Health Care Anal (2013) 21:189–192
DOI 10.1007/s10728-013-0246-3

EDITORIAL

Editorial: Religion and Health

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Published online: 11 April 2013
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For a variety of reasons, religion and faith, with their accompanying beliefs and practices, are once more becoming overtly visible in public life and discourse. Sometimes this increased visibility focuses on problems such as accommodating the needs of groups of service users or staff. Sometimes it ranges round the increased role that religion and faith might have in promoting and providing better health and care services. One thing seems to be clear; religion in all its many forms and manifestations is not something that can be ignored in publicly used and provided health services. It is here, and it is here to stay.

In fact, faith and religion never went away. If the blinkers of a certain kind of secularist Enlightenment rationalism are removed, it is clear that religion and faith communities have been integral to the philosophy, formulation, delivery and motivation for providing health care in the West. From the hospices of medieval Europe right up to the hospices inspired by the palliative care movement, religion has been a motivating and sometimes an inhibiting force. It has often been intrinsic not only to institutional and social provision, but also to personal motivation, practice and survival. The health service in most developed nations accommodates a variety of patient beliefs and practices, and draws professionals from an increasingly diverse range of backgrounds.

In the contemporary context of enormous religious pluralism in supposedly secular society and liberal, egalitarian health care structures, the time has come to reprise critically the nature, place and actual and potential position and contribution of religion and faith groups in all their aspects. Should religion, for example, be

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understood as contributing to or resisting effective biomedicine? Are faith groups a resource for, or an obstacle to, health as defined by government? Should religion be respected, nurtured, controlled, confined or promoted within publicly-provided health services? Is religion as formally understood to be regarded as toxic, tribal and divisive, while the less determined phenomenon of spirituality is more inclusive, universal and permissive? Do we know what religion is, anyway, or do we just hope to recognise what it is when we see it in practice? Encompassing all these questions is the overriding issue of faith, beliefs and practices varying across a wide spectrum within each tradition, making dualistic questions of 'either/or' almost redundant.

Given the continuing ubiquity and growing public salience of religion and faith at all levels of health care use and provision, it is surprising that there is not more understanding of its relative importance. In this special edition of *Health Care Analysis* we begin, selectively, to begin to open a wider debate about religion and health care to enable a broader, better informed discussion to ensue.

Fortunately, there is increasing interdisciplinary academic and practitioner interest in the relationship between religious beliefs and practices and health as communities becoming increasingly multicultural. This special edition of *Health Care Analysis* is the culmination of 3 years of interdisciplinary work at University of Birmingham amongst colleagues in the Religion and Health research group. Our membership includes academics and practitioners from law, theology, ethics, sociology, clinical medicine, chaplaincy public health policy and communication, many of whom are contributors to this edition.

In 2009 we hosted a national interdisciplinary workshop to discuss the challenges facing the health service with regard to accommodating and promoting religious beliefs of patients, clients and staff. It became clear at this event that boundaries in society and attitudes towards belief structures are becoming more fluid, difficult to define and increasingly challenging to understand. Whilst religion is a protected characteristic with the Equality Act 2010, there is genuine discussion about the degree of protection religious beliefs ought to be afforded, especially when they are in conflict with other protected characteristics. Within health care, the most high profile conflicts between religious beliefs and medical practice continue to be issues concerning the beginning and end of life, and the role of conscientious object amongst increasing numbers of health care professionals. But rather than offer further reflections on these high profile, well-publicised issues, this special edition seeks to move towards exploring the underlying issues which produce the tension so often expressed in high profile cases.

We begin by exploring the fundamental concepts of religion and religious beliefs, and the way in which these interact within the healthcare arena. Stephen Pattison, a theologian, introduces the conceptual debate around religion and spirituality, defining some of the parameters of the discussion. He outlines a range of assumptions and ignorance which often inadvertently create tension, showing how these can be overcome with greater awareness and a more nuanced understanding. Pattison argues for the importance of greater religious literacy and the importance of a mutual dialogue between health care providers and inhabitants of faith communities.

