100 physicians, faculty members,

and chaplains from hospitals and medical schools throughout the United States.

As chaplains in health care settings, representing a wide range of religious traditions, and as biomedical researchers, we are troubled by the uncritical embrace of this trend by the general public, individual physicians, and American medical schools. We are concerned that broad generalizations are being made on the basis of limited, narrowly focused, and methodologically flawed studies of the place of religion in medical practice. These generalizations fail to recognize the diversity among physicians, patients, and practice settings and fail to distinguish between superficial indexes of religiousness, such as self-reports of church attendance, and personal religious motivation. Such generalizations will lead to considerable confusion until more and better research is done.

In this article, we examine three stated or implied justifications for making religious activities adjunctive medical treatments: religious activity is associated with good or improved health, such activities provide comfort, and patients want their medical care to include attention to religious matters. We will demonstrate that attempts by physicians to integrate religious interests into medical practice are not nearly as well justified or simple as the literature suggests.

## Is There Empirical Evidence of a Link between Religion and Health?

Numerous authors[12,13,14,15] assert that there is substantial empirical support for the idea that religious activities promote health. We believe the evidence is generally weak and unconvincing, since it is based on studies with serious methodologic flaws, conflicting findings, and data that lack clarity and specificity.[16] Two recently reported, well-conducted studies, however, have shown that attendance at religious services is associated with reduced mortality.[17,18] Yet, for several reasons, such epidemiologic studies do not provide justification for physicians to encourage patients to attend religious services or to engage in other religious activities.

First, the strongest evidence of an effect of religion on health comes from studies of church attendance. There is no convincing evidence that other religious activities are associated with improved health. However valuable praying, reading the Bible, and watching religious television programs may be for a religious life, there is insufficient evidence linking these activities to health.

Second, the data on church attendance must be viewed with caution. Religious services are diverse in style and content, as the difference between a Quaker meeting and a Roman Catholic mass illustrates. Do advocates of the connection between religion and health propose that such differences are unimportant? No doubt patients make choices about the services they find helpful, but exercising such choices can create conflicts when, for example, a person departs from his or her family's religious tradition. Studies of church attendance neglect such details. Consequently, we believe that an endorsement of church attendance for reasons of health is premature.

Third, even well-conducted epidemiologic studies reflect only associations at the population level; they do not provide evidence that a recommendation to attend religious services actually leads to increased attendance, let alone better health. Evidence from epidemiologic studies must be confirmed by rigorous clinical trials, because only a clinical trial in which patients were randomly assigned either to receive or not to receive a recommendation

to attend religious services could help determine whether such a recommendation would increase church attendance and lead to better health. Since any effects on health are likely to differ according to whether patients attended religious services on their own or because of a physician's recommendation, such a trial would be problematic and difficult to conduct.

## Should Physicians Recommend Religious Activity as a Way of Providing Comfort?

Koenig et al.[14] imply that even in the absence of supporting evidence, it would still be permissible for physicians to recommend that patients engage in religious activities because such activities provide comfort. The authors state, "The primary task of the physician is `to cure sometimes, to relieve often, to comfort always.'" It certainly is true that for many patients, religion provides comfort in times of difficulty. Whether physicians can or should encourage this path to comfort, however, is another matter entirely.

Physicians have considerable influence, which presumably derives from their medical expertise, and patients often regard their recommendations as authoritative. For example, the recommendation that a patient with pneumonia take antibiotics and restrict his or her activity is likely to be followed because the patient accepts the physician's authority. The same influence is exerted when a physician inquires about or recommends religious activities. Physicians and patients alike are on dangerous ground if they believe that advice about religious matters has the same medical support as a recommendation for antibiotic treatment. Such assumptions can have a coercive effect, and they raise ethical questions about patients' autonomy in matters of religion.

For many patients, religious pursuits are a private matter, whether or not there is evidence of a solid link between religious activity and health. Marital status is associated with health,[19,20] but physicians do not dispense advice regarding marriage. There is evidence that early rather than late childbearing may reduce the risk of various cancers,[21,22] but we would recoil at a physician's recommendation that a young woman, either married or single, have a child to reduce her risk of cancer. These matters are personal and private, even if they are related to health. Many patients regard their religious faith as even more personal and private than their health.

