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Life stance has a major impact on medical practice. However, there is an explicit reluctance to approach the issue – God has become an elephant in the room. We need to address it

The elephant in the room

Some years ago, I was responsible for a seriously ill boy from a Muslim family. His father at times appeared to be extremely frustrated, and not only because of his son's illness. A longer conversation with him revealed why: he was unhappy with the hospital's singularly technological orientation. He felt that we were absurdly secular, even cynical at times, in our attitude to life and death. He sought to find God in the hospital – but all he could find was machines.

His son died after a long period of illness. I later witnessed the subsequent religious ceremony, which was a strong demonstration of collective faith and reconciliation with a cruel fate. Many families appear to be paralysed when the greatest of all tragedies – the death of a child – strikes. The previously frustrated father, however, had strong skills in coping that stemmed from his Islamic life stance.

What can we learn from this story? First and foremost that life stance *has an impact* in the context of medicine (1, 2). This should come as no surprise. Both doctors and clergy are concerned with questions of life and death, European hospitals have roots reaching back to the monastic orders of medieval times, and – perhaps most importantly – having a life stance is a fundamental characteristic of being human. We seek for meaning and coherence in life, especially in critical life situations (2). We may believe in no god, or in one or many gods, but we cannot escape from the phenomenon of faith itself – we cannot escape from the question of God's existence.

An increasing body of empirical studies confirm the numerous points of contact between life stance, religion and medical science. First, your outlook on life has consequences for your health. Most studies indicate that religious faith/practice has positive effects on both mental and physical health. The underlying mechanisms could be of a psychological (better ability to cope with stress), social (strong networks in religious groups) or behavioural nature (less risky behaviour) (3). A recent study documented a positive correlation between self-assessed religiosity/spirituality, thickness of certain areas of the cerebral cortex and resistance to depression (4). At the same time, certain religious convictions may have strongly negative health effects, such as when certain sects encourage parents of sick children to prioritise «spiritual» rather than biomedical treatment (5).

Second, your life stance will have an impact on key value choices. The opinions of terminal cancer patients regarding life-prolonging treatment at the end of life are strongly associated with their attitudes to religious questions (6, 7). The same applies to parents of seriously ill neonates (8). Moreover, this applies in equal measure to doctors – what *we* believe in may have an effect on important aspects of our clinical practice (7, 9). Our collegial discussions on abortion, conscientious objection, euthanasia and circumcision are obvious examples, although our less transparent value choices, such as decisions regarding treatment of very elderly patients, may be equally important.

Third, our life stance is associated with certain neurobiological phenomena. For example, spiritual experiences in Carmelite nuns produce a specific activation pattern in their brains, detectable in a functional MR scan (10), and there is an association between certain EEG characteristics and whether someone perceives religion/spirituality as personally important (11). In other words, there appears to be a specific correlation between religious faith and the function of the brain (12).

Despite this documentation, we as a profession are strangely dumbfounded when confronted with issues of life stance. There is a widespread reluctance to approach this issue, in relation to patients as well as colleagues. God has become an elephant in the room; on the ward as well as in the morning meeting room. Most doctors find it easier to speak with patients about their sex lives than about their prayer life. This situation has complex historical causes. Ever since the Enlightenment era, the development of medical practice has been characterised by an emphasis on its purely scientific and technical aspects, while life stance – and Protestant Christianity in particular – has been seen as a purely personal matter (3). However, not identifying the elephant is unprofessional, especially in a society which is increasingly characterised by heterogeneity in terms of life stance.

Internationally there is an increasing awareness of the correlation between life stance and medical practice (2). Many American universities provide their medical students with comprehensive theoretical and practical training in how life stance issues can and should be addressed in the doctor-patient relationship (13). It is time for us to catch up. For a start, we could challenge each other to identify the elephant in the room. This alone could have helped the frustrated father of my Muslim patient. Happy Easter!

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