# THE HEALING OF EFFECTS OF PRAYER: A LITERATURE REVIEW OF RESEARCH AND RESULTS

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## ABSTRACT

**Objective:** To review the literature that describes the current theories as to the healing effects of payer and how this can be used from a health care practitioners point view.

**Data Collection:** Relevant articles in English were obtained through a search of text in the Logan College of Chiropractic library, and peer-reviewed scientific journals retrieved through searches of MEDLINE, PUBMED, and the Index to Chiropractic Literature. Key search terms were *prayer healing, intercessory healing, distant healing, healing effects of prayer, prayer therapeutics and prayer therapy.*

**Data Synthesis:** The principle criterion for inclusion/exclusion included selecting sources available through the Logan College of Chiropractic library, and using the most current information available.

**Conclusion:** Various forms of prayer healing, including distance healing and "psychic healing" are widely practiced, but insufficient formal research has been done to indicate whether such efforts actually affect health. The limiting methods of the studies being performed make it difficult to draw specific conclusions. The data seems to sway slightly in favor of prayer as a healing form. As to the exact nature of this it's still unknown. I believe that there is a combination of energy connection, external influences and the power of the mind involved. When all these are lined up through such practices as prayer they are powerful. More research needs to be performed to find out the exact source or this healing influence. All healers, medical, holistic and spiritual need to come together in acknowledging this as a prominent and important healing method.

**Key Indexing Terms:** Intercessory Prayer, Distant Healing, Prayer Therapy, Spiritual Healing, Psychic Healing, Remote Healing and Religious Healing.

## INTRODUCTION

Many alternative medicine therapies emphasize healing from a holistic mind, body, and spirit perspective; any discussion of the therapies would be incomplete without this perspective (1). Mind-body approaches to medicine have gained increasing acceptance in recent years. What about spirituality? Throughout time, the power of prayer has been questioned by science. The analytical mind of the scientist calls for proof of the existence of a higher being. These scientists, both the faithful and nonbelievers alike, have produced studies into the affects of prayer on our physical as well as spiritual well-being.

Prayer is an ancient healing practice not generally available in our health care system. However, the majority of Americans believe in the power of prayer. A recent *Time/CNN* poll found that 82% of Americans believe that prayer can cure serious illness. 73% believe that praying for others can cure illness, and 64% want their physicians to pray with them (1).

Three basic definitions of prayer are: 1. The act of praying, or of asking a favor; earnest request or entreaty; hence a petition or memorial addressed to a court or a legislative body. 2. The act of addressing supplication to a divinity, especially to the true God; the offering of adoration, confession, supplication, and thanksgiving to the Supreme Being as public prayer; secret prayer. 3. The form of words used in praying; a formula of supplication; an expressed petition; especially, a supplication addressed to God; as a written or extemporaneous prayer; to repeat one's prayers (2). Although many who pray do believe in God or a Higher Power, such a belief is not a necessary prerequisite for prayer (1).

When applying the definition to a healing perspective prayer is thought of as "systematic, purposeful intervention by one or more persons aiming to help another living being (person, animal, plant or other living system) by means of focused intention, hand contact, or passes to improve their condition. Spiritual healing is brought about

without the use of conventional energetic, mechanical, or chemical interventions. Some healers attribute healing to God, Christ, other higher powers, spirits, universal or cosmic forces or energies; biological healing energies or forces residing in the healer; psychokinesis (mind over matter); or self-healing powers or energies latent in the healee. Psychological interventions are inevitably part of healing, but spiritual healing adds many dimensions to interpersonal factors (3).