Attempts to link religion to health oversimplify both. Religious practices can be disruptive as well as healing. Conflicts between Catholics and Protestants and among Christians, Jews, and Muslims are evident at national levels. There is also disagreement about religious practice and belief among families and individuals, which can arise from interfaith marriages, different interpretations of doctrine, or conflict over acceptable behavior. Health care chaplains know that these conflicts can result in lingering doubts, fears, and antagonism. The declining participation of baby boomers in the religious traditions in which they were raised is not simply a matter of superficial choices about what to do on Sunday morning or the belief that worship services and sermons are irrelevant. In many instances, their choices reflect an effort to manage complex feelings that reside just below the surface.

Engaging patients in conversations about religious matters is not a simple process. The medical literature on religion as a source of comfort tends to assume a Christian context. In reality, however, cultural and religious diversity is increasing rapidly in the United States. If the Islamic and Jewish populations are considered together,

for example, they constitute the nation's fifth largest religious group.[23] It is therefore increasingly difficult for physicians to know how to engage patients in meaningful discussions about religion, or even discussions that do not offend them. No doubt, many patients wish to obtain medical care from physicians who share their religious heritage, but managed-care plans make this increasingly difficult by limiting the choice of a physician.

Moreover, physicians are not trained to engage in in-depth conversations with their patients about their spiritual concerns. Such discussions are not the sole domain of any one profession, but many health care facilities have chaplains or other community clergy who have received systematic postseminary training and clinical supervision in such areas as pastoral psychology, ethics, and multicultural pastoral care and who are endorsed by their denominations. Thus, patients who seek spiritual support can be appropriately referred to these professionals.

Assessing the spirituality of patients and providing spiritual care require skill and at least an implied covenant between the provider and the recipient of such care. Although one might argue that physicians may also participate in this covenant with patients, the results of a study of physicians, nurses, patients, and family members at one medical facility suggest otherwise. The authors point out that the "religious backgrounds, beliefs, activities and coping behaviors of patients and families were notably different from those of health care providers, particularly physicians."[24] Addressing patients' spiritual concerns across these gulfs is a complicated and sensitive matter. For all these reasons, it is not clear that physicians should engage in religious discussions with patients as a way of providing comfort.

## Do Patients Want Religious Matters to Be Incorporated into Their Medical Care?

Some studies report that patients want physicians to attend to their spiritual concerns. King and Bushwick found that 48 percent of the patients they surveyed indicated that they wanted their physicians to pray with them.[4] Maugans and Wadland reported that 40 percent of the patients in their study wanted physicians to discuss religious issues with them.[25] According to a report by Ehman et al., two thirds of patients in an outpatient practice at a university hospital said they would be interested in having a physician inquire about their religious or spiritual beliefs if they became gravely ill.[26] These data have prompted some to remark that, regardless of the evidence, "we should address [religion in medical practice] because the patient surveys are saying that we should be addressing it."[5]

These studies raise several issues of concern. In most of the surveys, only a minority of the patients reported that they were interested in having a religious or spiritual component as part of their medical care. In addition, several features of the studies raise questions about the generalizability of the findings. King and Bushwick studied hospitalized patients, who may respond differently from outpatients to inquiries about religion and spirituality. Moreover, more than 85 percent of the patients surveyed were Protestant. Only 37 percent of the respondents in this study stated that they felt their physicians should discuss religious matters more, whereas 47 percent wanted no discussion of such matters.[4] Although a larger proportion of the patients in the study by Ehman et al. expressed an interest in inquiries about religion and spirituality, they did so only in the context of a hypothetical grave illness.

There are other questions about generalizability. Evidence that patients want religion and spirituality to be incorporated into clinical medicine generally comes from studies in family practice settings, where physicians and patients are likely to know each other well. We believe that had these studies been conducted in tertiary care surgical settings, for example, the responses would have been different. The degree to which patients express an interest in incorporating religion and spirituality into medical care depends on the clinical setting, the interpersonal and communication skills of the physician, the nature of the specific physician–patient relationship, and the characteristics of the patient. The limited evidence does not justify inquiries about religious matters with all patients or in all settings. Moreover, family practice physicians report lack of time (71 percent), inadequate training (59 percent), and difficulty identifying patients who want to discuss spiritual issues (56 percent) as substantial barriers to raising questions about religion with their patients.[27]

Apart from the quality of the data on patients' interest in a religious component of health care, we question the assumption that this interest justifies the incorporation of religious matters into medical practice. Patients often ask for things that are unrealistic or that may not be in their best interests. The decision by physicians to accede to these wishes is complex and requires weighing the conflicting ethical principles of beneficence (the physician's responsibility to act in furtherance of the patient's best interests as the physician sees them) and autonomy (the patient's right to act independently in an informed manner).[28] The mere fact that some patients want physicians to address religious matters is not sufficient in itself to justify this practice.

