Religion, culture, conscience and chaplaincy

Joshua Hordern

Abstract

Religion, belief and culture should be recognized as potential sources of moral purpose and personal strength in healthcare, enhancing the welfare of both clinicians and patients amidst the experience of ill-health, healing, suffering and dying. Communication between doctors and patients and between healthcare staff should attend sensitively to the welfare benefits of religion, belief and culture. Doctors should respect personal religious and cultural commitments, taking account of their significance for treatment and care preferences. Good doctors understand their own beliefs and those of others. They hold that patient welfare is best served by understanding the importance of religion, belief and culture to patients and colleagues. The sensitive navigation of differences between people's religions, beliefs and cultures is part of doctors' civic obligations and in the UK should follow the guidance of the General Medical Council and Department of Health and Social Care. In particular, apparent conflict between clinical judgement or normal practices and a patient's culture, religion and belief should be considered carefully. Doctors' own religion or culture may play an important role in promoting adherence to this good practice, complementing the role of chaplaincy. In all matters, doctors' conduct should be governed by the law and arrangements for conscientious objection that are in effect. The strongest ethical arguments in favour of conscientious objection provisions concern the moral integrity of professionals, the objectives and values of the medical profession, the nature of healthcare in liberal democracy and the welfare of patients. In practice, arguments mounted against conscientious objection have not been found persuasive.

Keywords Belief; chaplaincy; communication; compassion; conscientious objection; culture; democracy; equality; religion

Key points

- Religion, belief and culture are potential sources of moral purpose, welfare and personal strength for doctors and patients. A patient's spiritual, social and cultural background is important to history-taking, handover and healing. The presence of chaplaincy, complementing but not substituting for doctors' roles, underlines the important place of religion, culture and conscience in healthcare
- A patient's beliefs may not be in line with their religion or culture's mainstream nor should they necessarily be decisive in determining their treatment
- While a doctor's own religion, culture or beliefs should not adversely affect their patients, they may play a positive role in promoting patient care and adherence to good, lawful practice
- A doctor's expression of their beliefs can be helpful in promoting patient care but doctors should think carefully before articulating their own beliefs even if they are supported by law
- Doctors with a conscientious objection may explain the reason for it. However, they must not express disapproval and must inform patients of their rights to see another doctor. Accommodation of conscientious objection, within certain constraints, reflects healthcare institutions' civic obligation to afford democratic recognition and consideration to societies' multiple beliefs and practices

Recognizing the place of religion and culture in healthcare

Religion, belief and culture should be recognized in healthcare as potential sources of moral purpose and personal strength in people's lifelong journey amidst ill-health, healing, suffering and dying. They should not be viewed solely or primarily as sources of problems in the delivery and reception of care. Rather, religion, belief and culture can mutually enhance the welfare of both clinicians and patients amidst the everyday challenges of patient experience and clinical practice. The conduct of medical practice should be informed by discerning application of this general principle. In particular, communication between doctors and patients and between healthcare staff should attend sensitively to the possible welfare benefits of religion, belief and culture.

The General Medical Council (GMC) specifically recognizes the importance of understanding spiritual, social and cultural factors when taking a history, and of sharing relevant factors with colleagues when handing over (Good Medical Practice).[1] The Department of Health and Social Care (DHSC) for England and the Royal College of Psychiatrists emphasize the potential value of spirituality and prayer to patients' mental health and well-being. Moreover, the DHSC affirms that 'an individual's religion or beliefs are increasingly acknowledged as playing an important role in the overall healing process'.[2]

Equally, the GMC recognizes 'that personal beliefs and cultural practices are central to the lives of doctors [and] that all doctors have personal values that affect their day-to-day practice'. It does not 'wish to prevent doctors from practising in line with their beliefs and values' where they are consistent with overall GMC guidance.[3] With this in mind, a positive and open attitude to doctors' own religious and cultural beliefs is important for fostering a compassionate working environment. The general principle is that high-quality communication and ethics will be achieved by 'medical professionals whose particular view of the world — of what is good and right, of what makes moral

Joshua Hordern *MA PGDip MSt (Oxon) PhD (Edin) is the Professor of Christian Ethics in the Faculty of Theology and Religion, Healthcare Values Partnership, Harris Manchester College, University of Oxford, UK. His research interests include compassion in healthcare, medical professionalism, precision medicine and religion in public life. Competing interests: none declared.*

sense — forms them in the virtues that make them capable of practising medicine humanely'.[4]

Fair and respectful treatment

In short, healthcare institutions are an important context in which people's personal religious and cultural commitments must be recognized as worthy of democratic respect and dignity. This recognition is limited in two ways. First, recognition should not give rise to any unlawful action. Second, recognition does not entail the approval or endorsement of any particular belief.