It is important for researchers to stay objective in there work. "We are not out to prove that a deity exists," says Prof. Diane Becker of Johns Hopkins. "We are trying to see whether prayer has meaning to people that translates into biology and affects a disease process (4)." Dozens of studies have shown that individuals who pray regularly and attend religious services stay healthier and live longer than those who rarely or never do -- even when age, health, habits, demographics and other factors are considered. Finally Prayer whether for oneself (petitionary prayer) or others (intercessory prayer}--affects the quality, if not the quantity, of life, says Dr. Harold Koenig, director of Duke University's Center for the Study of Religion/Spirituality and Health: "It boosts morale, lowers agitation, loneliness and life dissatisfaction and enhances the ability to cope in men, women, the elderly, the young, the healthy and the sick (4)."

The literature search for this study began March 10, 2004, at the Logan College of Chiropractic library in Chesterfield MO. The vertical file was tried first, but no information was found there. The computerized card catalog at the Logan College library was tried next. This yielded no satisfactory results. A third literature search was conducted on March 11, 2004 at Logan College utilizing PUBMED searching 'intercessory prayer' and it generated 31 articles from 1988 to 2001. Six articles were chosen to review. The next entry was 'prayer therapy' and this yielded the same results. Next EBSCOHOST was used key word 'intercessory healing' this produced no results. The next phrase search was 'intercessory prayer' and produced 199 articles. From this 18 were chosen. Using searches as 'prayer therapeutics', 'prayer healing' and 'prayer therapy' yielded similar results. The final search was performed using Ask.com with the key words 'intercessory prayer.' This produced 400 results, which were used. At this

time the decision was made to use information that had been acquired at the time. The selection strategy began with selecting peer-reviewed scientific journals that Logan College subscribes to. Doing so returned 48 articles and books to review. Next duplicate articles were removed from the many searches performed, and then the articles that did not pertain to this study were eliminated. Finally, the most current information available was selected unless older information was important or needed to fulfill the goals of this study. After performing the above selection strategies 29 references made up of 25 articles, 1 book and 3 websites were used for this literature review.

## DISCUSSION

### Historical Research

In 1872, Galton published the first known study on petitionary and intercessory prayer. He compared the mean age of death among males from various professions between 1758 and 1834. He hypothesized that if intercessory prayer was healing, he would see men from professions such as the clergy, missionaries, and the royalty to have longer lives, as it was common for these groups to be prayed for frequently. He found no statistical evidence that prayer prolonged life. Members of royal houses had the shortest life span while the clergy lived only slightly longer than men in other professions. Eminent clergy, however, lived shorter lives than either lawyers or medical professionals. He also compared rates of stillbirth between the praying and non-praying classes. Again, he noted no survival benefit of prayer (5). A flaw in this study is that the praying classes tended to be those with the most psychosocial stressors and hardships, which would tend to shorten survival.

In 1965, Joyce and Welldon conducted the first randomized, controlled, double-blind trial of intercessory prayer. This means neither the patients, nor those collecting data, knew who was being prayed for and who wasn't. This helps to eliminate bias in the study. The study included 48 patients with psychological or rheumatoid diseases. They

found that the group that was prayed for (5 out of 16 improved) and the group that was not prayed for (1 out of 16 improved) (5).

Collipp, chairman of the pediatric department at Meadowbrook Hospital in New York, conducted the next randomized controlled, double-blind trial of prayer in 1969. He selected 18 patients with leukemia between the ages of one and 19 years old. Half of the children were prayed for daily by a protestant prayer group in Washington D.C. for 15 months. A specific group did not pray for the other half. (Note that you cannot account for other people that may be praying for the patients such as family members.) The outcome was survival at 15 months. 70% of the patients who were prayed for survived, while only 25% in the not-prayed for group survived (5).

