

MIHAELA FRUNZA

Ethical Aspects of Spiritual Medicine. The Case of Intercessory Prayer Therapy

Abstract:

The main purpose of this article is to explore, from an ethical perspective, one particular branch of what is today called "spiritual medicine": namely, prayer therapy. Several landmark studies in the literature will be thoroughly examined, respectively the classical study of Byrd (1988), the replica of Harris et al. (1999), and the controversial study of Leibovici (2001). Beginning with these studies and the related controversies surrounding them, the religious features and ethical consequences of prayer therapy are investigated. The ethical aspects of prayer therapy – the informed consent issue, the issue of respecting bioethical principles, and the issue of medical competence in offering such techniques – are thoroughly addressed. Finally, an alternative way of framing the prayer therapy discussion is offered, in the context of public-private dichotomy.

Mihaela Frunza
Lecturer,
Ph.D,
Department
of
Systematic
Philosophy,
Babes-Bolyai
University,
Cluj,
Romania.



Author of the book:

Ideologie si feminism (2004).

Editor of the books: *Fetele toleranței* (2003), *Gender and the (Post) East-West Divide* (2004), *Tinerii și politica* (2006).

E-mail: mihafrunza@yahoo.com

Key words:

ethics, prayer therapy, complementary medicine, religion, public/private debate

In the future it will be considered unethical for a physician not to pray for his or her patient as part of quality health care.
- Larry Dossey, MD

The emergence of complementary and alternative medicine (CAM) is of such importance that the proponents of it speak about "the falling of the bamboo curtain" (Weeks 2001, IX). The connections with Cold War imagery that this metaphor evokes have never been more appropriate than in this case, both for physicians and for scholars studying religion. Today, under the influence of what various authors call "occulture" (Partridge 2005, 2), "wellbeing culture" (Partridge 2005, 3), or "the mystical nebulous" (Champion 1996), Western medicine is rediscovering the connections with (Eastern) spirituality.

A major factor for this phenomenon must be related to the holistic philosophy underlying CAM therapies, which aims at more effectively addressing the personal needs of the patients than does traditional, disease-oriented, medicine.¹ Inside this richly illustrated phenomenon that ranges from aromatherapy to Zen Buddhism, a particular place that is still subject to contestations is constituted by "spiritual medicine" which encompasses aspects connected to "the effects of religion and spirituality on health outcomes" (Lawlis 2001, 473) and covers techniques such as prayer therapy, therapeutic touch, shamanism, transpersonal medicine, etc. However, although widely used by those who

believe in praying when in suffering (patients and relatives alike), prayer therapy provokes many controversies that to date have not been solved.

Beware of Fruitless Discussions: Terminological Cautions and Endless Controversies

Before entering the discussion of prayer therapy itself, some cautionary and preliminary notes are needed concerning the key terms that are used in or ground the discussion throughout this paper. There are two basic areas of concern that deserve at least minimal clarification: that of the conceptual doublet “religion/spirituality” and that of “prayer therapy” itself. The aforementioned is linked to many controversies and arguments, while the latter phrase requires only some specifications for those who are unfamiliar with it. The broad context in which both the relations among concepts and the subsequent misunderstandings are grounded is deeply connected to the so-called “Western world” that traditionally included the European and North American countries.

When one enters the arena of discussions concerning the possible and actual relations between religion and spirituality, one may get the impression that one is witnessing a dialogue between deaf people. Although the thorough conceptual clarification of the latter distinction is beyond the aims of the paper, due to the notorious confusion that surrounds the existing debate, some preliminary remarks need to be made.

If, for any “innocent” scholar from outside the field, religion and spirituality may seem to come from the same conceptual family, for those involved in health-related issues, they can be viewed on a scale that ranges from total similarity to total opposition, with a whole range of intermediate positions. This may be related to their different connections with the field of medical specialties. If religion and medicine have been historically associated with each other, at least in the “Western world” since the days of the Hippocratic Oath, and this relation only deteriorated in the last few centuries, when medicine gained a more “scientific” methodology that excluded other ways as “superstitious” and “unscientific,”² the word “spirituality” has only entered the arena in the last few decades, as a result of a holistic, New-Age-type influence. Thus, in a review of the prestigious medical database Medline, the word “spirituality” is to be found only in the 1980s (Mills 2002, 1). Another possible explanation is that, for many scholars, the word “religion” itself is not neutral, but is (more or less consciously) equated with “Christian religion”.

Yet, as a new-comer in the picture, spirituality has spectacularly recovered this ground, as a quick passage through the literature shows. For instance, for some authors spirituality is seen as divorced from religion: “Spirituality, as conceptualized in this article, is not equated with any of the religious experience” (Long 1997, 497), At the least, it involves a broader and more complex concept (Dalmida 2006, 118). To make the picture even more blurred, some authors mention up to 35 different definitions of spirituality, which may be classified into three categories: “theological or dogmatic interpretations that supply a ‘definition from above’, anthropological understandings that emphasize human nature and experience, and historical-contextual approaches that accentuate experience rooted in a particular community’s history” (McGinn 1993, apud Moberg 2002, 48).

In this paper, I delineate myself from the line of argumentation that aims at opposing religion and spirituality by subsuming them to the simplistically “institutional” vs.