The GMC emphasizes the obligation on doctors to 'treat patients fairly and with respect whatever their life choices and beliefs'.[1] This means that no patient should be disadvantaged because of their beliefs, but equally it does not mean that their beliefs should necessarily be decisive in determining their treatment. This is especially important where there is an apparent conflict between clinically indicated recommendations and a patient's religious or cultural commitments.

For example, an individual's interpretation of life and health may entail that suffering is not to be eliminated but rather endured and alleviated where possible. This view allows that suffering can be a time of learning, disclosure, even redemption and reconciliation. 'What it is for a person to suffer— and what constitutes compassion— are … contextualized' within traditions of morality, religion and culture.[5] By way of illustration, some Buddhist thought emphasizes maintaining consciousness in pain. This emphasis would have a practical impact on decisions about the choice and appropriateness of pain relief measures. Similarly, for many religions such as Christianity, life's journey does not end in death. Such belief is worthy of recognition and gives rise to treatment and care preferences that are relevant to a judgement of what is in the best interests of the patient.[2]

Understanding sensitivities

Apparent conflict between clinical judgement and culture, religion and belief should be approached sensitively and without assumptions about the significance of the belief to the patient's attitudes and preferences. An individual's beliefs may not be wholly in line with their religion or culture's normative teaching. Therefore doctors should be sensitive not only to the strength of a patient's belief, but also to the particular interpretation of religion or culture the individual holds.[2]

Paying attention to the nature of cultural or spiritual factors in taking a patient history therefore requires subtlety of thought. An open question such as 'Do you have a faith or belief that helps you at difficult times?' may provide the opportunity for patients to articulate their wishes and religious understanding. Listening carefully to the answer to such a question helps to avoid any assumptions being made that might adversely affect the patient's care. The experience of migrant populations who are particularly at risk of being misunderstood underlines the importance of sensitivity.

A doctor's own religion, culture or beliefs should not adversely affect patients,[2] either in the interpretation of a patient's religion or culture, or in the expression of the doctor's own beliefs. The GMC advises that 'You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress'.[3] This does not imply that a doctor may not express their own beliefs, but rather it forbids them doing so exploitatively or in ways likely to be distressing. There are commonly circumstances where a doctor's expression of their beliefs is appropriate in promoting patient care. For example, a doctor's personal understanding or experience of Hindu or Muslim rites can provide reassurance to patients or relatives concerned about following prescribed mourning or burial practices.[2]

Doctors should, however, think carefully before articulating their own beliefs even if they are supported by law. For example, a belief that brainstem death is actual death is in line with UK law. However, the articulation of such a belief by a doctor, especially in circumstances where organ donation is a factor, may be experienced as hostile by patients or their relatives, such as some Buddhists and Christians, who believe that only cardiorespiratory death is actual death.[3]

Similarly, a doctor may have a philosophical belief, again in line with UK law, that a pre-sentient fetus, especially one severely disabled and not compatible with life outside the womb, is not a child. But this belief should not adversely affect and cause distress to patients who may either be uncertain about or profoundly disagree with such a philosophical belief.[2] For example, many Christians, such as those whose views are represented by the Society for the Protection of Unborn Children, consider such a belief wrong and thus an inappropriate basis for care.

In many circumstances, it is difficult to know whether adverse effects will occur if doctors express their views. Much turns on the manner in which such matters arise and are discussed. Good doctors have an awareness of their own commitments and an understanding of the beliefs and commitments of others. They also believe that patient welfare is best served by taking seriously the possibility that religion, belief and culture may be important factors in patients' and colleagues' lives.

Legal obligations

In all matters, doctors' conduct should be governed by the legal regime in operation in their working context. UK equality legislation provides that services should be provided without discrimination based on protected characteristics (The UK Equality Act 2010 lists the following protected characteristics: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy or maternity, religion or belief, sex and sexual orientation.). For example, a religious belief that a particular sexual lifestyle or the use of alcohol is wrong should not adversely affect patients' care.

Such beliefs are themselves worthy of respect and protection in a plural, democratic society, are not unlawful and may be fully compatible with an affirmation of human dignity. Nonetheless, the GMC emphasizes that 'You must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition.'[1] Even if this is a doctor's deeply held belief, it should not translate into any implication of or expression of condemnation.

Religion or culture can itself play an important role in promoting adherence to such good practice. For example, a Christian

or other well-grounded commitment to the importance of mercy in human life can underpin some doctors' commitment to treat the health consequences of patients' damaging lifestyle choices without any condemnatory attitude towards the patient.[3] Such an attitude in no way suggests that treatment and recommendations should avoid providing information and advice so that a patient may decide to change their lifestyle and avoid actions deleterious to their future health.[1]

There are occasions when some interpretations of religion and cultural traditions may lead to unlawful actions such as carrying out or assisting in female genital mutilation. In such cases and depending on the circumstances, there are mandatory reporting and safeguarding procedures that doctors must carry out, as specified, in England, by the DHSC.