**Prayer in Coronary Studies**

There are two prominent studies currently in the literature supporting prayer as a healing method. Randolph Byrd explored effects of intercessory prayer by born-again Christians on 192 patients hospitalized on a CCU in California, compared with 201 in the control group. After signing an informed consent, patients were randomized into the two groups, and later checks showed that there were no significant differences between the groups on demographic or illness variables. Prayers were sent daily by three to seven Christians (6). Byrd devised a severity of illness assessment, as none existed for patients in a CCU. Each intercessor was asked to pray daily for a rapid recovery and for prevention of complications and death, in addition to other areas of prayer they believed to be beneficial to the patient. Significantly fewer patients in the prayer group required intubation; ventilation ($p < 0.002$) or antibiotics ($p < 0.005$), had cardiopulmonary arrests ($p < 0.02$), developed pneumonia ($p < 0.03$) or required diuretics ($p < 0.05$)." Despite the differences between groups, the mean times in CCU and duration's of hospitalization between groups were nearly identical (6).

As Byrd notes, some of the patients in the control group may have had outsiders praying for them, which presumably would have reduced the differences between groups. If this is the case, the results are even more impressive (6).

In a replicating study, William S. Harris and colleagues studied the effects of intercessory prayer in consecutively admitted patients on a CCU at the Mid America Heart Institute (MAHI), Kansas City, MO. There were 466 in the prayer group and 524 in the control group. Again, no significant initial differences were noted in comorbid conditions, age, or sex between the groups. Neither patients nor staff knew the study was being done, and therefore informed consent was not obtained (7).

Intercessors were recruited from the local community if they agreed with the statements: I believe in God. I believe that He is personal and is concerned with individual lives. I further believe that He is responsive to prayers for healing made on behalf of the sick. Intercessors were randomly assigned to 15 teams, each with 5 members (total 75). Intercessors were 35% non-denominational, 27% Episcopalian, and the rest Protestant or Roman Catholic. Prayers commenced by at least one intercessor by the second day after admission to the CCU. Intercessors were requested to pray daily over the following 28 days for a speedy recovery with no complications" and anything else that seemed appropriate to them. The 28 days covered the CCU patients entire hospitalization in 95 percent of the cases (7).

An internist and three experienced cardiologists assessed new events during the CCU stay. As no standard scales exist for the assessment of CCU cardiac status or progress, the researchers developed two of their own, the first with weighted and the second with unweighted values for various events, procedures and new diagnoses. A third rating, the Hospital Course Score used in the study by Byrd, was recorded as well (7).

All assessments and data analyses were conducted blindly. On both the weighted and unweighted scales, the treated group showed significantly greater improvements (both at $p < 0.04$). No significant differences between groups were found in the Byrd hospital

course scores, although there was a trend in favor of the E group. Interestingly, again no significant differences were noted between the two groups in duration of hospital stays (6,7).

**Prayer In Blood Studies**

A third study was published by Fred Sicher, Elizabeth Targ, and colleagues on effects of distant healing on AIDS. At California Pacific Medical Centers Complementary Medicine Research Institute. This study focused on 40 volunteers who had advanced AIDS. Volunteers were solicited through local advertisements. Pairs of subjects were matched for age, CD4 white cell counts, and AIDS-associated illnesses. They were randomly assigned to receive either distant healing or no healing. All received standard medical care from their own doctors, at several different medical centers (8).

40 healers in various parts of the United States sent distant healing. All healers had at least five years experience, including treatment of AIDS, and were accustomed to sending distant healing. Healers had only the first names and photographs of five of the subjects. They sent healing for an hour each day, six days per week, over a 10-week period. Healers were rotated randomly in weekly healee assignments, so that every healee had 10 different healers who sent healing over the course of their treatment. Healer's religious backgrounds included Christianity, Buddhism, Judaism, Native American and other Shamanism traditions, and healing traditions included several modern-day healing schools (8).

After six months, a doctor who was blind to treatment assignments conducted a medical chart review. There were no significant differences between healing and control groups on demographic and study variables prior to the start of distant healing treatments. At six months following the initial assessment, those sent distant healing had significantly fewer AIDS-related illnesses ($p < 0.04$) and lower severity of illnesses ($p < 0.02$). Visits to doctors were less frequent ($p < 0.01$), as were hospitalizations ($p < 0.04$), and days in hospital ($p < 0.04$)(8).

