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ARTICLE

Religion, Law and Health Care: Uncomfortable Bedfellows?

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Introduction

Religion is coming to have a new visibility and salience in British society in general and in the arenas of law and health care in particular.[1] While religion has never 'gone away', it is becoming more controversial and publicly discussed as lawyers and health care providers attempt to grapple with its potential implications in practice. Unfortunately, these attempts are often governed by a kind of piecemeal pragmatism which risks over-simplifying the interestingly complex nature of religion itself.

In this paper, we critically consider some of the factors and issues arising in the context of coming to terms with the realities of religion in the public sphere, particularly in health care. Our aim is to selectively consider nuanced understandings of the nature of these three areas separately as well as the space which lies between them from an interdisciplinary perspective to better reveal the ambiguities and challenges that lie before scholars and practitioners in law and health care. We start by considering the variegated, pluriform understandings of religion held by students of this phenomenon in theology and religion. While non-specialists may assume that religion is a unitary phenomenon that is easy to understand and define, scholars of religion have a very different understanding. In particular, the dominance of Christianity as the exemplar for religion is controversial, especially insofar as it implies a privileged position for articulate belief and thought. Unfortunately, it is exactly this paradigm that has largely informed legal understandings of religion for historical and other reasons. These are examined in the next part of the paper.

One of the main drivers for taking religion more seriously in the health arena is the growth of human rights legislation. It is to this aspect of law that we next turn, noting *en passant*, that human rights themselves are influenced

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1 L. Woodhead & R. Catto (eds.), *Religion and Change in Modern Britain* (Abingdon: Routledge, 2012).

heavily by Christian theology and practice though this is not always apparent. And this lasting but largely unrecognised influence of religion, especially Christianity, is also encountered specifically in health care settings in myriad ways and especially when matters of conscientious objection are raised. It is to the setting of health care that we turn to next to consider the place and importance of 'religion' and religious needs, before drawing some conclusions about prospects for more effective encounters and collaborations between what appear to be three increasingly uncomfortable bed-fellows: law, religion and health care.

It may be necessary, in the short-term, for discomfort to grow and intensify, but our hope is that understanding some of the diverse tensions and difficulties encountered when these three factors coalesce might lead to interesting, complex and fulfilling dialogues that deepen understanding. Proceeding by blind pragmatism and narrow understandings is likely, in the long term, to be costly and frustrating for all concerned. While we cannot propose answers to the tensions raised here, we hope that our contributions promote understanding so that scholars and practitioners can have more nuanced and productive debate.

The meaning of religion

Scholarly perspectives

Doctrinal or practice focused?

A starting point for analysing some of the apparent difficulties and misunderstandings surrounding legal dealings with religion and religiously-related matters is the unwitting adoption of limited, arbitrary understandings of religion and the religious. Religion is a complex, multifaceted and contested concept for scholars of theology and religious studies.[2] However, by tradition in the West, it is Christianity, particularly Protestant Christianity, that provides the authoritative paradigm of what a religion actually is and all other 'religions' are evaluated according to the presence or absence of their Christian-like characteristics.[3] Equally unfortunately, Christianity is often perceived as being defined by faith which is understood to be mainly as 'belief in God'.[4] However, arguably,

2 G. Davie, *The Sociology of Religion* (London: Sage, 2007), J. Hick, *An Interpretation of Religion,* (Basingstoke: Macmillan), D. Pals, *Seven Theories of Religion* (New York: Oxford University Press, 1996).
3 T. Fitzgerald, *The Ideology of Religious Studies* (New York: Oxford University Press, 2000).
4 G. Harvey, *Food, Sex and Strangers* (Durham: Acumen, 2013).

even in Christianity, belief and believing are not always of central significance.[5] Religions are not always or even mainly about believing, cognition or the ability to articulate verbally thoughts in the mind of an individual. They are complex webs of practices, artefacts, places, attachments, sensory attitudes and very much more. This means that categorising 'belief' as the defining characteristic of what counts as religious, before the law, is to reify artificially a single, and perhaps not ultimately a very important aspect of that which is taken to be religious.

Practically, this may serve to privilege the interests and abilities of those who are cognitively articulate before the law while much of what is of real religious significance might be excluded. Those 'religious' groups able to provide coherent, reasoned accounts of their 'beliefs' (such as Anglicans) might be more persuasive to a court than followers of other religious groups with less scripturally- and creedal-based traditions. For this reason, followers of some minority religious groups, such as Druids and Wiccans, have questioned why their beliefs are not regarded as 'proper' religions so that public institutions have equivalent duties to protect their rights to religious freedom.[6] This situation seems as unjust as it is arbitrary. To treat religion as solely, or mainly, concerned with belief is to risk a fundamental category mistake. Arguably, it is not really to identify with the totality of religion at all, but rather to focus on a limited aspect prominent in only some religions.