## Trivializing Religion

Religious officials and religious people in general should view with skepticism attempts to make religious activities adjunctive medical treatments. Such attempts come dangerously close to efforts to validate religion by its effects on health. Goldberg has pointed out that such efforts are not only unnecessary, but demeaning.[29] Religion does not need science to justify its existence or appeal. Religion and science, and religion and medicine, exist in different domains and are qualitatively different.

Attempts to use religion instrumentally, as one uses antibiotics or surgical procedures to treat diseases, may be deeply offensive to some people. Moreover, participation in religious activities can have different meanings depending on whether it is the result of an external influence, such as a medical recommendation, or of a personal motivation. If religion is considered only in its psychosocial dimension, it becomes indistinguishable from any other cultural practice.

An instrumental approach to religion may derive in part from the need to define variables for use in scientific studies. Although this approach may succeed in the sense that one can record, for example, the self-reported frequency of prayer, it is only superficially related to the personal and underlying meaning of religion. This distinction becomes especially important when research data are used as the basis of clinical recommendations. Religion is trivialized in these efforts.

## Conclusions

We have explored the current interest in connecting religious activity with health and medical care. There is a

long history of inquiry in this area, but only recently has it attracted widespread general and medical interest. Because the question of a link between religion and health care is so controversial, we must continue to address it, with discussions that cross disciplinary and specialty lines. We have challenged some of the assumptions that undergird the current literature in this area, and we have questioned the implications of making religious and spiritual matters part of medical care.

Most important, we are concerned that attempts to obtain scientific evidence of the health benefits of religious activity and to use such activity instrumentally in achieving beneficial health outcomes not only are superficial but also suggest that the value of religion derives from its effects on health. Religion is more than a collection of views and practices, and its value cannot be determined instrumentally; it is a spiritual way of being in the world.

Richard P. Sloan, Ph.D.
*Columbia University College of Physicians and Surgeons*
*New York, NY 10032*

Emilia Bagiella, Ph.D.
*Columbia University School of Public Health*
*New York, NY 10032*

Larry VandeCreek, D.Min.
Margot Hover, D.Min.
Carlo Casalone, M.D., S.T.D.
Trudi Jinpu Hirsch
Yusuf Hasan
Ralph Kreger
*HealthCare Chaplaincy*
*New York, NY 10022*

Peter Poulos, Th.M.
*New York Methodist Hospital*
*Brooklyn, NY 11215*

## References

1. Van Biema D. Does heaven exist? Time. March 1, 1997:70-8.
2. Kaplan M. Ambushed by spirituality. Time. June 24, 1996:62.
3. McNichol T. The new faith in medicine. USA Today. April 7, 1996:4.
4. King DE, Bushwick B. Beliefs and attitudes of hospital inpatients about faith healing and prayer. J Fam Pract 1994;39:349-352.[Medline]
5. Gundersen L. Faith and healing. Ann Intern Med 2000;132:169-172.[Medline]