Mood was assessed on the Profile of Mood States (POMS). Again there was

significantly more improvement in the prayer group ($p < 0.02$). A higher mean score (not significant) was found in the E group at baseline. This could have contributed to the greater improvement shown on this variable. CD4 counts and scores on other psychological assessments did not differ significantly between the two groups.

The authors point out that the overall improvements appear to indicate a global rather than a specific distant healing effect. They suggest that measures of viral load and activity of natural killer (NK) cells may be more useful measures of healing effects than CD4+ counts (8).

However, no comparisons between groups were made on the treatments used, administered by different doctors at different treatment centers. It is possible that there were significant differences between groups in these or in other unidentified variables, with the prayer group receiving medical treatment, which gave them some advantage compared to that given to the control group (9).

In a study published in British Medical Journal the effects of prayer on outcomes in patients with bloodstream infection was observed. Interventions In July 2000 patients were randomized to a control group and an intervention group. A remote, retroactive intercessory prayer was said for the well being and full recovery of the intervention group. The main outcome measured: Mortality in hospital, length of stay in hospital, and duration of fever. The results: Mortality was 28.1% (475/1691) in the intervention group and 30.2% (514/1702) in the control group (P for difference = 0.4). Length of stay in hospital and duration of fever were significantly shorter in the intervention group than in the control group ($P = 0.01$ and $P = 0.04$, respectively). The Conclusion: Remote, retroactive intercessory prayer said for a group is associated with a shorter stay in hospital and shorter duration of fever in patients with a bloodstream infection and should be considered for use in clinical practice.

Another significant aspect of these studies specifically those of Byrd, Harris et al, and Sicher et al is that they are published in respected, conventional American medical journals. Until recently, most medical journals would routinely reject articles on spiritual

healing.

**Basic Human Prayer Studies Positive and Negative Results**

Other studies have shown effects of intercessory healing on back pain (10), arthritis recuperation from surgery, hypertension, anxiety, anticipatory nausea in chemotherapy, and self-esteem (9).

In a study of LeShan healing, independent judges are able to identify from healees subjective reports when a distant healing treatment has occurred. Six healers trained by LeShan were used. A series of healings was scheduled for each of the 12 subjects. The first and the fifth healing for each person were present (healer and healee in the same room) and the remaining eight were distant (healer and healee separated by unspecified distances, all presumably in their own homes). A few healings were conducted over greater distances. Healers and healees were told that healings would be done at specific times of day scheduled by Goodrich. Unknown to them, half of the distant healings for each healee were scheduled at least an hour after the participants expected them (nonsynchronously)(11).

Healees reported such sensations as relaxation, drowsiness, heaviness, decreased anxiety, increased energy, and peacefulness. Sensations reported by healers included a more intense awareness of self and feelings of peacefulness (11).

Three judges who were blindly given healers and healees self-rating forms on their subjective experiences successfully identified whether the healings were synchronous or nonsynchronous (modest significance: $p < .005$). Goodrich, disclaiming recall for coding of data, also rated the forms and achieved significant results (11).

Beginning students of healing and healees both often question whether they are feeling something related to healing if they sense heat between the hands of a healer and the body of the healee, or whether they merely feel the natural heat of a warm hand. This doubting of ones own experience is even more marked with absent healings. It is most helpful to have the confirmation of Goodrich's thesis that such sensations are frequent

enough and distinct enough to be reliably identified by healees and by independent judges who reviewed reports of the healees perceptions (11).

However the following studies showed no effect: No effects of distant healing were demonstrated in studies of asthma (9), hypertension (12), anxiety (13), depression (14), self-esteem (13), in inadequately defined chronic problems (15), or in people who did not need healing (9). Though a study of distant healing in alcoholism showed no effects on drinking, there was a significantly lower dropout rate from treatment in the healing group (16).