“personal” model.³ Although it captures most of the diffuseness of the concept of spirituality, there are several problems with this model. First of all, opposing religion, as something solid, already established, and without further questioning, to spirituality as something vague, deeply personal, and involving mysterious “entities” and “energies,” is similar to opposing science and religion, to the detriment of the latter. Furthermore, the opposition says nothing about spirituality itself, and only devalues it in the eyes of religious scholars. At the same time, the issue of “institutionalization” is both time-related and deeply dependent of the person who judges it. For instance, for a practicing parapsychologist, parapsychology itself is a discipline with institutions such as university courses, conferences, and peer-reviewed journals. It is well defined and cannot be mistaken for any other spiritual discipline with which it may have connections. Thus, if we are to do justice to the terms, we must treat them on equal footing, and not disqualify any of them because of an alleged inferiority.

A view that seems more balanced in this aspect is that of Thorensen and Harris, who interpret this relation “as two overlapping circles (Venn diagrams), with spirituality being the larger circle yet sharing with religion many overlapping areas, but each having nonoverlapping areas” (Thorensen and Harris 2002, 4). However, what I find questionable is precisely the existence of those “nonoverlapping areas”. Keeping the metaphor of Venn diagrams, perhaps a more accurate picture would be that of two circles, with spirituality being the larger one, and religion the smaller one inside it. In this view, religion is indeed connected with institutions – namely, communities, tradition, and canonical texts, while spirituality is more diffuse, emphasizing the individuality, and being deeply grounded in affections. Spirituality encompasses the subjectivization shift that is noticeable in the Western world, a subjectivization through which individuals attempt to rediscover a path “they have chosen” (Partridge 2005, 6-7).

The other issue requiring clarification is the concept of “prayer therapy” itself. The word “prayer” is derived from the Latin *precari*, to entreat. It has been defined as “an intimate conversation with a higher being for the purpose of imploring or petitioning for something or someone” (Maier-Lorentz, 2004, 25). Prayer may use words or be wordless, and may be directed (when one indicates the desired outcomes) or nondirected (when one asks for being ready for the outcomes). It may be petitionary or personal prayer (when one prays for him/herself) or intercessory prayer (when one prays for somebody else’s benefit). This paper refers only to intercessory prayer, which has drawn interest as a therapeutic method and has been subject to scientific experiments.

Re-Enchanting the Medical Act: The Proportions of a Phenomenon

Whereas only a few decades ago very few people would admit a connection between spirituality and medicine, nowadays “the ‘S’ word (spirituality) can be spoken with comfort” in health care organizations (Kaiser 2000, 6), and there are talks about religion and spirituality as “hot issues” in medical journals (Thorensen 2002, 3). Like many Western practices, “modern medicine is re-enchanting” (Partridge 2005, 24), which does not mean it is replaced, but rather supplemented, by complementary and alternative medicine (CAM).

At present, there is a spectacular increase in the use of CAM therapies that in some cases led to discussions of whether or not they should be covered by the ordinary med-

ical insurance. According to statistics, between 35% and 50% of adult Americans use some form of CAM, and figures are similar for Europe (Makowski 2004, 4; Astin, Harkness and Ernst 2000, 903; Partridge 2005, 25). The number of people licensed to practice CAM therapies literally tripled from the 1970s to the 1990s. (Partridge 2005, 13-14). At the same time, more than 60 US medical schools out of 125 developed courses connected to religion, spirituality and health (Dossey 2000), although the content and quality of such courses is far from being unquestionable. Inside the medical field, the area that was most significantly touched by this phenomenon is undoubtedly nursing (Partridge 2005, 25-27).

Attesting to the importance of this phenomenon, almost every serious medical journal has begun to publish articles and even special issues dedicated to this topic. Thus, the number of published studies with the keywords religion and health and spiritual/spirituality and health included in the Medline database increased four times between the 1980s and the year 2000. Over a year, the rating of CAM as a subject matter in the journals of the American Medical Association increased from position 68 to 3 (Weeks 2001, VIII). Beginning in 1997, the John Templeton Foundation and the National Institute for Healthcare Research have sponsored conferences on the relation between religion and spirituality and physical health, while in 1999, the National Institutes of Health Office of Behavioral and Social Sciences Research created a separate panel of scientists in order to critically assess the publications in this field (Mills 2002, 1; Thorensen 2002, 3-4).

The studies documenting possible relations between religion/spirituality and health issues are so diverse, that they encompass almost everything in medicine (Gundersen 2000) from the immunity system (Roberts 1999) to cardiovascular diseases (Byrd 1988; Harris 1999), and from Alzheimer's (Stuckey et. Al 2002) to HIV-AIDS (Dalmida 2006).

Among the CAM procedures and techniques, "spiritual healing" was the fifth most frequent treatment used in the US. This can be related to the high value associated by Americans with prayer, which 82% of Americans believe to have healing powers (Astin, Harkness and Ernst 2000: 903). More importantly, high percentages of social workers seem to use intercessory prayer in their work, although the evidence regarding the success of this therapy remains controversial (Hodge 2007, 174).

Proponents of the power of prayer are more inclined to interpret positively any experiment done on prayer and to include sources that are questionable. Thus, Dossey enumerates 131 laboratory experiments on prayer effects, of which only 21 provided a statistically significance P factor at the .01 level. However, the legitimacy of these sources is questioned by those who note that "10 of these are unpublished doctoral dissertations, 2 are unpublished master's theses, and all the rest were published in parapsychological journals" (Baker 1994; Stenger 2001). Moreover, the scientific value of these studies is discounted by those who complain of the low scientific standards of the studies on which Dossey based his arguments. Thus, the statistical significance (the P value) of these studies is found to be inconsistent from a strictly scientific point of view (Stenger 2001).