Humanitarianism

There is more to humans than their minds and thoughts and there is more to religions than beliefs. Religions are often based on the a-rational and world-explaining myths. They even mythologise themselves. Theistic religions depend implicitly for their plausibility and authority on cultivating myths that they are eternally true, at least in part; that they provide the way or solution to the difficulties of existence and enable human flourishing; that they have always been there, or at least have been there implicitly, waiting to emerge; that they will always exist and that, in their fundamentals, they will not change. Values such as these mean that proselytising and colonising often become fundamental aspects of religious identity. People would not live and if necessary die for practices and beliefs that were not regarded as having some kind of ultimate authority and significance that they believe transcends lifestyle preference and choice, even in the context of health care provision and consumption.

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5 N. Ammerman (ed.), *Everyday Religion: Observing Modern Religious Lives* (New York: Oxford University Press, 2007), R. Orsi, *Between Heaven and Earth: The Religious Worlds People Make and the Scholars who Study Them* (Princeton: Princeton University Press, 2005).

6 J. Pearson, *Belief Beyond Boundaries: Wicca, Celtic Spirituality and the New Age* (Farnham: Ashgate, 2002).

Religions provide rich motivations, understandings and insights into the human story and condition. Historic 'world religions' can be seen as enormously important records of human trial and error undertaken often with the best of intentions and with the worst possible outcomes and lessons ought to be learnt from these endeavours.[7] From this perspective it is understandable that religions are often understood to be, and act as if they are, very conservative, as demonstrated by their reticence to the development of some health technologies.[8] They provide a reflective mirror and brake upon human endeavour. Learning from mistakes and misconceived over-optimism and certainty is an important part of what religions have to offer; whatever else, formal historical religious traditions are full of humanity in all its fullness and tragedy. At their best religions point up the value to 'slow thinking', albeit that it can be frustrating in a rapidly changing world and particularly in the health care arena.

Legal perspective

Judicial 'determination'

In contrast to the critical approach of academic scholars of religion who highlight the pluriform and contested nature and effects of the definition and content of religion and religions, until recently the courts had attempted valiantly to curb debate by avoiding the need to define religion. United Nations' instruments similarly have not defined religion in order to avoid ideological controversy that might cause tension between Member States.[9] Rather than attempting to *define* religion, judicial and legislative attempts have been directed variously at '*determining*' religion through ascertaining the content of the religious interests being claimed.[10]

In England specifically, a variety of means have been used to this end. These range from pronouncements by judges who consider a particular aspect of religion to be so commonplace as to be intrinsic to judicial knowledge and awareness. However, this 'common knowledge approach' carries risk. The judiciary, as legal arbiters, may not be the experts they perceive themselves to be, especially with religions that have a 'large cultural footprint.'[11] Benign and apparently well-meaning generalisations can lead to inappropriate homogenisation and consequent injustice when determining the rights of individuals, or of groups.

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7 J. Bowker, *Licensed Insanities* (London: Darton, Longman and Todd, 1987).
8 *Regina v. Secretary of State for Health (Respondent) ex parte Quintavalle (on behalf of Pro-Life Alliance)* [2003] UKHL 13.
9 N. Lerner, *Religion, Secular Beliefs and Human Rights* (Boston: Martinus Nijhoff, 2012).
10 P. Edge, 'Religion in English Courts', 1(2) (2012) *Oxford Journal of Law and Religion* 402-423.
11 *Ibid.*, 405.

Although it might be expected that a significant number of English judges would be members of the predominant religions of the society in which they practise it is apparent that the judiciary is far from representative of the population as a whole.[12] Judges and adjudicators may well be influenced by their professional education and seek analogies between their understanding of religion with the legal framework which they rely upon to determine religion. A technique such as this can be expected to inculcate underlying and possibly unacknowledged personally-held values and perspectives which may not therefore be amenable to challenge or exploration. For adjudicators with a legal background, their comfort zone might lie in decision-making that follows the process which most resembles that used for 'determining the law', namely by considering texts and having recourse to authority. The implication here is that those religions based on scriptures, doctrine and creeds might receive more positive consideration, at least before the courts.[13]

This arbitrary understanding of religion has broad implications particularly for resolution of disputes that concern competing human rights. The apparent randomness by which inclusion and exclusion criteria are applied in judicial determinations serves only to further confound the unpredictable nature of this area of law.

