



HEALING PRAYERS THAT WORK

IF YOU PERCEIVE YOU'RE BEING PRAYED FOR AND YOU
ARE BEING PRAYED FOR, YOU'LL LIKELY FEEL BETTER.

By ALLAN J. HAMILTON, M.D. / *Photography by* DANA EDMUNDS

IN MARCH 2006, THE LARGEST CLINICAL RESEARCH STUDY EVER CONDUCTED on the effects of prayer on medical outcomes was completed. Known as STEP (Study of the Therapeutic Effects of Intercessory Prayer), it included 1,800 patients undergoing coronary artery bypass graft surgery at five major medical centers. STEP was, by scientific criteria, a well-designed study: A double-blind, randomized trial evaluating prayer on behalf of another. The prayer was carried out at a distance — not in the patients' presence, or with their knowledge. The results of the STEP study: prayer made absolutely no difference to the outcomes.





OME PEOPLE APPLAUDED STEP'S conclusion because they hoped it would undermine what Dr. Arthur P. Sloan labeled "the unholy alliance of medicine and religion." Others, invested in seeing a connection between health and religious faith upheld, were dismayed. They worried that federal funds slated for alternative medicine, particularly prayer-related research, would diminish. Hospitals at one time bragged about their participation in spiritually oriented research protocols. Now their management discouraged further enrollment, insisting the jury was in and the verdict returned: prayer simply did not work. Still others wanted the tiresome debate to end.

But what if STEP was wrong? What if it had focused on the wrong measures or used inadequate methodology? Finally, what if the STEP results were irrelevant to the deeper issues surrounding prayer?

There are two fundamental questions facing any clinician evaluating the effects of prayer. First, who's praying? Second, what does the patient receiving the prayers believe? To illustrate these two concerns, let me tell you about one remarkable example that I personally witnessed of the effects of prayer. I was in the emergency room of my own hospital, seeing a trauma patient, when a colleague of mine was rolled into the next room. Hank (not his real name) had rushed to the ER because he felt his heart thumping erratically. He had taken his pulse and knew it was in a dangerous rhythm, so he drove himself to the ER.

Over the next hour, doctors tried a variety of pharmacological interventions, but nothing seemed able to slow down Hank's heart rhythm.

As I walked by, an ER physician was talking to him: "Look, no one wants to do this, but we're going to have to cardiovert your heart. We've got no choice."

Hank turned ashen. "You mean you're going to shock me?"

"Yep. There simply are no other options left."

"Well, could you just give me a minute to collect myself?"

The doctor looked up inquisitively. Hank folded both of his hands protectively over his heart. "I just want a moment to pray, if you don't mind. That's all," he added, almost apologetically. The doctor nodded and left the room.

Cardioversion is something you would not wish on your worst enemy. It's a blend of near-death experience by electrocution mixed in equal part with being kicked by a mule. And then there's the small but significant fraction of hearts that freeze up and stop beating entirely. I was not at all surprised that Hank wanted a moment to pray.

He had tears in his eyes and held hands with his companion in the room. They bowed their heads together. Hank spoke aloud. The prayer was surprisingly simple. "Lord, I ask you to lend me strength and courage for whatever lies ahead. Please watch over my family. And me, too. I ask you, Lord, to stand by my side because I am frightened." When he finished, he raised his head and pronounced, "Thy will be done. Amen."

As if a light switch had suddenly clicked on, the cardiac rhythm on the monitor overhead slowed, and Hank's heart jumped back to normal. Steady as a metronome.

"Is that NSR?" Hank suddenly turned and asked me, as I stood stupefied in the doorway. Normal sinus rhythm (NSR) is the heart's normal, healthy rhythm.

"It sure looks like it." I stepped up to take a closer look at the monitor. "Yes. You're back in NSR."

Hank closed his eyes, as much in gratitude as relief.

About five minutes went by. Hank's heart rhythm remained steady. The ER physician came around the corner, pushing the defibrillator cart. He stopped in the doorway and looked at the monitor. Then he ran a long strip of EKG paper to take another look.

"Well, now. How long have you been in sinus rhythm?" he asked Hank.

"Since I finished praying, I guess."

Hank had to wait for five more hours in the ER before they were convinced that his heart would not sink back into its wild supraventricular tachycardia. It never did. Eventually he was allowed to go home. He has had no further cardiac problems for two years now and remains completely off any heart medications.

Hank's case dramatically demonstrates that prayer can work in susceptible, believing individuals at a time when they feel a need to connect to a power greater than themselves.

But perhaps more important is what Hank's case does not mean: this case does not mean that every patient who comes into the hospital with SVT arrhythmias should be immediately diverted to chapel to pray. Nor does it imply that a study of the

10 STEPS TO HARNESS YOUR ENERGIES DURING ILLNESS

- 1 / Know that spirituality requires no defense or explanation.
- 2 / Take responsibility for collecting positive, and avoiding negative, energies around yourself.
- 3 / Choose or create your own special prayers and rituals.
- 4 / Be open to seeing a health crisis as an opportunity for personal transformation.
- 5 / Ask your doctors to pray with you.
- 6 / Remember that hospital chaplains, priests, ministers, rabbis, and other clergy are an invaluable resource.
- 7 / Enjoy connections to Nature.
- 8 / Know that prayer helps those who support you.
- 9 / Gather your own talismans, photos, and mementos and bring them into the hospital to inspire you.
- 10 / Create your personal soundtrack; get well listening to your favorite music.