Conscientious objection

Conscientious objection is an important practice for understanding the role of religion, belief and culture in healthcare. Discussion of conscientious objections may be considered under two sections: the circumstances in which it is commonly taken to apply; and the ethical basis for its role in the medical profession.

The *circumstances* in which conscientious objection is available vary across legal jurisdictions. The GMC advises that a doctor who is making a patient aware of any conscientious objection 'must not imply or express disapproval' although they 'may wish to mention the reason'[3] for that conscientious objection. Doctors are therefore permitted to explain the reason for not carrying out a procedure but should do so bearing in mind the concerns about sensitivity discussed above. Doctors who have a conscientious objection:

> must tell [patients] about their right to see another doctor and make sure they have enough information to exercise that right … If it is not practical for a patient to arrange to see another doctor, [they] must make sure that arrangements are made for another suitably qualified colleague to take over [their] role.[1]

The act of making such arrangements is itself morally complicated and difficult to describe in universally agreed terms. Some would see it as involving complicity in a moral wrong, while others, who similarly hold, for example, abortion to be a wrong, would see making arrangements for another colleague to take over as reasonable.[5]

Common circumstances where a conscientious objection is acted upon currently include abortion, fertility treatments and the withdrawal of life-prolonging treatment from patients who lack capacity (or, more unusually, from patients with capacity). If physician-assisted suicide or euthanasia ever became legal in any part of the UK, the same provision for conscientious objection would seem appropriate. But any doctor who currently assists a suicide or performs an act of euthanasia, perhaps even citing a positive claim on their conscience to do so, would be acting illegally under UK law.

The *ethical basis* for conscientious objection in these kinds of circumstances, among others, has been well established for some time. However, various criticisms of arguments for conscientious objection by doctors have been mounted.[5]

The strongest ethical arguments in favour of conscientious objection provisions concern the moral integrity of professionals, the objectives and values of the medical profession, the nature of healthcare in liberal democracy and the welfare of patients.

First, a freedom for medical professionals to exercise a conscientious objection recognizes the importance of professionals' moral integrity. The argument is that, where a specific action would contravene beliefs or values that are central to a person's identity, such actions should not be required of them by the state or by their employer.

Second, the possibility of conscientious objection matters for the objectives and values of the medical profession. Doctors are required to have an independent, critical mind in order to interrogate the status quo and arrive at their own view about the ethics of any particular practices. Ensuring that there is space for thoughtful dissent encourages rigorous thought among doctors and improves the quality of healthcare culture.

Third, healthcare is not cut off from wider political society. Disagreements that exist in society and politics should not be silenced in healthcare practice. Even if law permits certain acts, such as *in vitro* fertilization, to take place, this does not end debate about the ethics of such acts. A protection of conscientious objection means that doctors can be representative of the diversity of opinion among the people they serve. Since conscientious objection typically concerns the kinds of matters about which universal ethical agreement is impossible, it would be wrong and undemocratic to impose controversial ethical beliefs — for example, about the ethical legitimacy of abortion — on doctors' consciences.

Fourth, since moral integrity and independence of mind can prevent unethical practices that are harmful to patients from continuing, and since some patients benefit from there being doctors who have a conscientious objection about the ethics of certain actions, conscientious objection can serve the welfare of patients.

Such justifications for conscientious objection have more recently been subject to criticism. Critics have typically argued that conscientious objection should not be tolerated in the medical profession, for a combination of the following reasons.

First, they argue that doctors should be required to provide, and patients should be entitled to receive, the full scope of legally permitted services within the practice of their field. Accordingly, when people consider training as doctors — especially certain kinds of doctors (e.g. obstetricians, gynaecologists) — they should only do so if their beliefs and values are compatible with carrying out that full range of legally permitted treatments.

Second, they believe that the kinds of beliefs and values that often give rise to a conscientious objection — especially religious ones — are merely arbitrary and untestable so have no place in a scientifically governed workplace or a liberal political society. Moreover, they think that giving space to such beliefs and values is liable to permit unjust discrimination.

Third, they observe that doctors' conscientious objections have the possible consequence of bringing about an inequity of provision of certain treatments, especially in areas of a country that are generally inaccessible or lacking in sufficient numbers of doctors. They emphasize that conscientious objection by some doctors will lead to a heavier workload for others.

Fourth, they reckon conscientious objection is incompatible with the profession of medicine, in which doctors should put patients' interests before their own, especially any interests in

avoiding actions that contravene 'arbitrary' beliefs. On this view, doctors who exercise a conscientious objection give an uncaring, ill-founded and self-protective response to the justified requests of patients in need.