Legal definition

For legal advisors, the law's reluctance to define 'religion' means that it can be impossible to ascertain whether a person's faith falls within the accepted definition of religion, or of a particular religion, which could be fundamentally important for the success or otherwise of a client's case.[14] On this point, a recent decision of the Supreme Court may have grasped the nettle. In a case that concerned whether a chapel of Scientology could be recognised for the solemnisation of marriages, the Court first had to consider whether Scientology was a religion.[15] The Court considered *Segerdal*,[16] an appellate decision in which the Court had to decide whether a Church of Scientology could be registered as a place of meeting for religious worship. For these purposes Lord Denning had held that 'religion' in the context of 'religious worship' carried an implicit theistic notion. Since the Church of Scientology's services did not contain reverence

12 Judiciary of England and Wales, *Diversity: Gender, Age and Ethnicity* at www.judiciary.gov.uk/about-the-judiciary/judges-magistrates-and-tribunal-judges/judges-career-paths/diversity-gender-age-ethnicity#headingAnchor1.

13 P. Edge, 'Determining Religion in English Courts', 1(2) (2012) *Oxford Journal of Law and Religion* 406.

14 *Ibid*. at 402.

15 *R (Hodkin)* v *Registrar General of Births, Deaths and Marriages* [2013] UKSC 77.

16 *R v Registrar General, ex parte Segerdal* [1970] 2 QB 697.

for God, as understood by Lord Denning, it was concluded that the services did not amount to religious worship. Arguably, *Segerdal* therefore concerned the definition of 'worship', rather than 'religion' *per se*. This was followed by *Re South Place Ethical Society*[17]where the Court had to decide whether a society was charitable for the advancement of religion. In holding that the society's objects for the 'cultivation of a rational religious sentiment' were educational, though not religious, Dillon J. stated that:

'Religion, as I see it, is concerned with man's relations with God, and ethics are concerned with man's relations with man. The two are not the same, and are not made the same by sincere inquiry into the question: what is God?'[18]

Whilst recognising the difficulties of attempting to delineate meaning to 'religion' given the variety of world religions, societal and cultural change and the range of legal contexts in which issues could arise, the most expansive common law definition to date was given in *Hodkin*.[19] In overruling *Segerdal* it was held that, unless there was a compelling contextual reason, the notion of religion should not be confined to those religions which recognise a supreme deity, not least because this would be an unacceptable form of religious discrimination.[20] Lord Toulson went on to define religion as a:

'... a spiritual or non-secular belief system, held by a group of adherents, which claims to explain mankind's place in the universe and relationship with the infinite, and to teach its adherents how they are to live their lives in conformity with the spiritual understanding associated with the belief system.'[21]

In terms of definitions *Hodkin* certainly seems to be a welcome step forward in moving away from the paradigm of Christianity. Nevertheless, Lord Toulson's emphasis is still on belief and explanation and arguably gives insufficient regard to practice-based, non-theistic forms of religion. Hence, it is too early to forecast whether *Hodkin* will be a positive development in law and its potential implications for healthcare organisations and practice.

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17 *Re South Place Ethical Society* [1980] 1 WLR 1565.
18 *Ibid*. at 1571.
19 *R (Hodkin) v Registrar General of Births, Deaths and Marriages* [2013] UKSC 77.
20 *Ibid*. para 51.
21 *Ibid*. para 57. Note that this definition was given for the purposes of the Places of Worship Registration Act 1855.

Law and religion – an unsatisfactory interface

A rights based discourse

Historical incrementalism

In comparison to a rich, non-cognitive pluriform perspective, contemporary English law tends to view religion through the prism of rights-based discourse and tolerance. This approach, to some extent, reflects its historical background which has been influenced considerably by institutionalised Christianity and major historical developments. In particular, two distinct legal systems developed within Western Europe: the English Common Law and Western papal canon law. The former dealt mainly with matters 'temporal' and the 'Courts Christian' dealt with those of a spiritual nature.[22] Following the sixteenth century Reformation and England's separation from Rome, authority transferred from the Pope to the King, establishing the Church of England as the religious norm and liberating the Church from foreign influence. With incremental change between the seventeenth and twentieth centuries several legal disabilities were removed from followers of non-Anglican Christian groups, a key event being the Glorious Revolution of 1688-89 when William III and Mary II issued a decree to eradicate the need for religious conformity prior to assuming public office.

Although the period after William and Mary was characterised by a degree of religious tolerance there were no enforceable rights to religious freedom or equality. Non-conformists and Catholics, for example, continued to suffer a range of discriminations including proscription from attending English universities which continued until the nineteenth century. Even now, members of the Royal Family who are in line to the throne cannot become Catholics. Perhaps the most notable recognition of rights to religious freedom has come with the development of human rights, arguably itself part of a secular replacement for the God of Christianity that privileges the 'suffering innocent'.[23] While many perceive their development to be essentially a post-World War II phenomena, this view is not universally shared. Moyns, for example, has argued persuasively that the concept of individual human rights is rooted in the mid 1970's (rather than the signing of the Universal Declaration of Human Rights) and emerged as an anti-political moral response to the failures of revolutionary and social and political ideals.[24] Whatever its background, the major world faiths contributed to the human rights movement by enhancing the understanding of the

