Letter to the Editor

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Dear Editor,

I read with great interest the Winter 2002 issue of *Annals of Behavioral Medicine*. The article by Larimore and colleagues, however, is misleading and presents an unbalanced view of the data regarding spirituality/religion and medicine (1).

The authors repeatedly stated that "most patients desire to be offered basic spiritual care by their clinicians" (p. 69). To the extent that spiritual care is provided when physicians demonstrate compassion and understanding toward patients (2,3), the evidence is clear. Patients want empathic physicians. However, the authors further claimed that "patients want their physician to address religious and spiritual issues in the context of a clinical visit" (p. 70). The evidence for this statement is less conclusive. The authors cited Matthews et al. (4), who in turn referenced King and Bushwick (5) and Maugans and Wadland (6). These two articles report the results of nonrandom surveys of roughly 200 adult inpatients and 150 adult outpatients, respectively. As such they are of limited generalizability and are insufficient evidence to support Larimore and colleagues' claim. In addition, a more recent study reported that although a majority of community-dwelling adults would want to speak to someone about spiritual concerns if seriously ill, only 3% would choose to speak to a physician (7).

Larimore et al. also stated that "between 46 and 78% of patients indicate that they would like their physician to pray with them" (p. 71). Putting aside the limited generalizability of the studies from which these figures were drawn, what are physicians to make of the other 22% to 54% of patients? Might the patient–physician relationship not be harmed if physicians approach prayer with patients who do not request it? Preliminary evidence suggests that it may (8).

Larimore and colleagues (1) stated that "the vast majority of the cross-sectional and prospective cohort studies have shown that religious beliefs and practices are consistently associated with better mental and physical health outcomes" (p. 70). Many of these studies, however, have methodological flaws that limit the conclusions one can draw from them (9,10). Finally, the authors made the statement that "claims of possible negative effects of religion on health … are highly speculative and have no basis in population-based systematic reviews" (p. 70). On the contrary, studies have shown that aspects of religion may be associated with negative health outcomes (11,12).

The role of spirituality and religion in health and medicine is complex and deserving of further study. In light of this, the conclusions Larimore and colleagues draw from their article should viewed with some skepticism.

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