**Prayer Effects on a Non Humans**

The best series of non human studies in the intercessory prayer literature is on the waking of mice from anesthesia. Healers sent distant healing from across a room, sometimes from behind a one-way mirror, to one of a pair of mice that were littermates who had been matched for gender and weight, and anesthetized in the same anesthetizing box. They were able to selectively waken the designated mice significantly more quickly than the control mice ($p < 0.02$-$.00003$) (9).

An interesting side note came from one of these studies. The researchers asked the healers to randomly alternate waking mice on either side of the table. The healers said they could only do this if there was at least a twenty-minute interval between wakings of successive mice. Otherwise, they warned, some of the distant healing effects from the previous waking would linger on that side of the table. If the next mouse was a control mouse, and if it were placed on the side where a mouse had been sent healing within less than a twenty-minute interval, a residual of the healing effect could influence that control mouse to waken more quickly (9).

The researchers were reluctant to spend so much time waiting between trials, so they kept one side of the table for healing for half of each series of mice, waited an appropriate interval, and then reversed the side for healing. In one series, they deliberately studied this alleged "linger" effect. Without allowing an interval between sending healing to one

side of the table and placing control mice on that side of the table, they found that indeed the mice placed on that side of the table woke more quickly--even though healing was not being sent at that time to that side of the table (9).

Distant healing also ameliorated the development of amyloidosis (a collagen disease) experimentally induced in hamsters, slowed the growth of experimentally induced tumors in mice, and protected mice from effects of radiation (17).

One of the most intriguing studies of mice, indeed, the study with some of the most far-reaching implications in the healing literature, is that of Jerry Solfvin on malarial mice. Solfvin gave his laboratory workers two vials, one labeled "babesia" (babesia rhodanii are malarial organisms) and the other "non-babesia," for injecting two groups of mice. Each mouse was given a code number and injected with malaria from one of the vials. A slip of paper, on which the code number and "babesia" or "non- babesia" were recorded, was sealed in an opaque envelope, with only the designation of " babesia " or "non-babesia" written on the envelope. These were handed to another experimenter, who sealed them in yet another envelope, again recording "high" or "low" on the second envelope. Solfvin divided the "high" and "low" groups of envelopes into two piles, one designated to receive distant healing and the other as a control group. Thus, Solfvin had no way to know which mice were in which malarial group, and the laboratory workers had no way to know which mice were to receive distant healing (9).

In reality, the vials given to the handlers contained identical doses of malarial organisms, and Solfvin never contacted a healer to send distant healing to the mice so designated. The study was actually one of illness and healing expectancy effects.

In Experiment 1 there were three animal handlers. Two were "sheep" (believers in psychic phenomena and healing) and one was a "goat" (disbeliever). The mice handled by the sheep demonstrated random results. Those handled by the goat showed significant effects ($p < 0.021$) for illness and a trend towards significance ($p < 0.09$) for distant healing effect. Both of these effects were significantly in the opposite direction to that predicted in the study, but consistent with the expectations of the goat.

In Experiment 2 there were five animal handlers and the malaria was designated as either "high" or "low" babesia. There were significant healing expectancy effects in the direction of positive expectation ($p < 0.05$) in all groups and a marginal trend in the illness expectancy ($p < 0.05$-.10).

Solfvin notes:

> This healing expectancy effect is definitely a parapsychological one in the sense that it cannot be entirely explained in terms of known sensory processes, since the target animals were not known by anyone until the end of the study. We have therefore produced a paranormal healing effect, or something that resembles a healing effect, in a well controlled laboratory study, which cannot be attributed to a specific psychic healer, or healing treatment. It must therefore be attributable to something else and that something else may be operating in other psychic healing situations as well.
>
> In experimental studies of psychic healing treatments the experimenters may have reason to expect positive results. The healer may have performed well in pilot or screening trials, may have brought an impressive anecdotal case history of successful healings, or may make a strong personal impression on one of the experimental staff members. The results of the current study, modeled after this situation, suggest that the expectation structure may be an important contributor to the results, regardless of what the healer does.