22 J. Baker, *An Introduction to English Legal History*, 4th ed. (London: Butterworths, 2002).
23 S. Hopgood, *The End Times of Human Rights* (Ithaca: Cornell University Press, 2013) x.
24 S. Moyn, *The Last Utopia. Human Rights in History* (London: The Belknap Press, 2010).

meaning of humanitarianism and its implications in the form of rights and responsibilities.[25]

The Human Rights Act 1998

The overarching right to freedom of thought, conscience and religion is protected most comprehensively by the European Convention on Human Rights.[26] Article 9(1) is an absolute right in that: 'Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.' Article 9(1) is broad in its application and confers absolute protection on the internal aspects of religious belief (the '*forum internum*') and proscribes interference with freedom to have, or adopt, a religion or belief of one's choosing. Domestic courts are more ready to find that these rights have not been interfered with as a means of avoiding the need to consider in detail the theological merits of individual cases.

Article 9(2) defines the right to express or manifest religion or belief (the '*forum externum*'). It is a qualified right in that restrictions may be applied to pursue a legitimate aim.[27] Any restrictions imposed, however, must be a proportionate response to the achievement of a legitimate aim.[28] To further confound the issues, and add an additional layer of unpredictability, Member States are permitted a wide discretion or 'margin of appreciation' when it comes to striking a balance between competing Convention Rights.[29] Typical competing rights in the context of freedom of religion include the freedom of expression (Article 10) and the right to privacy (Article 8). To date, most of the litigation has concerned the interpretation and application of Article 9(2), namely the expression and manifestation of religious belief, rather than alleging interference with the absolute right to freedom of thought, conscience and religion.

In the context of healthcare, contemporary English law recognises the potential of religion as a public good and extends a range of protections. Thought, conscience, religion and belief (or none) is protected variously as a human right and by the Equality Act 2010. Health professionals have a statutory right to

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25 G. Davie, 'Law, Sociology and Religion: An Awkward Threesome', 1(1) (2012) *Oxford Journal of Law and Religion* 235-247.

26 Incorporated into English law by the Human Rights Act 1998.

27 In accordance with the derogations in Article 9(2) namely the protection of health, morals, public safety and order, or for the protection of the fundamental rights and freedom of others.

28 Limited to minimal interference and enacted in a fashion that is non-discriminatory: see P.M. Taylor, *Freedom of Religion. UN and European Human Rights Law and Practice* (2005).

29 *Evans v UK* Application number. 6339/05 *para* 106.

conscientiously object to participating in abortion or treatment regulated by the Human Fertilisation and Embryology Act 1990. The right to religious liberty has been recognised by common law in circumstances that range from refusals of treatment,[30] the exercise of self-determined choice,[31] and welfare of the child determinations.[32] The European Court of Human Rights has recognised freedom of religion as one of the 'most vital elements that go to make up the identity of believers and their conception of life.'[33]

Potential shortcomings

There is a global tendency for the collective aspects of freedom to manifest religion or belief (most often in the form of freedom of assembly or association) to be prone to state interference across Member States of the European Union,[34] leading to unpredictable outcomes. In effect, the right to freedom of religion safeguards a restricted and conservative form of religious life only; arguably this better protects personal beliefs and preferences rather that worship in community or congregation with others. In its application this tends to favour Western scriptural religions that emphasise personal faith and commitment such as Christianity rather than those characterised by less doctrinal, and more communal forms of religious practice and expression.

Law and religion applied in the contemporary healthcare context

Implications for health care

It might be difficult for health professionals to comprehend the central significance of their patients' religious commitments and adherences and to appreciate the context in which believers situate their lives. It is within this 'bigger picture' that followers enact rituals and observances such as dietary and funeral practices. For those who do not share the same faith, subordinate and external rituals and practice can be perceived mistakenly as being of utmost significance for believers. Often, it is those practices that support and exemplify commitment and belief which are assumed by outsiders as the being most important aspects of what it means to be a committed adherent of a religious group. Unless underpinned by informed collaborative dialogue well-meaning

30 *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.
31 *Airedale NHS Trust v Bland* [1993] AC 789.
32 *Re C (Medical Treatment)* [1998] 1 FLR 384.
33 *Kokkinakis v Greece* Application number 14307/88. 25 May 1993 para. 31.
34 N. Lerner, *Religion, Secular Beliefs and Human Rights* (Boston, Martinus Nijhoff, 2012) 10.

attempts to meet perceived needs might lead to wasted efforts and resources if these fail to meet their intended objectives. Seemingly unappreciative service users might then be perceived as demanding, awkward or non-conformist. While this might well be so, efforts spent on addressing assumed, rather than actual needs, are unlikely to be fruitful. In fact, for the devout, a more fundamental and intractable concern might be that the central notion of their relationship with God or the transcendent surpasses the biomedical aims of health care. No matter what equality and diversity policies are put in place it is this challenge which is likely to be most significant for predominantly secular health care organisations.

