Effects of Christian Prayer in the Hospital Setting

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Christian prayer is defined as a way of communication between an individual and God (Kim-Godwin, 2013). Prayer plays a large role in Christianity because one is able to talk directly to God at any given moment. It is "a human response to serious human questions," confusion, or fears (McMillan & Taylor, 2017, p. 280). Christian prayer in the hospital setting is more like intercessory prayer than individual prayer. Intercessory prayer is where one person prays for another person believing they are interceding and reaching God (Oliver & Dutney, 2012). This results in positive improvements of mental health and spiritual well-being. Intercessory prayer between the clinical staff and patient allows for a bonding experience prior to surgeries or major procedures. Both parties are able to gain peace and trust from the experience of prayer. It has been proven that there are small yet significant gains in spiritual well-being. Prayer is known as one of the most common therapies for patients throughout hospitalization and the healing process. One study has shown that about "9 of 10 Americans believe in prayer" (McMillan & Taylor, 2017, p. 279). It is important that nurses understand the large role spiritual care has on the recovery of a patient (Minton, Isaacson, & Banik, 2016). Christian prayer within hospitals reflects positive or negative results due to the patient's preference versus nursing staff's preference.

During time of crisis or uncertainty, patients are comforted by prayer leading to less anxiety and better mental health. Prayer helps the patient to find meaning and hope when there seems like there is no explanation (McMillan & Taylor, 2017, p. 280). Opportunities for closure and a "sense of closeness to God" are created by prayer (McMillan & Taylor, 2017, p. 281). There is a correlation between prayer and positive mood change in those who are religious (McMillan & Taylor, 2017, p. 281). Often patients will request prayer from nurses or other clinical staff

resulting in various responses. Nurses are taught about the importance of spiritual care for patients and most are willing to respect that. If the nurse was uncomfortable with praying for the patient, often they would provide alternatives such as praying silently or calling the chaplain. A study was conducted to measure and compare the amount of ease versus dis-ease a group of nurses had on various situations of patients requesting prayer. Four questions were asked, and each required a written response from the nurse. Results of die-ease were more prominent in nurses of different ethnicity or religious affiliations (Minton et al, 2016). Prayer comes natural to those of Christian faith (Minton et al, 2016). Three themes found in nurses with ease include the openness to be a calm voice, asking whether the patient prefers silent or spoken prayer, and recommending calling the chaplain (Minton et al, 2016). Characteristics of dis-ease include hesitancy, asking who God is, and only agreeing during extreme circumstances (Minton et al, 2016). More specific responses include asking the patient for specific prayer requests or to simply pray *The Lord's Prayer* (Minton et al, 2016). In other cases, the nurse mentions offering invitations to other team members or family that are present to pray as well. Unfortunately, some nurses responded rather hostile stating that "if I was not in the middle of saving lives" they would consider it (Minton et al, 2016, p. 2190). This type of response represents the lack of emotional patient care while there are more respectful ways to decline. Other nurses alluded to stabilizing the patient and making sure the physical needs are properly managed prior to engaging in prayer. Nurses must learn how to properly respond to prayer requests because just over 50 percent of hospitals provide chaplain services (Minton et al, 2016, p. 2186). Nurse-patient spiritual relationships require participation from both parties and "is one of mutuality" (Minton et al 2016, p. 2187).