This study indicates an external source of healing that may be different but connected to prayer.

**Prayer Healing Effects on Plants Bacteria and Yeasts**

Plant studies provide a cheap, and easy method for prayer research. Formal studies

have shown significant effects of distant healing with plants. Other studies showed no effects of distant healing on plants. Each of these studies had problems in their designs that might explain the failures to demonstrate healing effects (9).

Distant healing produced significant effects on enhancing and retarding growth of bacteria (18,19,20) and yeasts (21,22). These studies suggest that healers may be able to slow or halt the progress of an infection by retarding the growth of infecting organisms.

Carroll Nash explored effects of distant healing on bacteria that mutate between two forms, "lac negative" and "lac positive," showing that healing could selectively increase either form. If this is an effect on mutation, it provides encouragement to believe that healing might influence mutating cells, such as cancers, in the body. However, as Nash notes, an alternative hypothesis is that the distant healing selectively influenced the growth of one or the other form rather than influencing mutation rates (23).

**Prayer Healing Effects of DNA**

Glen Rein and Rollin McCraty, at the HeartMath Institute, showed that distant healing could alter the rate of winding and unwinding of strands of DNA (24).

The implications of these studies are far-reaching, indeed. First, this could be a mechanism for the action of healing within the body, since DNA controls many of the functions of cells in the body. Second, if healing intent can influence these complex molecules that control genetics, it is possible that intent could influence heredity and evolution (9). This may be a mechanism for the effects in Nash's study of bacterial mutation.

**Areas to Consider in Prayer Research**

NINE METHODOLOGICAL CONSIDERATIONS

1. The issue of informed consent poses significant challenges in investigating the effects of intercessory prayer. By having consent the subject assumes there is a

possibility they are possible being prayed for. This expectancy may affect the outcome.

**2.**Subjects in the treatment group ideally should have a modest problem that is being prayed for, not one that is life threatening. It is thought if the problem is serious the patient or family may pray on their own.

**3.**Our lack of knowledge about the dose-response relationship of prayer makes interpretation of prayer experiments difficult. No one knows the amount of prayer needed to observe results.

**4.**Prayer studies ideally should be conducted outside the public eye. This would protect the study from outside influences.

**5.**Subjects in prayer studies should ideally have a problem that elicits unconditional love and empathy from the intercessors. It is thought that those who don't "believe" may not be capable of delivering proper prayer techniques.

**6.**Subjects should be prayed for by multiple intercessors. This is to coincide with the idea of history stating group prayer is most effective.

**7.**Studies in intercessory prayer ideally should be conducted by investigators who believe it is effective or who are genuinely open to this possibility. This falls under the assumption that one's beliefs can indeed influence the physical world, including, presumably the out come of the experiment.

**8.**Studies that examine the effects of intercessory prayer on lower organisms should be encouraged, because they are easier to control and offer more reliable outcomes than do studies in humans. This would help exclude outside factors.

**9.**Research protocols in prayer studies should be considered sacred, reverential exercises. Science believes that dispassion is the ideal attitude for an experimenter. Experimenters in prayer have often observed, however, that a sense of holiness often correlates with a positive outcome of the study. Healers agree: they generally believe that a sense of sacredness and reverence is required if distant, prayer-based healing is to succeed (25).

In a Hastings Report a concern relates to how to subject prayer to the design of the standard randomized clinical trial, which requires uniformity and careful empirical

measurement. Questions abound about how prayer could be organized to meet these requirements. To ensure uniformity, the same prayer would have to be used for all those in the treatment group. Since Byrd concluded that prayer to a Judeo-Christian God was efficacious, a prayer from this tradition might be used (6). This, however, would be inappropriate for Muslim or Hindu patients, whose prayer rests on a somewhat different vision of the sacred. Creating an interdenominational prayer that incorporated common approaches to the divine would still not be appropriate for, say, a Zen Buddhist, since verbal prayer is discordant with that tradition's wordless approach to spirituality.