By its very nature health care concerns birth, death and illness recognisable in turn for their propensity for periods of great happiness, stress, anxiety and suffering. Since it is widely accepted that religious commitment and belonging can make a positive difference to the lives of followers, there would seem to be little point in attempting to eradicate the central most important aspects of religious belief and practices even where these do not align readily with the biomedical model of western health care.[35]

Potential for mutual accommodation should not be underestimated in interactions between health care and religious communities and ought to be capitalised upon by policy makers.

Service users

Compared with the number of claims based upon religious discrimination or interference with religious freedom in school and in the work place relatively few cases involve health care situations. Those that have been brought have tended to involve health professionals or employees in the health services rather than patients. Patients' claims tend to be high profile and often include alleged breaches of alternative rights as an adjunct to thought, conscience and religion. In *Pretty*,[36] for example, her belief in 'death with dignity' pursued (in the lower courts) under Article 9 was abandoned in favour of arguments under privacy, inhuman or degrading treatment and the right to death as a corollary of her right to life.

The most meritorious cases are often not those that are pursued because individuals or organisations do not want to litigate, or perhaps lack the resources

35 H. Koenig, *Medicine, Religion and Health* (West Conshohocken, PA: Templeton Foundation Press, 2008).

36 *Pretty v UK* (Application no. 2346/02) judgment of 29 April 2002.

to do so. A more likely response might be a complaint to the organisation, the Care Quality Commission, or to the professional regulatory bodies.

Health professionals

Health care workers, like members of the rest of society, may be active members of religious communities. In fact, their religious commitment may be an important part of their motivation and personal support system for doing the jobs that they do. Their faith often consciously or unconsciously influences their practice, as well as other parts of their lives. Nevertheless, rights to religious freedom must be balanced against the rights of others, including those of colleagues and patients. One major concession recognised by law and the regulatory authorities is respect for 'conscientious objection' as the right to refuse to participate in treatment or procedures that are otherwise lawful.[37] While conscience is not now solely the province of overtly practising religious people, it has often been closely associated with members of particular religious groups, especially in the recent past with Roman Catholics, and treated as sacred.[38]

In theory, conscience clauses attract considerable protection in English law. Statutory rights to conscientiously object are expressly included in the Abortion Act 1967 and the Human Fertilisation and Embryology Act 1990, although their rationale in certain situations is perhaps questionable.[39] While it is certainly true that abortion and infertility treatments are morally controversial, the same can be said of many other aspects of medicine, such as withdrawal of life-sustaining treatment from patients who lack capacity. The conscience clauses of both Acts were concessions that had to be made in order to get the legislation passed and it is this that justifies their apparently random selection for statutory protection which has implications. Although objections might be based on clear, rational thought (just as much as intuition or 'moral repugnance') the conscientious objection clause serves only to distance the refusal from ordinary moral thinking to be dealt with separately from the generality of practice and positioned in a mystical world of belief.

A strange lacuna of 'sacrality' is created over this very restricted range of issues and rational thought more or less ceases in the face of some non-specific

37 General Medical Council, *Personal beliefs and Medical Practice* (London, General Medical Council, 2013).

38 P. Strohm, *Conscience: A Very Short Introduction* (Oxford: Oxford University Press, 2011).

39 Schedule 3(2) of the National Health Service (General Medical Services Contracts) Regulations 2004 permits doctors to refrain from providing emergency contraceptive services, even though this does not cause abortion.

urge that may be informed by nothing more than observance to what is taken to be religious teaching but which might well be based on ignorance. In this way objectors, as well as those who do not object, may find themselves over-differentiated from others, and possibly stereotyped – this to the detriment of valuing the moral experience (religious and non-religious) to which all practitioners are accustomed. This means that the public (citizens, patients and professionals) potentially loses out due to the arbitrary character of what conscientious objection is taken to be and where it is taken to be relevant. Those who do not raise conscientious objections may then have to engage in a kind of moral labour which is equally difficult and onerous. Conversely, this effort is not afforded the same protection, or honour, extended to the apparently heroic business of the statutory conscientious objections. It is difficult to imagine that anyone particularly relishes the duty of participating in abortions; and those who do not refuse to be engaged may find themselves to be an overburdened minority.[40] More insidiously, doctors who are willing to undertake abortions could be perceived as having a less sensitive morality or perhaps a less principled approach than those who claim the label and moral high ground of 'conscientious objection'.