A more objective literature review of the studies published before 2000 on "distant healing" (covering intercessory prayer, therapeutic touch and other forms of healing at a distance) concluded that in 57% of these studies beneficial results were reported (Austin et al. 2000, 910). The study further deduced that, as the number of studies that passed the selection criteria in the review was still low (for instance, only five studies on intercessory prayer were included), there was a need and indeed a necessity to intensify

research in this area by designing new studies. In another words: “they [the results of the tests] clearly provide evidence that the effects of prayer can be studied with empirical methods and can include objectively measurable and clinically important health outcomes...Needed at this point is replication of such effects by other researchers using very similar procedures and examining a broader range of person, health, and socio-demographic factors” (Thorensen 2002, 8).

However, a more recent survey on seventeen intercessory prayer experiments was more skeptical in concluding that: “the findings are unlikely to satisfy either proponents or opponents of intercessory prayer” (Hodge 2007, 185). Nevertheless, such literature reviews have their own limitations, such as the heterogeneity of the experiments included in the report, which clearly reduces their predictive power (Astin, Harkness and Ernst 2000, 908).

I chose to focus on three studies on prayer, two of them measuring the efficacy of prayer for cardiovascular diseases, and the third focusing on bloodstream infection. The first two are so vividly discussed in the literature that they can be considered almost “canonical” while the later one, more controversial, opens the discussion of the most paradoxical aspects of prayer-related studies.

Praying from/for the Hearts and Praying for the Past: Controversial Experiments

Two decades ago, in the 1980s, Dr. Randolph Byrd conducted a 10-month double-blind study at the coronary care unit of San Francisco General Hospital. A total of 393 patients consented to participate in the study, which aimed at assessing the effects of intercessory prayer. Roughly half of the patients were randomly assigned by a computer either to the “prayer for” group, or for the control group. The prayer group patients were assigned to three to seven people who prayed for them, while the the control group was not assigned for prayers. Neither the patients themselves nor the medical personnel knew who belonged to which group, although they knew about the study being developed. The intercessors belonged to the “born-again” Christians, mainline protestant churches, and the Roman Catholic Church. The two groups were similar at the start, meaning that there was no statistically significant difference between them. By analyzing what happened to the patients after entering the study, Byrd concluded that, overall, the prayer group did better than the control group: “the prayer group had less congestive heart failure, required less diuretic and antibiotic therapy, had fewer episodes of pneumonia, had fewer cardiac arrests, and were less frequently intubated and ventilated” (Byrd 1988, 829). For many of the factors analyzed in the case of the two groups, there were differences, either in favor of the prayer group (for instance, only 1% suffered gastrointestinal bleeding, compared to 2% of the control group), but the differences were not statistically relevant (the probability P was not above .05). In order to reach a higher degree of probability, he combined the items into a “severity score” for the entire duration of the hospitalization utilizing the values good, intermediate, or bad. Here, a statistically relevant difference was perceived in favor of the prayer group, which overall did better than the control group (Byrd 1988, 828). However, a factor that statistically did not differ between the two groups was the duration of hospitalization.

While there were some who praised Dr. Byrd’s study, their number was balanced by those who found various inconsistencies. For instance, there are authors who quali-

fy the experiment as allegedly showing: “that intercessory prayer is very effective in the healing process” (Maier-Lorentz 2004, 26). However, in the original article, Dr. Byrd’s own conclusion seems moderate, even tentative: “Based on these data there seemed to be an effect, and that effect was presumed to be beneficial” (*italics mine*).

A purposeful replication of Byrd’s experiment was done by Harris and colleagues several years later, using a larger sample (n=990) of patients admitted to the coronary care unit of a private hospital. One significant difference from Byrd’s experiment was that in this case, both patients and doctors were unaware of the study taking place, and informed consent was neither requested nor obtained from the patients. The intercessors were again taken from various Christian traditions (nondenominational, Episcopalian, Protestant groups, and Roman Catholics). In order to qualify, they were asked to agree with statements claiming faith in a personal God that is receptive to prayers. They were asked to pray for four weeks for the patients, about whom they knew only the first name and nothing else (Byrd’s intercessors were given updated information on the state of health of the subjects) (Harris et al. 1999, 2273-4). Although the Byrd’s severity score was proved to be statistically irrelevant for this study, another measure was designed to sum up the different variables of patients’ treatment in the hospital, the MAHI-CCU score (Mid America Heart Institute Coronary Care Unit). The results of this newly designed score showed a statistically relevant difference between the patients in the prayer group and those from the control group, in favor of the former. Similarly to Byrd’s results, the duration of hospitalization in CCU was not affected by the fact that the patient belonged to one or the other group.

