



Sigurd Høye (born 1972), editor of the Journal of the Norwegian Medical Association, researcher at the Centre for Antibiotics in Primary Care, Department of General Practice, University of Oslo, and general practitioner.

Photo: Einar Nilsen

In what ways is a pill similar to a communion host?

Take, eat!

Easter marks the dramatic culmination of the ecclesiastical year and is the celebration of the institution of one of the church's most important sacraments – Holy Communion. In the Norwegian Protestant church, Holy Communion includes the following: The communicants receive a white, circular-shaped and edible object, stamped with a mark that testifies to its origin. The communicant ingests the product *per os*, but the mechanism of its effect is not immediately comprehensible to the user. All drug prescribers in this country are probably nodding their heads in recognition at this point.

Drug use co-varies with national – and religious – affiliation. In traditionally Catholic and Orthodox countries such as France, Italy and Greece, the use of antibiotics is twice that of traditionally Protestant countries such as Norway and Sweden (1). The anthropologist Reginald Deschepper and collaborators have investigated attitudes to and use of antibiotics in two neighbouring towns located on each side of the Belgian-Dutch border (2). In predominantly Catholic Belgium, the participants referred to their respiratory infections as bronchitis and used antibiotics frequently. In the predominantly Protestant Netherlands, similar afflictions were referred to as the common cold, and people were sceptical about antibiotics. The researchers speculate whether this may be due to different religious traditions – in Catholicism, rituals involving physical objects play a prominent role. A pill might be perceived as a secular counterpart of the sacraments, which are the key to salvation. On the Dutch side of the border, the emphasis on self-restraint and frugality that characterises Protestant ethics may explain the greater reticence with regard to the use of drugs (2).

Other researchers have found that in countries with a high proportion of atheists, antibiotics are used less frequently (3). Even though cultural aspects other than confessional affiliation also may explain these differences (4), the example provides an apt illustration of the relationship between religiosity and health-related behaviour.

The healthcare services have assumed many of the roles that previously were filled by the church. Using some imagination, we can see that the healthcare services possess many of the same dimensions as religion (5): the ethical (lead a healthy life, and you will live to be old), the dogmatic (the explanatory models of academic medicine), the ritual (the tight structure of the consultation, including the laying on of hands in the clinical examination) and the institutional.

In earlier times, the church was there to provide us with answers to life's important questions. Today, health has become the paramount issue for us (6). The essential questions have hardly changed, but

to people – and their helpers – these questions are grouped under health. Moreover, good health no longer includes the absence of fevers and coughs and relief from pain, less sickness absence, better functioning and a longer life. In their book *Helse på norsk [Health in Norwegian]*, Per Fugelli and Benedicte Ingstad show that health is just as much a matter of meaning, vitality and community (7).

This is a challenge to all health workers. An ambitious solution would be to let the doctor function also as a kind of priest and assume responsibility for all the problems that the patient presents as health-related. Especially within general practice, which is characterised precisely by its miscellaneous nature, the doctor-priest has periodically been regarded as an ideal. The general practitioner and anthropologist Cecil G. Helman referred to himself as a «suburban shaman» (8). A sample of general practitioners described their role as more like that of a priest than that of a psychotherapist (9). The problem, however, is that the doctor will not necessarily have the competence or the inclination to serve spiritual needs in a multifaith society (7).

A basic skill in general practice is the ability to reveal why the patient has chosen to call on the health services (10). Irrespective of the extent to which we succeed in being, or wish to be, a priest, we should at least practise developing one of the priest's basic skills: to reveal the religious aspects in a context extraneous to religion – within our own institution as well as in the person seeking help. If not, we are at risk of functioning as involuntary pastors in a public redemption service and offering the patients stones when they are asking for bread (11). Even such a trivial matter as a self-limiting respiratory infection may cause the sufferer to feel loss of control, guilt for not avoiding a draught, or hope for a miraculous cure. When we say «take this and eat it» to our patient, we ought to know whether we are responding to the patient's need for redemption or for conventional health.

In today's all-encompassing notion of health, health workers must by virtue of necessity recognise their limitations. Religion should not be reduced to health assistance, and health should not be communicated as religion. Fugelli and Ingstad find no reason to accentuate the priest within the doctor and warn against «the ultimate medicalisation»: allowing religion to become the last victim of the colonisation of the life-world by medicine (7). If the doctor's role is to become more like that of the priest, we should prioritise that of the spiritual adviser, not the administrator of the sacraments. Correspondingly, if the consultation is to serve as a secular counterpart to the sacraments, confession is a better choice than communion. Potentially miraculous, white, round objects are distributed free of charge in church. >>>

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