As a qualified, rather than absolute, right a conscientious objection cannot be exercised lawfully where a patient's health, or life, is at risk. In similar vein professional ethical guidance provides that doctors may opt out of particular procedures on the basis of their personal belief and values provided that this does not directly or indirectly discriminate against, or harass individuals or groups of patients.[41] The guidance, as well as the law[42] requires that patients are informed of a health professional's conscientious objection as early as possible and that arrangements are made for a suitably qualified colleague to take over care.

This approach, which appeals to proportionality, does not prevent abortions from taking place but it could satisfy conscience to the extent that practitioners are not personally involved with terminations of pregnancy. Nevertheless, this seemingly pragmatic option has been rejected by some conscientious objectors who consider that doctors who agree to refer patients to abortion services are equally complicit. In these circumstances a more creative approach might be to refer patients to gynaecology services on the basis of their 'pregnancy' rather

40 A major survey in 2007 revealed that 19,6% of general practitioners are anti-abortion (Marie Stopes International, *General Practitioners attitudes to abortion*, 2007).

41 General Medical Council, *Personal beliefs and medical practice* (General Medical Council, London, 2013) para. 8.

42 National Health Service (General Medical Services Contracts) Regulations 2004 Schedule 3(2)(e).

than referring for an abortion. Seemingly intractable conflicts such as these, which concern the competing rights of individuals and have real potential to jeopardise the doctor patient relationship, might best be resolved by proactive policy implementation and work rotas that involve discussion and collaboration within functioning health care teams.

An interesting body of jurisprudence has developed around the dress codes of employees in juxtaposition to their rights of equality and freedom of religion. Until recently the courts had tended to determine questions of religious discrimination from the perspective that only those actions which employees were 'obliged' to take because of their faith would amount to a right protected as a manifestation of their religious belief. In effect, this meant that Christians did not have a protected right to wear a crucifix or a purity ring whereas Sikhs have a recognised right to wear turbans even in contravention of health and safety legislation.[43] In *Eweida*[44] the European Court of Human Rights recognised, for the first time, that rights to religion can apply at work. Previously religious rights were deemed to be protected adequately by an employee's 'right to resign'. Although ultimately the European Court confirmed that wearing a cross on a chain by a Christian nurse did pose a risk to health and safety in the hospital environment, the court rejected the Government's argument that Shirley Chaplin's freedom of religion was not engaged since the wearing of a visible cross was not a recognised 'requirement' of Christianity. Whereas previously a practice had to be required or mandated by the religion in question this is no longer the case. Following *Eweida* actions can now be protected as long as a 'sufficiently close and direct nexus' exists between the act and the belief. This is a fundamental change that, in theory, broadens the sort of practice based on religious belief that can be protected at work. While counter arguments based upon health and safety arguments seem likely to trump religious rights this decision nevertheless suggests that practices described as 'religious obligations' may be protected more readily.

Most hospitals have policies that prohibit the wearing of long sleeved garments, head and face coverings and the wearing of jewellery and artefacts in clinical areas in line with infection control and health and safety policies.[45] The Department of Health's decision to amend the uniform policy intended to be

43 See, *Playfoot* [2007] EWHC 1698 and compare with Sikhs who have a statutory exemption from legislation that requires them to wear head protection whilst on a construction site (sections 11 and 12 of the Employment Act 1989).

44 *Eweida v UK* (Applications nos. 48420/10, 59842/10, 51671/10 and 36516/10) judgment of 15 January 2013.

45 National Institute for Health and Care Excellence, *Infection: Prevention and Control of healthcare-associated infections in primary and community care* (London, 2012).

rolled out across the NHS was in response to rising levels of nosocomial infection.[46] The 'bare below the elbows' policy was intended to protect long sleeves from contamination and to ensure that hands could be washed sufficiently to prevent transmission of infection. This seemingly uncontroversial policy had unintended implications for minority religious groups. A sizable proportion of female Muslim staff, for example, were adversely affected by the policy because their religious beliefs meant that they would not normally expose their forearms in public. Sikh staff wearing kara bracelets were similarly affected.[47] Following a roundtable debate between the Department of Health, Muslim Chaplains and Islamic Scholars[48] the uniform policy was amended to include only those staff who worked in direct clinical care. [49]For members of staff who wished, for religious reasons, to cover their forearms or wear a religious bracelet when not engaged in direct patient care, pragmatic compromises were identified. These included the wearing of long sleeves or bracelets that could be pushed up the arm and secured in place to permit hand washing and direct patient care or alternatively disposable over-sleeves elasticated at the wrists and elbows that could be disposed of following each patient contact. This pragmatic solution was made possible following informed dialogue and compromise with all interested parties.