If the two studies previously discussed are somehow fitting the profile of medical experiments, the third one provoked even more controversies. In 2000, Leibovici conducted a double blind, parallel group, randomized, controlled trial of a retroactive intervention in a university hospital. The subjects were 3393 patients who were diagnosed with bloodstream infection during 1990-1996. They were randomly assigned to two groups, one for whom prayers were made (prayers for the group, not for individuals) and a control group. The outcomes of their hospitalization were than compared, with significant differences found with respect to mortality rate, length of stay and days of fever, the general conclusion being that: “Remote, retroactive intercessory prayer can improve outcomes in patients with a bloodstream infection” (Leibovici 2001, 1451). The most controversial aspect of the experiment undoubtedly concerns the premise that a procedure may retroactively influence the status of patient. Here, the author’s explanations are at least provocative: “As we cannot assume a priori that time is linear, as we perceive it, or that God is limited by a linear time, as we are, the intervention was carried out 4-10 years after the patients’ infection and hospitalization” (Leibovici 2001, 1450).⁴

This experiment can be associated with a whole range of controversial experiments that attempt to investigate the effects of prayer and other forms of spiritual intervention on animals, plants, human tissues, fungi, yeast, bacteria, and cells (Lawlis 2001, 481-6; Dossey 2001). The reactions to these studies were highly divided, the more recent ones attracting numerous vivid replies from the medical and scientific community (the study of Harris et al. was followed by fifteen letters to the editors in the next volume of the journal that originally published it, while the online edition of Leibovici’ study received no less than 86 rapid responses, most of them ranging from outrage to mockery).

Quantifying the Unquantifiable? Methodological Flaws and Religious Concerns

There are several methodological problems that are criticized by authors reporting on them, and that are to some extent assumed by the authors of the studies investigated. The first issue concerns the necessity of ensuring two pure parallel groups for design purposes. Even if one uses a computer to randomly assign the patients into two similar groups, it is not possible to prevent additional prayer, either by the patients themselves or by those closely related to them. Therefore, no “pure” control groups can ever be obtained, simply because their special situation makes them even more suggestible to prayers (Cohen et al. 2000, 41).⁵ This factor was thought to be very annoying by all critics, some of whom even disqualified the whole enterprise by comparing it to something as trivial as “a hypothetical study allegedly demonstrating the beneficial effects of reading periodicals on the course of CCU patients” (Posner 1990) or even concluding that “there can be no such thing as a controlled experiment concerning prayer” (Avalos 1997).

Another problem concerns the methodological impossibility of directing prayers solely to the prayer group, when, for instance, patients’ first names (which are revealed to the intercessors) may be shared by patients in the control group, who might unintentionally benefit from the prayers. Likewise, it is difficult to probe the quantity and the seriousness of the prayers, since the only people who can testify about the prayers are the intercessors themselves. Moreover, if we are to scientifically measure the effects of the prayers, then the prayers themselves should be uniform – which on the one hand would be impossible to prove, and, even if it would be possible, on the other hand it would discriminate against those who prefer other types of prayer or whose religion does not involve prayers (Cohen et al. 2000, 41-42).

In addition, some authors claim that the factors that were reported as showing an improvement in the condition of the prayer group are not independent, and thus are not reliable. For instance, two indicators that were statistically significant in Byrd’s study – the incidence of pneumonia and the prescription of antibiotics, are closely connected in practice, and cannot be said to be independent (Sloan and Bagiella 2002, 16). Moreover, the probability factor of these experiments, and of experiments testing the efficacy of prayer in general, has been found to be inconclusive by several scientists (Cohen et al. 2000, 42; Sloan and Bagiella 2002, 16; Stenger 2001).

Finally, for each study testifying to the efficacy of prayer, a counter-study can be found that shows inefficacy or even negative effects of prayer. The literature review of Astin and colleagues found that nine out of twenty three controlled trials of distant healing showed no effect (compared to thirteen similar studies that found a positive result and one study that showed negative results) (Astin, Harkness and Ernst 2000: 908). However, the number of documented studies is still low and they are too dissimilar to allow for a meaningful comparison. For example, the number of subjects can range anywhere from a few dozens to a few hundreds, and the effects of prayer are tested for medical conditions as diverse as smoking dependence and severe leukemia (Hodge 2007, 177-180).

Among the aspects that were subject to strong criticism were the religious consequences. Many of those who devaluated prayer experiments has tried to show that these studies imply a very negative relation not only to prayer, but also to God. Although usually the authors designing the experiments carefully distinguished between God and

prayers that are addressed to God, proposing for their tests only the effects of prayer (regardless of theological difficulties concerning God's status),⁶ all the articles do involve at least some presuppositions about the character of a God that answers health-related prayers.⁷ However, there is a long way between these presupposition and such ironic statements as: "a scientific study... indicates that God exists, and that he had interceded in the recovery of a group of coronary care unit patients!" (Posner, 1990).

Scientists and religious people alike have shown reluctance in putting prayer to scientific tests, such as these double-blind, parallel group, random trials. One reason for this uneasiness is that they, in contrast to some authors' declarations, felt that not only prayer is being subjected to tests, but God himself is, and many assumptions involving the issue of prayer involve something unacceptable concerning God. For instance: "In prayer, God is petitioned, not controlled; God is trusted, not tested." Therefore, the profoundly religious gesture of a believer praying to the personal God cannot be reduced to a merely "mechanical exchange of supplications for goods and services" (Cohen et al. 2000, 43).