When measuring a "dose-response effect" of a medication, investigators assess whether larger doses increase the desired effect. They also examine whether the standardized amount evokes a uniform response over time or only after a certain point in the experiment. Investigators would similarly have to quantify the dose-response effect of prayer and evaluate whether more is better. This would require prescribing prayer in a certain amount and degree of intensity (25). Yet there is no way to ascertain the quantity of prayer carried out for those who are ill or to measure its degree of flow (26).

Furthermore, investigators would have to decide before the experiment began what outcomes they were studying and how serious and how discrete these would have to be to prove that prayer alone had created or prevented them. If the initial experimental design had no hypothesis about what specific results were sought, and about what means had to be used to prove that prayer had brought about these results, the efficacy of prayer could not be established incontrovertibly. This requirement would be difficult to meet, for many illnesses do not have well-delineated outcomes, such as death, that would allow the efficacy of prayer to be demonstrated. Investigators would have to declare in advance what specific outcome they were looking for, such as restoration of motor function in someone who had suffered a paralytic stroke or return of a normal coronary angiogram in someone with prior evidence of significant coronary obstruction. Finally, when multiple variables are compared, an appropriate statistical analysis should be used (26).

If a study seemed to show that intercessory prayer did not produce the expected beneficial medical effects, this would not clearly display that it had been inefficacious.

Proponents of testing prayer could argue that it had not been carried out with the appropriate intensity, uttered by persons of sincere faith, or pursued by sufficient numbers of people (25). If, on the other hand, a study seemed to show that prayer had produced therapeutic results, this would not necessarily demonstrate that it was prayer that had brought about these results. Opponents of testing prayer could claim that they were accidental and that the study had not been conducted on a well-defined set of patient behaviors, controlled adequately for confounding variables, or pursued with sufficient numbers of people. Thus results demonstrating either the failure or success of prayer could be dismissed as having omitted certain significant empirical factors--and there would always be more of these to consider (26).

After considering these views it is necessary to view the results of experiments over all. This the result of a study that examined the efficacy of prayer type healing research. The methodological limits of several studies make it difficult to draw definitive conclusions about the efficacy of distant healing. However, given that approximately 57% of trail show a positive treatment effect, the evidence far merits further study (27).

**Social and Ethical Concerns of Prayer Research**

That health care professionals should inquire about the religious faith of their patients is not a radically new claim. At one time in the American past there was a close connection between medicine and religion; health caregivers accepted the importance of patients' religious beliefs to their care and were apt to ask about them. By the 1960s, however, the relation between medicine and religion had weakened considerably and professional staffs in some secular institutions were warned that it was unethical for them to inquire about the religious beliefs of their patients. Such inquiries, it was feared, would intrude into a sacrosanct personal area and violate patient privacy. Moreover, they might intimidate patients at a time when they were highly vulnerable. At some institutions, sanctions awaited members of the professional staff who spoke aloud of a Higher Power or prayed openly at the bedside (26).

This professional barrier against professional discussions of religion and spirituality with patients has begun to lift in recent years. The contemporary move toward more holistic therapy and a growing respect for cultural, ethnic, and religious diversity are partly responsible for this. One of the insights behind these changes is that patients do not present themselves simply as malfunctioning organic machines, nor do they come with their experience or their symptoms conveniently divided into bodily, social, and emotional ones. They come as living unities, with moral, spiritual, and psychological goods and harms as well as physical needs. Health care professionals are called to attend to the multifaceted character of their patients and to the connections they constantly manifest between body and mind, experience, and conviction. They are constrained to treat patients as whole persons--for those are the only kinds there are (26).