In practice, these criticisms have rarely been found sufficiently persuasive to reduce protections for conscientious objection. Law and professional guidance, by permitting conscientious objection, already limit the expected requirements of doctors' actions vis-à-vis the scope of practice they undertake, while simultaneously providing protections against unjust discrimination based on race, sex or other characteristics. Moreover, moral integrity and independence of mind have been thought to be what society and law should require of doctors, rather than the silencing of dissent.

Judging well-formed religious or non-religious ethical views as 'arbitrary' has seemed to trivialize the interests and vocations of doctors, establishing an illiberal intolerance of some towards others. Similarly, describing those who exercise a conscientious objection as uncaring prejudges the substantive moral issue. Finally, logistical challenges in providing timely access to legally permitted services, while real in some cases, do not have the necessary ethical force to dislodge a commitment to protecting doctors' moral integrity. Nonetheless, they do call for careful thought about what constraints are necessary to make accommodation work in practice. In sum, those who approve of currently prevailing laws (e.g. permitting abortion) must respect the consciences of doctors who adhere to reasonable, legally permitted, if perhaps unpopular, ethical standards.

There are four key foci for further reflection on practice. The first concerns how to ensure conscientious objection is not allowed to 'run amok'.[5] Answering this in practice requires a process for determining which ethical standards should not be respected. For example, as noted earlier, refusing on religious grounds to treat a patient with an alcohol-related condition should not be permitted.

Second, since conscientious objection sustains important debates about the objectives and goals of medicine, it involves a contest about the moral integrity of not only individuals, but also the medical profession. That medicine is a site of a continual ethical debate is unsurprising, especially in liberal democracies. As such, conscientious objection may be approached positively in practice as providing opportunity for mature discussion about life's hardest questions.

Third, conscientious objection is an aspect of transitions in healthcare away from paternalism and towards a model of healthcare as a societal partnership between patients, the public and doctors (and other healthcare staff). A partnership model does not envisage patients as consumers claiming from any doctor an entitlement to whatever is legally available. Instead, it suggests neither an imposition of doctors' ethical views on patients nor that doctors should be compelled to put aside their values and beliefs.

Fourth, while some reject conscientious objection as unjust to patients, it is arguable that the status quo is unjust in a different sense. Doctors occupy a legally privileged place in much healthcare law. UK law protects conscientious objection for doctors but not nurses, midwives, care professionals and pharmacists. One UK legislative proposal (the Conscientious Objection (Medical Activities) Bill) sought to extend the protection of conscientious objection in this way. How conscience should be accommodated, within certain constraints,[5] across all healthcare staff remains a crucial and urgent question of justice.

Chaplaincy and the duties of a doctor

Some have argued that it is improper to expect that doctors (or, arguably, other healthcare staff) should be prepared to have conversations about religion and belief with patients, carers or colleagues. The standing of chaplaincy in a health service such as the UK NHS is a signal of the kind of ethos such a service is adopting with respect to this matter. The availability of chaplaincy is a vital sign that indicates understanding of the importance of spiritual, religious and belief-based needs among patients, carers and healthcare staff. This is a developing area in which chaplaincy is commonly multi-religious and often humanist, and in which a diversity of beliefs and absence of belief are important factors to which chaplaincy attends.

In some contexts, such as the NHS, chaplains are specifically contractually employed and paid by an NHS trust, thereby emphasizing that religious, spiritual, belief-based and pastoral needs, closely associated with matters of culture and conscience, are essential concerns in a health service. Such chaplaincy is integral to NHS Trusts' delivery of the NHS Standard Contract and adherence to the NHS Constitution, as the 2023 NHS Chaplaincy guidelines emphasize.

While the chaplaincy role is properly recognized, it remains vital for doctors' professional duties and identity that chaplaincy is seen as a partner with doctors, *complementing* rather than a *substituting for* doctors' appropriate understanding of and engagement in matters of religion, culture and conscience. Such humane, clinical competences remain important elements in compassionate health environments that sustain the healing process.

Democratic recognition as civic obligation

In conclusion, in communication and ethical discernment about religion and culture, doctors should seek to understand patients' and colleagues' beliefs, be sensitive to them in practice and comply with the law. It is a general principle that everyone deserves careful recognition and consideration of their conscientiously held beliefs and views in a democratic society. Healthcare institutions are vital environments for the realization of this principle in practice. Doctors should ask sensitively, gain information relevant to the care of patients and contribute where appropriate. In this way, doctors have a civic obligation to enhance a society's overall capacity to understand the multiple religious and cultural beliefs and practices that characterize its life. ◆

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