Similarly, if the result of the test was judged positive, i.e., testifying to the beneficial effects of prayer, than the critics observed it is unacceptable to think that God could be impressed by the sheer number of those who prayed and would answer only those prayers. If the results were negative, what would this say about God? Could he be unable to help those in suffering? In any case, quantifying the unquantifiable (e.g. the "quantity" of prayers for the prayer group vs. the nonexistence of such quantity in the case of control group) seems to lead to paradoxical formulations and problems (Posner 1990; Avalos 1997).

Religious people even noted that the issue of prayer to a personal God in the Judeo-Christian tradition fails to be addressed by such an experiment. Thus, a true believer never addresses petitionary prayers, not even intercessory ones, or even if s/he does, s/he by no means obligates God to answer them. God's answer arises from a magnitude of love, but is by no means determined by the prayer. And, consequently, answered prayer does not test its inner efficacy, but rather testifies to the omnipotence of God, who is above all prayers. As one author puts it, we cannot know whether a prayer has been answered by an infinite God, because we don't have the means to prove the existence of such an infinite being; especially in the Judeo-Christian tradition, and in theistic traditions in general, the possibility of scientifically testing prayer is severely undermined (Cohen et al. 2000, 42; Avalos 1997).

No Adverse Effects? Ethically Related Questions and Worries

Using intercessory prayer therapy as a medical remedy raises ethical questions about the very method itself. Apparently, there is a paradoxical situation: one needs to rely on scientific tests that can be replicated and can guarantee results, but the scientific experiments in which prayer therapy was tested are questioned particularly for their "unscientific" methodological flaws. Alternatively, one may indeed attempt to prove that prayer is beyond such ordinary human ways of proving efficacy, and that it cannot be subjected to tests, but then, how can one use it in clinical situations, if its efficacy cannot be compared with that of more traditional medicine?

One way of questioning the ethics of testing prayer as if it would be a scientific phenomenon that can be tested and replicated in a laboratory is to dispute the scientific-looking settling as a whole. The major factor that enables the connection with scien-

tific experiments is the design as a double-blind, parallel group, random controlled trial. It is necessary to include a control group for whom the alleged health-improving factor (prayer) is not provided.

On the other hand, for those who are really convinced by the healing power of prayer, there is the ethical question of refusing people what can be considered a form of treatment: "I realized that if prayer worked, withholding it might be the equivalent of denying my patients a valuable medication or surgical procedure... there are powerful personal, professional, and ethical repercussions for any physician who takes seriously the evidence supporting the effects of spiritual meaning in health" (Dossey 2000).

Therefore, these authors even conclude that prayers' effects can only be legitimately tested only on animals, plants, and other living creatures such as bacteria or fungi. However, this results in prayer being simultaneously offered and refused what is needed for accepting it into the clinical environment: namely, it is offered a scientific ground through experiments on lower life forms, but it is refused precisely what would legitimize its use, experiments on humans.

Among the ethical (negative) concerns, the most serious one targets the issue of informed consent, which many of the studies on intercessory prayer do not respect, and which is consequently regarded as "immoral experimentation on human subjects" (Turner 2006, 487). Concerning the studies we have already mentioned, the opinions of their designers were split. If, on the one hand, in Byrd's experiment consent was requested and obtained on behalf of the 393 participants (Byrd 1988, 826), in the study of Harris and colleagues, consent was not requested, and the authors even declared that they were granted an exemption from the rule of consent by the hosting institutions. The main reason invoked in support of this apparent rule violation was the concern that, if consent were to be sought and obtained, the patients willing to participate in the study would form a special group of people that were "prayer receptive" (Harris et. al 1999, 2275). That would have biased the study. Moreover, the study of Leibovici was designed in a way that made the issue of informed consent irrelevant. Indeed, how could one possibly request consent for allegedly improving the treatment of the patients ten years after the disease had passed?

However, Turner presents several arguments to show the importance of obtaining informed consent on behalf of the patients involved in the studies. Firstly, the fact that in Byrd's study 12.7% of patients declined to participate indicates that there is a potential number of people who, for various reasons, refuse to take part in such an experiment. Secondly, the very religious nature of prayer made it a delicate subject both for non-religious people, who might encounter difficulties in accepting prayer as a possible solution for their condition, and for people with a religion other than that of the intercessors. (Turner 2006, 488). Finally, the issue of possible side-effects of a "drug" that has not been officially tested (such as prayer) cannot be neglected. Turner even describes this attitude saying: "[it] is morally objectionable to doctors to subject patients to additional health risks" (ibid.).

If we are to comment on Turner's objections, he does bring some valuable issues to the discussion. The issue of informed consent is of crucial importance in medical ethics. Although specialists agree that there are cases in which the request of informed consent may be waived, in understandable cases such as those of children, persons with disabilities, unconscious persons, or persons requesting emergency treatment (O'Neill 2003, 47), testing for prayer efficacy does not seem to meet the criteria. Thus, the existence of people who actually refuse to participate in prayer-testing experiments shows

that, in the case of studies deliberately not asking for informed consent, there may be people whose wills are negated.

Secondly, the question of incompatibilities among the religious (and in some cases a-religious) views of patients and intercessors may open the question about the religious freedom of those patients, whose rights may appear to be violated. Although advocates of the efficacy of prayer regardless and even despite the religious convictions of patients and intercessors praise the effects of Buddhists' prayers for Fundamentalist Christians (Dossey 2002, 21), there may be people whose religious convictions would be deeply affected, should they even consider the possibility of non-canonical prayers on their behalf. Especially having in mind the special situation of ill people, the burden of having to cope with somebody else's (possibly conflictual) religion and convictions may have additional detrimental effects. This is related to the issue of how to address the spiritual needs of patients without asking embarrassing questions about one's religious affiliation and most intimate beliefs – especially in a state-supported, secular institution such as a medical clinic.