From a philosophical perspective, Peter Sedgwick then critiques the commodification of health and beliefs about health and care provision within an overall

instrumentalist approach in modern society. He describes an impoverished approach to health and ethical reflection, drawing on Oakeshott's work. He reminds us that genuine ethical reflection needs to accommodate all that is important to the individual, including religious beliefs and practices.

One of the most important lenses through which issues of health and religion are now being mediated and interpreted is that of law. The next two papers explore some of the legal challenges involved in accommodating religious beliefs within health care services. Academic lawyer Jean McHale situates her discussion of these both within the legal realm of protected rights and the pragmatic realm of increasing financial constraints. She explores the tension this creates and offers some suggestions on ways in which both sets of concerns can be accommodated. While most of the papers in this edition refer mainly to the UK, philosopher Peter West-Oram illustrates another aspect of legal consideration by exploring the US Patient Protection and Affordable Care Act. He examines the relationship between public health and private beliefs, especially where they concern conscientious objection. He argues that religious groups ought not to receive special exemption, especially when such requests compromise public health and important points of individual liberty.

The remaining papers in this edition focus on a range of more pragmatic ethical concerns that demonstrate the scope and breadth of the relations between religion, faith communities and health. One key area for the provision and development of religious and spiritual care and sensibility has been within chaplaincy, publicly paid for in many health care institutions including hospitals and community facilities. The provision of chaplaincy has traditionally been provided along religious denominational lines. Senior chaplaincy manager Chris Swift discusses the need for the restructuring of chaplaincy services in an increasingly diverse and less orthodox religious society. Caring for patients who have spiritual needs continues to be an important part of chaplaincy work. Swift argues that such care needs to be increasingly individualised within a multicultural society. He suggests research is needed to identify areas where chaplaincy can help both patients and the health service to provide the type of patient-centred care it strives to offer.

Assumptions are often made about the beliefs and practices of specific groups which may be unfamiliar to the majority population. And one of the most interesting things about these groups is that often their attitudes and practices are disparate, unfocussed and variable so that there is no one approach that fits all the members of any particular group, let alone the members of all groups designated 'faiths' or 'religions'. By way of a case study, Religious studies academic Jagbir Jhutti-Johal explores specific challenges in caring for members of the Sikh community as an illustration of the challenge of delivering care to a multicultural society. She outlines Sikh beliefs and practices which may or may not be shared by Sikh patients and staff, and situates the challenge within palliative care services and requests for non-alcohol and non-animal based medications.

Ethicist June Jones and Socio-linguist Andrew Shanks show how one particular religiously related issue, close to the sensitivities of a particular group, educes complex reactions and responses. There are difficult to deal with in public health care services as they centre around the priority that should be given to belief over

clinical practice. They use textual analysis to examine medical and nursing commentary in the aftermath of the Department of Health policy on 'bare below the elbows'. This had a direct impact on the ability of Muslim female staff to maintain modesty in the workplace. The analysis demonstrates that doctors and nurses related to the work-wear policy in different, illuminating ways. Contributors to the Nursing Times, in particular, express views which indicate unease with personal and religious beliefs being allegedly placed above concerns for patient safety.

This special edition, disparate and pluriform as it is, reflects some of the fascination and fragmentation of understanding and response that surrounds religion and faith in the provision of health care. We hope it will help to stimulate more analysis and deeper discussion, derived from a richer understanding of the complexities in providing health care to a society where religious beliefs play an increasing important role for some but remain a source of deep consternation for others. At stake here, in part, are important issues about the nature of being human, the ways in which health and illness are conceived and dealt with, and the ways in which humans work together to help each other to discover what living full, health lives, individually and in community, might mean. If religion and faith do not become part of a positive discussion, if they do not find a place of mutual critical understanding and respect within thinking about health, then they risk becoming perceived as part of the problems of modern society rather than as an integral part of a rich tapestry of understanding and practice that might benefit hard-pressed health care institutions and society generally, not just those who self-identify as 'religious' or members of faith communities.