Clinician-initiated prayer has more precautions due to ethics. Nurses must take into consideration that not all people are religiously affiliated. Patients are more responsive to a nurse offering prayer if they have previously had brief conversations and if genuine respect and kindness are displayed. The nurse should always ask permission, have a good affinity established, and have a spiritual assessment completed on the patient prior to praying (Kim-Godwin, 2013, p. 214). The clinical staff should pray in a manner that is compatible to their own beliefs as well as the patients. Silent prayer is a good alternative for nurses who want to pray for a patient but do not wish to pray aloud or offend the patient. There is a possibility for the "imbalance of power" to influence the patient's response to prayer even if they are uncomfortable with the idea (McMillan & Taylor, 2017, p. 282). Patients often view the clinician as superior to them and this possibility must be eliminated. Some patients have noticed that nurse-initiated prayer only occurs due to circumstances, such as cancer or other terminal illnesses (McMillan & Taylor, 2017). In one study, massage therapists offered prayer to the patients once the massage was completed. It is important to note that this hospital was a Christian affiliate hospital. A survey was taken based on levels of comfortability the patients experienced. It was found that 78.8 percent of patients would have been comfortable to say no in that situation and 50.7 percent would like someone to pray with them daily during their stay (McMillan & Taylor, 2017). From this study, only 7.8 percent of the patients would have found a different type of prayer, other than the offered generic Christian prayer, more helpful (McMillan & Taylor, 2017). An example of clinician-initiated prayer practiced is Anesthesiologist Christopher O'Connor who offers to pray with his patients before going into surgery. Over time, he noticed that most of his patients "seemed genuinely surprised" by the offer (O'Connor, 2017). He offers the patients a choice to lead the prayer or to have him say it.

With practice, O'Connor has created a non-denominational or more generic prayer that would not conflict with Christian values. This was necessary due to his previous Catholic background and traditional prayers. O'Connor noticed that elderly patients were more accepting of the idea compared to those below the age of thirty who would often accept due to parents or spouse's presence. African American patients were almost always accepted, took initiative, or held hands with those in the room (O'Connor, 2017). O'Connor found that those who prayed had lower pain scores, minimal nausea, and more relaxation after surgery (O'Connor, 2017). Overall, he believes that prayer provides a bonding experience prior to surgery allowing the patients a sense of peace before this significant event.

Various scientific results and reasoning for the positive results of intercessory prayer with patients in the clinical setting have been found. One study goes as far to state that there is "no scientific explanation possible" for the results being seen (McMillian & Taylor, 2017). Prayer is a major coping mechanism for patients it has been proven that patients who pray more often had "significantly less smoking and alcohol use" compared to those who did not pray (Kim-Godwin, 2013, p. 210). There are present signs of decreased anxiety and depression resulting in an overall increased mental health (McMillan & Taylor, 2017). A study of cancer patients was conducted to understand the impact of intercessory prayer on patient's mental health. Intercessory prayer was added to a set routine of treatment for these patients. To determine the participants, questionnaires were used to determine the current mental health condition and whether the patient was religiously affiliated or not. Blinding was used to prevent bias and skewed results; this means that the church members were told to pray for the well-being of the patients (Oliver & Dutney, 2012). The prayer group included church members from a distant suburban church to avoid interference with the patients. The research team did not make rules for

the frequency or nature of the prayers. In the end, there were either positive or no changes in the patient's spiritual well-being. This was tested on a scale holding three psychometrically important elements which were "peace, meaning, and faith" (Oliver & Dutney, 2012, p. 20). The well-being of the patients held a slightly higher score compared to those who chose not to participate. It was found that there were small, but statistically significant results of decreased anxiety and depression resulting in an overall positive improvement in mental health (Oliver & Dutney, 2012). The differences between both groups were not significant although peace was one of the higher differences (Oliver & Dutney, 2012).

Reflective preparation is encouraged throughout their nursing career to allow the nurse to conversate with peers about spiritual care. Many clinicians are told only to pray with the patient if that patient has initiated a prayer request. This leads to the question of society being too sensitive to prayer. It has previously been noticed by a Korean physician that prayer in the United States is discouraged due to "over-emphasizing patient rights" and a focus on "separation of church and state" (Kim-Godwin, 2013, p. 213). Possible opportunities of improvement and stronger clinician-patient bond are prevented from occurring if clinicians are unable to offer prayer. Overall, Christian prayer must be practiced in the hospital setting in an ethical and noncoercive manner towards patients.

References

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