Thirdly, the issue of possible negative effects of prayer has been openly admitted even by the most open supporters of prayer.⁸ Thus, Larry Dossey, an advocate of prayers and its results, the author of more than half a dozen books on related topics, states in a magazine article that the power of negative prayers has been proven not only through experiments on lower organisms, because of ethical issues involved in applying them to humans, but also through apparently well-intentioned, positive requests: "If all the prayers for prosperity were answered, the environment would probably not be able to survive the impact" (Dossey 1997, 52).⁹ Coming back to medical ethics, the two medical principles of beneficence and non-maleficence need to be carefully weighted and balanced in order not to endanger the patient's health. This is true especially for suggestionable people.

What is interesting when talking about the possible harmful effects of prayer is that the issue is usually brought into discussion by the very people who oppose prayer therapy or are reluctant to admit any benefit of it. Although they raise serious doubts on the positive effects of praying, by questioning the relevance of the experiments and their possibility of replication, they tend to admit without much ado the probability of harming effects, and even dismiss entirely the "positive experiments" due to implausible adverse consequences. Yet, the negative effects of prayer for humans are even more difficult to document, as so far such experiments have been done only on animals or lower life forms.

Another line of argumentation is the objection that truly religious people who agree to pray for the patients in an experiment should attempt to subvert the experiment and pray for the patients in the control group as well (Turner 2006, 489). Actually, this objection is related to the methodological ones that question the possibility of establishing a pure "control group" for whom no prayers are said. However, the subtlety in this argument is to exploit an inner dimension of the religious feeling that grounds any type of prayer: compassion. Thus, really compassionate people who accept to intermeditate between ill patients and God must be horrified not to offer the same gesture for people that have been randomly assigned not to be the part of the prayer group.

Finally, there is a series of objections raised by those who claim that, even if prayer's therapeutic virtues can be somehow accepted, doctors are not the best qualified people to apply them, and consequently should keep themselves separate from these therapies. Either by saying that prayer is a complex phenomenon that cannot be mas-

tered by physicians (Lawrence 2002, 76) or by simply stating the physical impossibility of doctors utilizing the precious time dedicated for patients for practicing uncertain therapies such as prayer (Lawrence 2002, 74), the conclusion is that doctors should do what they were trained to do – i.e. treating the patients – and not engage themselves in time-consuming, poorly-managed techniques such as prayer.

The basic argument is that the medical professional ethics imposes several constraints upon the doctors that do not allow them to engage in spiritual activities such as praying at the bedside of patients (Cohen et al. 2000, 41). Although doctors should show respect for a patient's own religion, provided that it does not interfere with the medical act (such as in the case that a specific religious tradition impedes a patient from passing through a particular medical intervention), this “does not require that doctors and nurses substitute for chaplains and ministers” (Cohen et al. 2000, 45).

At the same time, the opposite idea is also advanced by proponents of prayer therapy, who claim that praying for/with the sick person should become a routine for doctors and nurses. Thus, there are doctors who openly admit to praying for their patients as part of their daily schedule (Dossey, 2000, 11-14) or who are at least willing to recognize that there are alternative ways in which patients may be healed: “just because you, as a physician, may not understand how a treatment works, never argue with a patient who has discovered an effective healing path” (Edelberg 1996, 6-7). As stated at the beginning of this section, these doctors even claim that it is unethical for qualified professionals not to use this valuable therapy, whose adverse effects are so far little, if at all, documented. In his provocative article, Leibovici even reinforces this argument with a financial one, by saying that prayer therapy is very cheap and that it should be used, even retroactively (Leibovici 2001, 1451).

One additional way in which prayer therapy could be understood from the ethical perspective is through the private/public debate. Indeed, through attempting to offer a scientific foundation for prayer, and consequently through including it in medically accepted procedures, one is attempting to take out a previously private practice (that was and is widely used by patients and their families) and introduce it into the public realm. Although the discussions concerning prayer therapy have not been framed so far in the terms of the private/public debate, the whole controversy reaches a new dimension when looked at from this angle.

This is true especially when one is familiar with the debates over the private and the public in the US context, especially those involving the civil rights' movements of the 1960s and onwards and the women's movements of the same period. In these cases, a similar endeavor was at stake, namely that of bringing into the public field issues previously constrained to the private realm, such as domestic violence, discrimination in employment and education, and so on.¹⁰ Constant struggles were needed on behalf of those involved in the civil rights movements and in women's movements in order to transfer previously “private” issue to the public agenda, because in this way “the public” was called to action to solve these problems. The difficulty of transforming these issues into public concerns is telling about the difficulties proponents of prayer therapy have to face when attempting to legitimize it through scientific experiments.