The concern of prayer in a health care setting is the harm it can cause towards the patients mental state. Religion can sometimes have deleterious effects upon health. Clinicians must differentiate between spirituality and religion when considering the patients beliefs. Some will describe themselves as spiritual but not religious believers. Spirituality is about the search for transcendent meaning. Most people express their spirituality in religious practice. Others express their spirituality in their relationship to nature, music, the arts, a set of philosophical beliefs, or relationships with friends and family. Religion, on the other hand, is a set of beliefs, practices, and language that characterizes a community that is searching for transcendent meaning in a particular way, generally based upon belief in a deity (28).

The religious community voices objections to prayer studies. One is the belief that prayer experiments are done by unbelieving heretics bent on "testing God." I believe this is a mischaracterization of researchers involved in prayer, and is irrational as well. Does anyone really believe that a die-hard skeptic would spend valuable time and scarce research funds investigating a phenomenon that he bitterly opposed in the first place? Researchers usually choose topics toward which they feel cordial, not those they consider fallacious (25).

There is a subtler objection in regards to the religious. They seemed troubled by the absence of any correlation between the effect of the prayer and the religious affiliation of the person praying. The prayer experiments showed clearly that no religion has a monopoly on prayer, and that prayer is a universal phenomenon belonging to all of humankind and not to any specific religion. Some fundamentalist groups found this implication offensive, and chose to condemn all the experimental evidence favoring prayer in an attempt to preserve their own sense of specialness (25).

The scientific community posses their own objections. They hold a belief that the mind has more to do with healing than the actual prayer. Those who oppose the idea of intercessory prayer do so mainly because of the prevalent belief that human consciousness can be generally equated with the workings of the brain, which means that the effects of the mind are confined to the physical brain and body. According to this view, consciousness cannot in principle cause things to happen at a distance, whether of its own accord or by acting through a transcendent agency. From this standpoint, intercessory prayer raises the old bugaboo of "spooky action at a distance" and is considered outrageous (25).

An argument can be made by reviewing history is when Newton invoked the idea of universal gravity; he was attacked by his contemporaries as surrendering to mysticism. They disapproved of the mysterious force of gravity because Newton could not explain why bodies behaved in accordance with his proposed laws, or how physical bodies could act at a distance on one another. "This sort of worry no longer bothers us, but not because we have answered it. (29)."

## CONCLUSION

The public has shown increasing interest in the connection of religion, spirituality, and health. It is crucial that spirituality and religious faith not be reduced to just a simple therapeutic method. Practitioners have a responsibility to respect the religious beliefs of their patients. Physicians need to learn to open to discussing spiritual concerns with their

patients; to addressing these issues in a respectful, careful and professional way; and to knowing how and when to refer patients to other members of the health care team for spiritual support.

The relationship between healing and prayer has been the subject of considerable empirical investigation. Hundreds of studies have been performed, some of which were conduted at very high standards, i.e., major universities and hospitals, rigorous designs, and large sample sizes, with subsequent publications in major indexed journals. While many studies have found positive effects of prayer on healing, there is not yet a strong enough consensus to conclude that the healing effects of prayer represent a predictable phenomenon. The number of studies not finding positive healing effects of prayer and approximately equal to the studies that did. The lack of consensus for so important a research topic strongly indicates the need for continues study.

The views and beliefs of spiritual people must be observed with respect. Researches must be ready for the social response when prayer is proved or disproved as a healing therapy. It may be detrimental to remove the hope of those who believe so deeply. However if it were proven to be true this would support prayer as therapy and the practitioner would be inclined to take a more serious position.

More research is necessary to clear up the debate. Fear can't be the deciding factor as to whether we look for more answers. The unknown must be pursued for the good of those in need of healing. It is the responsibility of the health and scientific community to take a solid objective look at the data presented.

If prayer and spirituality are proven to be a viable healing method it will become the responsibility of the healer and the patient to examine their own faith. This will open a whole new dimension of health care.

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