6. Slomski AJ. Should doctors prescribe religion? Med Econ 2000;77:145-159.
7. Marwick C. Should physicians prescribe prayer for health? Spiritual aspects of well-being considered. JAMA 1995;273:1561-1562.[Medline]
8. Yankelovich Partners, Inc. Family physician survey: Oct. 1, 1996. Report no. 050304. Radnor, Pa.: John Templeton Foundation, 1996.
9. Larson SS, Larson DB. Clinical religious research: how to enhance risk of disease: don't go to church. Christ Med Dent Soc J 1992;23:14-19.[Medline]
10. Matthews DA, Larson DB. Faith and medicine: reconciling the twin traditions of healing. Mind/Body Med 1997;2:3-6.
11. Sides H. The calibration of belief. New York Times Magazine. Dec. 7, 1997:92-5.
12. Levin JS, Larson DB, Puchalski CM. Religion and spirituality in medicine: research and education. JAMA 1997;278:792-793.[Medline]
13. Matthews DA, McCullough ME, Larson DB, Koenig HG, Swyers JP, Milano MG. Religious commitment and health status: a review of the research and implications for family medicine. Arch Fam Med 1998;7:118-124.[Medline]
14. Koenig HG, Idler E, Kasl S, et al. Religion, spirituality, and medicine: a rebuttal to skeptics. Int J Psychiatry Med 1999;29:123-131.[Medline]
15. Levin JS. Religion and health: is there an association, is it valid, and is it causal? Soc Sci Med 1994;38:1475-1482.[Medline]
16. Sloan RP, Bagiella E, Powell T. Religion, spirituality, and medicine. Lancet 1999;353:664-667.[Medline]
17. Hummer RA, Rogers RG, Nam CB, Ellison CG. Religious involvement and U.S. adult mortality. Demography 1999;36:273-285.[Medline]
18. Oman D, Reed D. Religion and mortality among the community-dwelling elderly. Am J Public Health 1998;88:1469-1475.[Abstract]
19. Ebrahim S, Wannamethee G, McCallum A, Walker M, Shaper AG. Marital status, change in marital status, and mortality in middle-aged British men. Am J Epidemiol 1995;142:834-842.[Abstract]
20. Adler NE, Boyce T, Chesney MA, et al. Socioeconomic status and health: the challenge of the gradient. Am Psychol 1994;49:15-24.[Medline]
21. Ramon JM, Escriba JM, Casas I, et al. Age at first full-term pregnancy, lactation and parity and risk of breast cancer: a case-control study in Spain. Eur J Epidemiol 1996;12:449-453.[Medline]
22. Lambe M, Thorn M, Sparen P, Bergstrom R, Adami HO. Malignant melanoma: reduced risk associated with early childbearing and multiparity. Melanoma Res 1996;6:147-153.[Medline]
23. Lindner E, ed. Yearbook of American and Canadian churches: 1998. Nashville: Abingdon Press, 1998.
24. Koenig HG, Bearon LB, Hover M, Travis JL III. Religious perspectives of doctors, nurses, patients, and families. J Pastoral Care 1991;45:254-267.[Medline]
25. Maugans TA, Wadland WC. Religion and family medicine: a survey of physicians and patients. J Fam Pract 1991;32:210-213.[Medline]
26. Ehman JW, Ott BB, Short TH, Ciampa RC, Hansen-Flaschen J. Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? Arch Intern Med 1999;159:1803-1806.[Medline]
27. Ellis MR, Vinson DC, Ewigman B. Addressing spiritual concerns of patients: family physicians' attitudes and practices. J Fam Pract 1999;48:105-109.[Medline]
28. Beauchamp TL. The "four-principle" approach. In: Lindemann Nelson H, Lindemann Nelson J, eds. Meaning and medicine: a reader in the philosophy of health care. New York: Routledge, 1999:147-55.
29. Goldberg S. Seduced by science: how American religion has lost its way. New York: New York

University Press, 1999.

# Related Letters:

**Medicine and Religion**
Koenig H. G., Nicklin D. E., Kaufman A. S., Hite R. W., Cameron J. R., Hall D. E., Suchman A. L., Castro D., Loo L. K., Stottlemyer D. L., Sloan R. P., VandeCreek L., Hover M.
[ Full Text ]
N Engl J Med 2000; 343:1339-1342, Nov 2, 2000.
**Correspondence**

# This article has been cited by other articles:

- Koenig, H. G., Nicklin, D. E., Kaufman, A. S., Hite, R. W., Cameron, J. R., Hall, D. E., Suchman, A. L., Castro, D., Loo, L. K., Stottlemyer, D. L., Sloan, R. P., VandeCreek, L., Hover, M. (2000). Medicine and Religion. *N Engl J Med* 343: 1339-1342 [Full Text]
- Barnes, L. L., Plotnikoff, G. A., Fox, K., Pendleton, S. (2000). Spirituality, Religion, and Pediatrics: Intersecting Worlds of Healing. *Pediatrics* 106: 899-908 [Abstract] [Full Text]

ARTICLE
- Table of Contents
- Editors' Summaries
- Related Letters to the Editor
- Find Similar Articles in the Journal

SERVICES
- Add to Personal Archive
- Download to Citation Manager
- Alert me when this article is cited

MEDLINE
- Related Articles in Medline

Articles in Medline by Author:
- Sloan, R. P.
- Poulos, P.
- Medline Citation