Similarly, although on a different scale, by attempting to “publicize” the so far “private” experience of praying, proponents of prayer therapy are (more or less voluntarily) raising questions about how to treat a practice that may be put on an equal footage with other respectable medical practices. Should prayer become a routine inside the clinical environment, like the morning report? Or perhaps it should be confined to a separate

zone, where intercessors could silently (or loudly, depending on their “technique”) pray for patients? Should patients be asked to be assigned to prayers and should they be allowed to withdraw – perhaps by displaying a “Do not pray for” sign similar to “Do not resuscitate”? Should intercessors in some way be rewarded for their “job” – if they are providing a service similar to intubating a person? These and other related questions remain to be resolved by anyone who envisage such a thing as transforming prayer into a publicly, possibly insurance-covered medical procedure.

Conclusions

Although widely used by those in suffering and their relatives (or perhaps because of this), prayer is still far from being generally accepted in the array of medical techniques and procedures. The scientifically-designed experiments through which the efficacy of prayer can be measured have provoked wide discussion and have raised questions about their methodological accuracy and about their religious implications. However, the ethical concerns surrounding this debate are especially intriguing, and are worth discussing at large. New insights on this matter are offered if one looks at it through the lens of the public/private debate.

Nevertheless, if proponents of prayer therapy wish to see their practice accepted by the medical profession, they must be willing to frame it in the scientific language of efficacy, probability, and disease-curing. This means more evidence is needed in the form of scientific tests and experiments that will perhaps become more accurate in methodological terms. However, if the perspective of the public/private debate is to be accounted for, then it will take more than a few additional experiments to legitimize prayer therapy so as to introduce it into the clinical environment.

References:

- Astin, John A. 2000. The Efficacy of “Distant Healing”: A Systematic Review of Randomized Trials. *Annals of Internal Medicine*, 132: 903-910.
- Avalos, Hector. 1997. Can Science Prove that Prayer Works? *Free Inquiry*, 17 (3). On-line available at: http://secularhumanism.org/library/fi/avalos_17_3.html Last accessed on July 30th, 2007.
- Baker, Robert A. A Skeptic’s Notebook. If Looks Could Kill and Words Could Heal (There’d be a lot more dead and a lot fewer sick people around). *Skeptical Briefs Newsletter*. September 1994. Online available at: <http://www.csicop.org/sb/9409/skept.html>. Last accessed on July 30th, 2007.
- Bowman, Kerry. 2004. What are the limits of bioethics in a culturally pluralistic society? *Journal of Law, Medicine and Ethics* 32 (4): 664-669.
- Byrd, Randolph C. 1988. Positive Therapeutic Effects of Intercessory Prayer in a Coronary Care Unit Population. *Southern Medical Journal* 81 (7): 826-829.
- Champion, Françoise. 1996. “Spirit religios difuz, eclecticism si sincretism” in Jean Delumeau (ed), *Religiile lumii*. Bucuresti: Humanitas.
- Cohen, Cynthia B., Sondr E. Wheeler, David A. Scott, Barbara Springer Edwards, Patricia Lusk, and the Anglican Working Group in Bioethics. 2000. Prayer as Therapy. A Challenge to Both Religious Belief and Professional Ethics. *Hastings Center Report*, May-June 2000: 40-47.

- Dalmida, Safiya George. 2006. Spirituality, mental health, physical health, and health-related quality of life among women with HIV/AIDS: integrating spirituality into mental health care. *Issues in Mental Health Nursing*. 27: 185-198.
- Dossey, Larry. 1997. "Can Prayer Harm?" *Psychology Today*. March-April: 49-52, 75-77.
- Dossey, Larry. 2000. "An Interview with Larry Dossey", *Tikkun*, March/April 2000, 15 (2): 11-14.
- Dossey, Larry. 2001. "Nonlocal mind: The seminal experiments of Bernard Grad." *Advances in Mind-Body Medicine* 17 (1): 8-20.
- Dossey, Larry. 2002. "Measuring the Power of Prayer", *Whole Earth*, Spring 2002, 20-21.
- Edelberg, David. 1996. "Commentary: Into the heart of healing", *Making the Rounds in Health, Faith & Ethics*, 5/20/96, 1 (18): 6-7.
- Elshtain, Jean Bethke. 1993. *Public Man, Private Woman. Women in Social and Political Thought*. Princeton, New Jersey: Princeton University Press.
- Gundersen, Linda. 2000. "Faith and Healing", *Annals of Internal Medicine*, 132 (2): 169-172.
- Harris, William S., Manohar Gowda, Jerry W. Kolb, Christopher P. Strychacz, James L. Vacek, Philip G. Jones, Alan Forker, James H. O'Keefe, Ben D. McCallister. 1999. A Randomized, Controlled Trial of the Effects of Remote, Intercessory Prayer on Outcomes in Patients Admitted to the Coronary Care Unit. *Archives of Internal Medicine*, 159: 2273-2278.
- Hodge, David R. 2007. A Systematic Review of the Empirical Literature on Intercessory Prayer. *Research on Social Work* 17: 174-187.
- Kaiser, Leland R. 2000. Spirituality and the Physician Executive. *The Physician Executive*, 26: 6-13.
- Lawlis, G. Frank. 2001. "Spiritual Medicine" in *Mosby's Complementary Alternative Medicine: A Research-Based Approach*, ed. Lyn W. Freeman, 473-492. St. Louis, MO: Mosby.
- Lawrence, Raymond J. 2002. "The Witches' Brew of Spirituality and Medicine" *Annals of Behavioral Medicine* 24 (1): 74-76.
- Leibovici, Leonard. 2001. Effects of remote, retroactive intercessory prayer on outcomes in patients with bloodstream infection: randomized controlled trial. *British Medical Journal* 323: 1450-1451.
- Lloyd, Genevieve. 1984. *The Man of Reason. "Male" and "Female" in Western Philosophy*, London: Methuen.
- Long, Ann. 1997. Nursing - a spiritual perspective. *Nursing Ethics* 4 (6): 496-510.
- Maier-Lorentz, Madeline M. 2004. The Importance of Prayer for Mind/Body Healing. *Nursing Forum* 39 (3): 23-32.
- Makowski, Suzana K. E. 2004. Assessing local market and organizational readiness for the integration of complementary and alternative medicine into ambulatory care centers. *Journal of Ambulatory Care Management* 24 (1): 4-11.
- Mills, Paul J. 2002. Spirituality, Religiousness, and Health: From Research to Clinical Practice. *Annals of Behavioral Medicine* 24 (1): 1-2.
- Moberg, David O. 2002. Assessing and Measuring Spirituality: Confronting Dilemmas of Universal and Particular Evaluative Criteria. *Journal of Adult Development*. 9 (1): 47-60.
- O'Neill, Onora. 2003. "Some limits of informed consent" *Journal of Medical*