The tension between competing rights of freedom of religion and freedom of expression was tested following a complaint to the General Medical Council about a general practitioner who discussed his Christian beliefs with a patient during a consultation.[50] The revised guidance provides that doctors must not express their political, religious and moral beliefs to patients in ways that exploit their vulnerability or are likely to cause them distress.[51] For any religious doctor the suggestion that expressing their belief might exploit their patients seems to be counterintuitive. Although the Nursing and Midwifery Council avoids direct reference to the religious beliefs of its constituents, adherents must similarly avoid proselytising their faith.[52] Doctors are advised to give patients

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46 G. Jacob, 'Uniforms and workwear: an evidence base for developing local policy', *Department of Health* 2007.

47 J. Jones & A. Shanks, 'Laid Bare: Religious Intolerance Within Online Commentary About "Bare Below the Elbows" Guidance in Professional Journals' (2013) HCA 21: 271-281.

48 Roundtable discussion with the Department of Health, Muslim Chaplain and Islamic Scholars (10 January 2008) www.mcb.org.uk/downloads/infectioncontrol.pdf.

49 Department of Health, Uniforms and workwear: Guidance on uniform and workwear policies for NHS employers (2010).

50 C. Dyer, 'GP accused of "pushing religion" on patient opts for full GMC hearing', *British Medical Journal* 2011; 342.

51 General Medical Council, *Personal beliefs and Medical Practice* (London, 2013) para. 54 at www.gmc-uk.org/static/documents/content/Personal_beliefs_and_medical_practice.pdf_51462245.pdf.

52 Nursing and Midwifery Council, *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives* (London, 2008) para. 59 at www.nmc-uk.org.

the option of seeing another clinician if they believe that their personal moral or religious views are likely to influence their advice or treatment.[53] The difficulty here is that religion is not an external to people, or to their lives, and may well inform the whole of a person's identity, sense of self and belonging. It is therefore difficult to identify which parts of our psyche and persona influence our moral values. How can individuals ascertain which facets of themselves influence their decision-making and clinical advice? It is difficult to appreciate which espoused values and assumptions are enacted in particular situations. For this reason it would seem preferable for patients, as well as their doctors, to be frank about the possible influence of their moral and religious perspectives in order to inform the therapeutic relationship.

Organisations

Religion is an important issue for the health services from the workers it provides to chaplaincy services and formal and informal care in the community collaborations. It exists, implicitly and explicitly, at several intersections as both a resource and sometimes a challenge. The choice for the health services is whether to aim for constructive collaboration with religious communities or whether to side-line religion and its followers until required in order to show compliance with policies of equality and diversity.

Tacit suspicion of religion and the religious can be empowering to those who wish to scrutinise religion's favourable or malevolent effects. Endeavours such as these require categorisation of religion alongside other human and social phenomena such as education or the economy. Implicitly, this underpins some of the debates about the place of religion in secular social policy and health care. If religion is considered to be inherently good for people and communities by, for example, enhancing health, then it can be used to help deliver social benefits. It not, then, like any other social practice, it should be altered until it conforms. The argument runs as follows: if, for example, an adherent distrusts allopathic medicine and prefers amulets or prayer, then that patient needs re-educating to accept orthodox medical advice.[54] This imperative is likely to be all the stronger where care of children or people who lack capacity is concerned.

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53 British Medical Association, *Expressions of Doctors' Beliefs*, http://bma.org.uk/practical-support-at-work/ethics/expressions-of-doctors-beliefs.

54 S. Pattison, Religion, 'Spirituality and Health Care: Confusions, Tensions, Opportunities', *Health Care Analysis* 2013: 21;3, 193-207.

Future directions

Reality check

In the predominantly secular health service there may be a tendency to stereotype the religious as demanding service users or alternatively as committed providers of care, whether as employees or volunteers who can deliver secularly-defined social and health benefits. As far as the law is concerned, freedom of religion is a human right protected by law provided that it is practised conservatively and preferably as a private philosophy. However, understanding religions and religious people is a complex, and fascinating matter. Taking into account the reality of religion is not merely a matter of meeting specific needs at the bedside for the purposes of satisfying 'tick-box' criteria to show compliance with the equality and diversity agenda. Nor is it trying to ensure that followers abandon their distinctive beliefs and insights when they engage with health care institutions and policies, adapting to the beliefs and practices of individualistic secular biomedicine or at the very least to that which aligns more readily with Western ideals. What is required is more effective dialogue and discussion between and within religious and health care communities together with engagement of front line decision-makers committed to the development of anticipatory policies to promote equality and human rights. Religion, however understood, is not an accidental external either in society or in health care.[55]

Pluralism will, at times, justify differential treatment to faith groups in order to promote harmony and social justice. In the event of discrimination or a violation of human rights, recourse to judicial review or civil action is available to safeguard equality of opportunity. Nevertheless, recourse to legal action is viewed rightly by many as a symptom of failure.

Equality – a potential solution?