*“Lord, I ask you to lend me strength and courage
for whatever lies ahead. Please watch over my family.
And me, too. I ask you, Lord, to stand by my side because
I am frightened.”*



effects of prayer on arrhythmias should be undertaken.

I attended a symposium on spiritually oriented research projects. After hearing Hank’s remarkable story, someone suggested that a study be undertaken to determine if prayer could produce significant cost savings by eliminating cardioversion. In other words, could prayer be shown to save third-party payers the added expense of cardioversion?

I was dumbfounded. I wondered what would happen if prayer were reduced to something as mundane as reimbursement. Of course, many attendees at the conference objected. It seemed ridiculous to equate prayer — a request to be connected with the unseen powers of the Universe or God — with a demonstrable reduction in healthcare costs. Many argued that even if Hank still had to proceed with cardioversion, prayer was effective if it just made him feel better and not a penny was saved.

THE FEELING OF PRAYER

Recently, I participated as an investigator in a federal study at the University of Arizona evaluating the impact of nondominational healing prayers from a distance on patients undergoing open-heart surgery. As was done in the STEP study (the results

of which have not yet been published), our team collected data on well-defined complications following cardiac surgery. And, as in STEP, we found no difference in the complication rate between patients who received prayer and those who did not.

Almost as an afterthought, we had added a small questionnaire to the end of the study. In it, subjects were asked to report their sense of well-being and describe their capacity to perform the routine activities of daily living after their surgical recovery. We queried the subjects in both prayed-for and non-prayed-for groups as to whether they felt they had been the recipients of prayer. In this last analysis, some important differences emerged: The group of patients who felt as if they had received prayers (and, in fact, really had) was the only single cohort of subjects to show higher scores in their subjective reports of well-being, healthfulness, and ability to carry out daily activities. In short, the cohort of subjects that perceived they had been prayed for and actually were prayed for was the only one that felt demonstrably better than the others. I would emphasize *feeling* better, but not being better.

Critics might argue that it is unimportant if patients feel better after an operative procedure. As a surgeon, I would disagree. Surgery has clear goals. First, the procedure must address a specific, real medical problem. But, second, surgery should aim to make the patient feel better. Subjective reports of well-being may represent a valid component of surgical outcome. Our project was on a smaller scale than the STEP study, but it raised a fundamental issue: it may not only matter that prayer gets transmitted out into the ether (so to speak); it may be just as important which patient receives the prayers. Patients may have to feel they are the beneficiaries of prayer before it can work.

WHY NATIVE AMERICANS OPTED OUT

There was a unique twist associated with our study. The state of Arizona has one of the largest populations of Native Americans in the United States. The Navajo, Hopi, Pueblo, Apache, Yaqui, and Tohono O’odham peoples are amongst them. Given the concentration of tribes in the state, it was only natural that we found ourselves recruiting Native American subjects. At the University of Arizona, we have an extensive Native American Cardiology Program and, since all tribal members referred in for cardiac surgery come through this program, we requested permission to speak with the various tribal councils about the research project and recruitment.

Every Native American group we met with eventually gave

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Prayers (continued from page 51)

us the same answer: “Our people have their own prayers and rituals, and we would rather you did not interfere with your prayers and research protocol.” In a nutshell, here were individuals, embedded in some of the most spiritually oriented cultures in the country, and they were telling us we might foul up their own healing energies with our research-related prayers. I wondered if Native Americans might be such finely tuned receivers of healing energies that our own intercessory efforts could inadvertently jam their program of rituals and blessings.

LEARNING FROM VOODOO

I would argue that most research studies on prayer are probably crude in their design. It seems unlikely that something as private, personal, and subjective as our notions of spirituality and religious faith could simply be ignored in the assessment of the potential impact of prayer. It is our faith — our sense of a connection to a power greater than ourselves and beyond the physical world — that

determines our openness to prayer, and, perhaps, our susceptibility to its effects.

Consider for a moment what would happen if the same experimental design used in the STEP study were applied instead to evaluate the effects of voodoo curses on victims. We would enlist a panel of witch doctors far away from the group of victims, who would have no idea whether or not a curse or spell had been cast. Given such a design, we would no doubt find that voodoo produces no significant difference in outcome between the cursed and non-cursed groups. Why? Because we know from anthropological studies that voodoo requires two components: a strong belief in voodoo and knowledge of a curse existing. So the underlying question about STEP and other studies (including my own) arises: why think prayer would work any differently?

Prayer may work independently of objective measures such as the number of infections or arrhythmias after cardiac surgery. In the final analysis, my friend Hank demonstrated the effectiveness of prayer in his own life, in his own way. He did so in a private moment of need for prayer. The significance of his personal, anecdotal episode is neither enhanced

nor diminished if it cannot be statistically corroborated.

All of us who believe in prayer should take heart: the power of spiritual intervention during the course of human illness will not be determined or disproved by one research study — or even a hundred. There is a saying in medicine: an anecdotal experience of one counts more than all the “n” in the literature, meaning that what we personally experience has a more direct result on our beliefs than all the statistics published in our scientific journals. That may sound like scientific heresy coming from a physician, but it is a simple reflection of human nature. If we have a personal belief that prayer matters, that it works in our lives, we will not be dissuaded by mere statistics. This is simply the recognition that not all human experience can be reflected or captured in controlled, double-blind methodology. As Shakespeare wrote in *Hamlet*, “There are more things in heaven and earth, Horatio, than are dreamt of in your philosophy.”

S&H

Allan J. Hamilton, M.D., is a Harvard-trained brain surgeon. He holds professorships at the University of Arizona. See more on page 8.



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