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Guest editorial

The influence of faith and belief on the formulation, content and operation of health law in the United Kingdom

The articles in this special edition of the Journal of Medical Law and Ethics are based upon a selection of conference papers that were delivered as part of the David Price Memorial Seminar Series.[1] The series of six interdisciplinary conferences, based upon specific sub-themes under the overarching title of 'The influence of faith and belief on the formulation, content and operation of health law in the United Kingdom' were held at the Universities of De Montfort, Leicester, Birmingham and Nottingham Trent. The project was funded by an Arts and Humanities Research Council (AHRC) Research Networking Scheme[2] which was awarded to the Midlands Health Law and Ethics Consortium in 2012.[3] The seminars involved wide interdisciplinary participation with professional practitioners, lawyers, clinicians, and representatives from the regulatory authorities, stakeholders, policy makers, chaplains, patients and representatives of faith groups.

Faith and belief are of central significance to the delivery and use of healthcare and their influence is pervasive. Knowledge and recognition of the pivotal moral and ethical aspects of faith and belief is essential to appreciate their interaction with contemporary healthcare within a plural society.

Despite recognition that respect for the religious and cultural needs of patients, service users and staff can contribute to their wellbeing and satisfaction, the subject of faith and belief and health law remain comparatively under researched albeit with the exception of a few, highly publicised areas such as abortion, circumcision, blood transfusion and post mortems. The successful multi-disciplinary David Price Memorial Seminar Series has broadened the debate by considering aspects of health law that have to date been unexplored, or comparatively unexplored, in the context of legislative and common law developments.

Any discussion about faith and belief needs to begin by exploring the concepts of faith and belief themselves and our research was no different. The Consortium decided that an expansive definition of faith and belief was the most useful for the purposes of the research project. The Consortium wanted to explore not just organised religious beliefs and doctrinal faiths but also to explore sets of beliefs that individuals would not consider to be religious (such as atheist or humanist views) as well as the extent to which someone's own faith and belief might differ from established doctrine. In our estimation, then,

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1 Professor David Price was Foundation Professor of Medical Law at De Montfort University and the original Principal Investigator for this research project.

2 Grant Ref: AH/1026448/1.

3 The Midlands Health Law and Ethics Consortium is a collaborative team of academic medical lawyers from the Universities of Birmingham, De Montfort, Leicester, Nottingham Trent and Nottingham.

the crucial point was that someone had a set of beliefs or a faith, not where that faith came from and whether it complied with an established religion.

Levels of awareness of diversity of faith and beliefs have grown recently and to some extent equitable treatment of people and inter-faith relations has improved. Yet discrimination on the grounds of religion or belief, religious intolerance and prejudice persist in certain areas within the United Kingdom. To some degree Article 9 of the European Convention on Human Rights protects against religious discrimination although the actual effects, particularly in the area of health law, have been limited. Implementation of the Equality Act 2010 similarly carries promise for the advancement of equality of opportunity on the basis of religion and belief perhaps most promisingly in the context of the duty imposed upon public bodies, such as health care organisations, to make reasonable adjustments.

The impact of faith and belief on the beginning of life can influence attitudes towards treatment of infertility, abortion, contraception and the care of neonates. Dietary constraints, including vegetarianism and veganism, can impact upon treatment regimens and might mean that medication or therapeutic modalities derived from porcine or bovine sources are unacceptable. Perspectives on death and the dying process can influence approaches to palliative care and the acceptability of conscious altering medication, organ donation and the definition and diagnosis of death. It is to the latter topic that Choong turns to in her submission that the dead donor rule might lead to fundamental tensions and fail to protect adequately the religious interests of followers of the Abrahamic faiths. She suggests a need for greater transparency and honesty from public campaigns designed to enhance organ donation. A call is made to enhance public trust by providing more information to would-be deceased donors in order to enhance their ability to make an informed choice that aligns with their own religious beliefs.

The theme of deceased organ transplantation and post-mortem examinations is continued by Elliot who considers religious belief and post-mortem choices. She considers the typical approach of followers of Christian, Muslim and Jewish faiths to cadavers, and the extent to which adherents are likely to tolerate acts which interfere with corpses and their burial. She examines current law that governs retrieval of organs post-mortem for transplantation and the conduct of autopsies to ascertain the cause of death. She ends by assessing the extent to which religious beliefs can be accommodated satisfactorily by current law.

A diverse workforce of healthcare practitioners from a range of faith and belief backgrounds is a positive aspect of contemporary healthcare notably for the knowledge, expertise and sensitivity they can bring to policy making and delivery of services to a diverse multi-faith society. Vickers considers the law that governs protection of religion and belief at work. She makes specific reference to the concerns of health professionals, and in particular the thorny issue of statutory conscientious objection provisions. The implications of the recent

decision of *Eweida*[4] is considered in the context of conscientious objections and requests to accommodate religious needs such as apparel and time off for religious observance. These rights are considered on the basis of proportionality which is identified as a crucial determinant to ascertain appropriate parameters for protecting rights to religion at work.

The theme of conscientious objection is continued in a novel perspective by Farrand who relies upon a Foucauldian analysis to reconceptualise the notion of conscientious objection as resistance against a dominant way of thinking within society. He suggests that conscientious objection cannot be divorced from the social, cultural and historical context in which the act being objected to takes place. As a consequence what might be considered a legitimate 'conscientious' objection in one jurisdiction may be seen as unconscionable behaviour in another. He then applies his theory to medical procedures that are tolerated by society, such as abortion, with those considered abhorrent, such as female circumcision.

Recognition and understanding of the influence of faith and belief in healthcare is essential to appreciate the possible tensions that can arise in health law. However, there is a very real need to avoid (even benevolent) religious stereotyping. Followers of religions are often characterised by individual and cultural differences within larger groups and particularly for those with a large cultural footprint. Furthermore, there are many complex arguments in the area of rights to freedom of religion and particularly in the context of the competing rights of others. When transposed into the area of healthcare such tensions can sometimes seem intractable and recourse to the law inevitable. Samanta and Pattison take a pragmatic approach and consider critically some of the factors that can arise with the realities of religion in the public space, and particularly in the health care arena. They start by considering the pluriform understandings of religion and the persistent dominance of Christianity as the exemplar for religion for English and European law. After considering the potential tensions that can materialise in healthcare care environments they consider the place and importance of 'religion' and religious needs, before concluding with suggestions for more effective encounters and collaborations between law, religion and health care.

Ultimately, respect for diversity of faith, religion and belief is a necessary aspect of society's commitment to equality and health law's response and recognition is essential to promote trust and confidence amongst the population.

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4 *Eweida and others v UK* [2013].