There is a growing propensity for religious disagreements to be framed as legal problems, to be solved by litigation or at least by reference to law.[56] If correct, this is certainly not a benign or useful development particularly in the healthcare context. An important aspect of the influence of law on society is the potential for high profile cases to sway public opinion when particular (and possibly partial) aspects are publicised. Selective reporting can make conflicts between freedom of religion and competing human rights appear more prevalent than evidence otherwise suggests.[57]

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55 L. Woodhead & R. Catto (eds.), *Religion and Change in Modern Britain* (Abingdon: Routledge, 2012).

56 R. Sandberg, *Law and Religion* (Cambridge, Cambridge University Press, 2011) 193-95.

57 M. Malik, *From Conflict to Cohesion: Competing Interests in Equality Law and Policy* (Equality and Diversity Forum, 2008).

A case in point concerns the display of religious symbols by employees at work and notably in hospital environments. In fact, evidence from tribunals indicates that most of the litigation that engages rights to religious freedom involve working hours and lack of opportunities to meet religious obligations.[58] Case law particularly that which concerns human rights, can have an insidious effect on public discourse and opinion.[59]

The approach of human rights law to freedom of religion, although written largely in positive terms, tends to offer protection in the way of freedom from interference by the state or from providers of public services. In its practical application it therefore offers rights-based protection from interference rather than providing more positive means of empowering individuals. Under the Equality Act 2010 'religion' means any religion and the Code of Practice provides that it is for the courts to determine what counts as a religion. It recognises that there is not always a clear line between the *forum internum* and the *forum externum* and imposing limits on rights to manifest religious beliefs may amount to unlawful discrimination. Nevertheless, successful claims based on indirect discrimination against publicly funded health care services are not cost neutral for society. Pre-emptive conflict avoidance strategies should be pursued wherever possible.

Tolerance and accommodation of difference is not a one-way system. Mutual engagement requires more than asking health care institutions to learn more about the nature of religion, spirituality and religious communities. There is also much ignorance in religious communities about the nature, aims and benefits of formal health care organisation and its delivery which is a matter that religious communities need to address more proactively. Although contemporary law already provides a comprehensive framework to protect freedom of religion and equality recourse to the law, rather than negotiation, mediation or conciliation, may be counterproductive. The most productive way forward is likely to be proactive co-operation and collaboration.

In the context of equality, European law establishes a hierarchy of protection against discrimination to different groups in different situations, most notably in the context of employment.[60] Although discrimination on the basis of race

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58 B. Savage, *Sexual Orientation and Religion or Belief Discrimination in the Workplace* (London, ACAS, 2007).

59 A. Donald, 'Advancing Debate about Religion or Belief, Equality and Human Rights: Grounds for Optimism?', 2(1) (2013) *Oxford Journal of Law and Religion*, 50-71.

60 European Union Agency for Fundamental Rights, *Inequalities and multiple discrimination in access to and quality of healthcare* (2013) 79 at http://fra.europa.eu/sites/default/files/inequalities-discrimination-healthcare_en.pdf.

or ethnic origin is convincingly protected, discrimination on the basis of religious belief is not. For instance whereas the Racial Equality Directive[61] specifically includes discrimination on the basis of race and ethnicity when accessing health care and health services as yet no equivalent protection extends to religion and belief. It remains to be seen whether future developments, perhaps spurred on by Member States, will be forthcoming.

Conclusion

Lawyers' interest in religion is becoming more apparent as disputes involving aspects of religion are referred to the courts with increasing regularity. Current relations between law and religion may, however, bring out the most stereotypical and least creative aspects of each which can be manifestly unhelpful in the health care arena. Lawyers, health care workers and scholars of theology and religious studies are trained differently and so understand the nature of the issues before them in unique ways. Ideally, while they ought to contribute their own positive perspectives to this important conversation, there is considerable scope for misunderstanding, narrowness, and working down to some kind of pragmatic lowest common denominator which may ultimately satisfy few.

In essence the approach of the theology and religious studies academy is to understand religion as broad, complex, diffuse, variegated and pluralistic in both form and practice and whereas the legal perspective tends to focus on the theistic and belief-based forms and aspects of religion. Protection of law tends to be rights based with a main focus on the *forum internum* with relatively little protection given for the manifestation of belief, or the *forum externum*. It is here that tensions may become apparent since it is the latter aspect which encompasses the 'practice' of religion which may be of fundamental importance for people. Nevertheless, to date there has been relatively little jurisprudence in the realm of religion and healthcare compared with areas such as education and employment.

The ultimate dilemma that secular health care organisations often set for themselves is this: how can a health care provider balance one group's rights to exercise and proselytise their faith against the competing rights of another group who wish to be left alone? Perhaps the wrong question is being asked. If the question is framed as 'how can we best deliver responsive care that meets the needs of patients and society' the answer might be more enlightened.

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61 Racial Equality Directive 2000/43/EC.