Ethics 29: 4-7.

Okin, Susan Moller (1989). *Justice, Gender, and the Family*. New York: Basic Books.

Partridge, Christopher. 2005. *The Re-Enchantment of the West. Volume 2. Alternative Spiritualities, Sacralization, Popular Culture and Occulture*. London: T&T Clark International.

Posner, Gary P. 1990. God in the CCU? A critique of the San Francisco hospital study on intercessory prayer and healing. *Free Inquiry*, Spring 1990. On-line available at http://www.infidels.org/library/modern/gary_posner/godccu.html Last accessed on July 30th, 2007.

Roberts TB. 1999. "Do entheogen-induced mystical experiences boost the immune system? Psychedelics, peak experiences, and wellness". *Advances in Mind-Body Medicine*. Spring; 15 (2): 139-147.

Sloan, Richard P. Emilia Bagiella. 2002. Claims About Religious Involvement and Health Outcomes. *Annals of Behavioral Medicine* 24 (1): 14-21.

Stenger, Victor J. 2001. Reality Check. *The Science of Prayer. Skeptical Briefs Newsletter*. December 2001, vol. 11, No. 4. Online available at: <http://www.csicop.org/sb/2001-12/reality-check.html>. Last accessed on July 30th, 2007.

Stuckey Jon C.; Stephen G. Post, Sally Ollerton, Stephanie J. Fallcreek, Peter J. Whitehouse. 2002. "Alzheimer's Disease, Religion, and the Ethics of Respect for Spirituality. A Community Dialogue". *Alzheimer's Care Quarterly* 3(3): 199-207.

Turner, Derek D. 2006. Just another drug? A philosophical assessment of randomized controlled studies on intercessory prayer. *Journal of Medical Ethics* 32: 487-490.

Thorensen, Carl E. and Alex H. S. Harris. 2002. Spirituality and Health: What's the Evidence and What's Needed? *Annals of Behavioral Medicine* 24 (1): 3-13.

Weeks, John. 2001. Foreword to *Mosby's Complementary Alternative Medicine: A Research-Based Approach*, ed. Lyn W. Freeman, IX-X. St. Louis, MO: Mosby.

Notes:

1 "Holistic medicine, although not a specialty recognized by the American Medical Association, is more of a philosophical approach than a specific therapy. Holistic medicine addresses issues of mind, body, and spirit as a seamless whole when determining how a disease came about and where the best chances for healing lie" (Edelberg 1996, 6-7).

2 "Western medicine came to its dominant position at the turn of the twentieth century in part as a by-product of society's virtually unquestioning faith in scientific positivism" (Bowman 2004, 664).

3 For instance: "Religion is a particular doctrinal framework that guides sacred beliefs and practices in ways that are sanctioned by a broader community of faith... Spirituality refers to beliefs and practices that connect persons with sacred and meaningful entities and emotions" (Stuckey et al. 2002, 200).

4 In the "rapid responses" that the BMJ website received for this article, roughly a quarter of them joked about design of such a study, and suggested to the author to "pray for the other half of the patients" as well, to see if the results of the study would change.

5 This methodological problem was assumed by all the authors of the studies

investigated, perhaps most clearly by Byrd 1988, 829.

6 “For example, we have not proven that God answers prayer or that God even exists. It was intercessory prayer, not the existence of God, that was tested here” (Harris et al. 2277)

7 For instance, Leibovici’s study assumes that God’s intervention is not limited in time, as we are; intercessors in the study of Harris et al. were asked to state their belief in a personal God; while both Byrd’s and Harris’ studies are open to metaphysical questions about the role of God-directed prayer in times of sickness.

8 However, in his classic study, Byrd’s patients apparently ruled out the possibility of adverse effects. Thus, when asked about their consent, the majority of them seemed to agree that, if no positive results would have been obtained, surely a prayer could not be harmful for anybody.

9 A comic version of what unpleasant things would happen, if all prayers would be answered is shown in the popular movie Bruce Almighty.

10 For theories about the public/private dichotomy, especially in the case of women’s and feminist movements, see for instance Ehlstein 1993; Lloyd 1984, 77-78; Okin 1989, 23.