

Religion and Healthcare in the European Union

Policy issues and trends

Dimitrina Petrova and
Jarlath Clifford

**NEF Initiative on Religion
and Democracy in Europe**



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Preface

The 'Religion and Democracy in Europe' initiative

The Network of European Foundations (NEF) is an operational platform primarily committed to strengthening the potential for cooperation in the form of joint ventures between foundations at the European level. The NEF offers its members the opportunity to identify common goals and, as an open structure, to join forces with other foundations in Europe which may share similar concerns and objectives. It is also open to collaboration with the public and private sectors in developing its initiatives. Its areas of intervention to promote systemic social change include migration, European citizenship, support for the European integration process, youth empowerment and global European projects. The NEF is based in Brussels.

In January 2007 the NEF launched a special initiative on 'Religion and Democracy in Europe'. This was conducted with the participation of Hywel Ceri Jones, NEF European policy adviser, and was based on a partnership between several foundations, including: Van Leer Group Foundation (chair); Arcadia Trust; Barrow Cadbury Trust; Bernheim Foundation; Compagnia di San Paolo; Ford Foundation; Freudenberg Stiftung; King Baudouin Foundation; Riksbankens Jubileumsfond; Stefan Batory Foundation; and Volkswagen Stiftung.

The 'Religion and Democracy in Europe' initiative focuses on the relation between religion and democracy in European societies, covering both religion and the public domain and religion and the state. The aim is to contribute to a better-informed debate on the topic through seminars and research on related issues.

The first year of activities, which included a roundtable with specialized journalists and a series of youth debates, culminated in the publication through Alliance Publishing Trust of a compendium in which all the material presented in

an international symposium held in Jerusalem was collected. This publication is available on NEF's website at www.nefic.org.

The second phase of the 'Religion and Democracy in Europe' initiative (2008–9) aims to develop a series of reports addressing specific aspects of the interaction both between the state and religion and between religion and society. The reports are a mapping exercise of existing practices and different approaches to specific issues, set in the broader context of the religion and democracy debate. They target practitioners, policy-makers and civil society actors. The reports have been developed by acknowledged experts and address the following questions:

- *Religion and Healthcare in the European Union* Dimitrina Petrova and Jarlath Clifford
- *Teaching about Religions in European School Systems* Luce Pépin
- *Conflicts over Mosques in Europe* Stefano Allievi
- *Religion and Group-focused Enmity* Andreas Zick and Beate Küpper

Through this and other activities, the 'Religion and Democracy in Europe' initiative aims to open up and contribute to the public debate on issues of strategic importance for the future of European societies.

For more information

For more on NEF and its activities, please contact info@nefic.org.

For more on the 'Religion and Democracy in Europe' initiative, please contact rienvangendt@vanleergroupfoundation.nl (chairman) or cristina.pineda@nefic.org (coordinator).

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Introduction

Background

The influence of religion on the state has a rich history in Europe. More recently, the level of debate and discussion concerning this relationship has increased significantly.¹ One demonstration of this was the vocal reaction by both proponents and opponents of the proposal to include references to God and Christianity in the draft constitution of the European Union.²

Healthcare does not remain unaffected by this debate. In fact healthcare policy formulation is underscored by many tensions regarding the nature of the state, democracy and the influence of religion on state policy and practice. A challenge falls upon the secular European states: in proposing, adopting and implementing healthcare policy, they ought to draw on different – sometimes competing – values in order to accommodate communities in which a range of religious identities (as well as a lack of religion and irreligious value systems) are an important aspect of diversity.

Europe cannot escape the fact that religious observance very often requires followers of particular faiths to pursue certain ways of life. The religious

¹ See, for example, Council of Europe Recommendation 1396 on Religion and Democracy (para 44), which states: 'Due to globalization, national borders have lost some of their earlier relevance in matters of culture and religion. Increased transnationalism implies that national decision-making has more restricted means to control religious developments in their territory than earlier.' This debate has also occurred in other spheres, such as legal and social theory. See, for example, J Habermas, 'Religion in the public sphere', *European Journal of Philosophy*, vol 14:1, 2006, pp 1–25.

² See, for example, the comments made by German chancellor Angela Merkel reported by Bruno Waterfield in 'Merkel resurrects "holy" EU constitution row', *The Parliament*, 29 August 2006. Available at www.theparliament.com/latestnews/news-article/newsarticle/merkel-resurrects-holy-eu-constitution-row.

affiliation of the majority of the population in each country is reflected in the cultural approaches built into the healthcare system. At the same time, many aspects of minority religions' observance differ from 'accepted' societal norms – particularly in respect to European societal norms. Both the healthcare implications of such practices and European and national healthcare policies remain unclear in terms of what constitutes an acceptable and lawful approach to a broad range of healthcare issues. For example, a report by the European Commission admitted that in relation to certain facets of healthcare, such as mental health, the relationship with religion remains ambiguous and requires further research.³ Recent proposals by the European Commission relating to the adoption of a new anti-discrimination directive prohibiting discrimination on a number of grounds, including religion or belief in the area of health,⁴ suggest that a broader examination of these issues is due. The European Commission proposals raise questions regarding not only the need for protection from discrimination in healthcare on grounds of religion or belief, but also the extent to which religious freedom rights should be respected or limited in national healthcare, and the extent to which religious approaches to health issues affect the people of the European Union.

Purpose and conceptual framework

The purpose of this paper is to map out the policy issues and policy trends arising from the interaction of religion with the sphere of public health, in the context of the European Union member states. The overarching question it addresses is: how do the religious needs of the community, religious doctrine, and religious practices in the European Union region affect public health policy?

Taking stock of the broad scope of these challenge-laden issues, the paper will employ a concise conceptual framework of societal values to analyse the interaction between religion and healthcare. The main assumption of this study is that the concept of public interest, however complex and dynamic, should be the major general principle guiding public policy. Secondly, the articulation and defence of the public interest in a democratic society are achieved by weighing several different, sometimes situationally contradictory, values (or public goods), including equality and human rights, democracy, economic efficiency, public health and safety, morals, public order, social cohesion, national security

³ See *The State of Mental Health in the European Union*, European Commission, Directorate-General Health and Consumer Protection, 2004.

⁴ See 'Proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation', European Commission, 2 July 2008. Available at www.equalrightstrust.org/ertdocumentbank/europa%20directive.pdf.

and protection of the environment. This paper does not aim to examine the policy issues at the intersection of religion and health in the light of all these values. While referring to some, this paper assesses policy mainly in the light of equality and human rights, together with public health.

For policy-makers in a democratic society, the protection of and adherence to equality and human rights is a core obligation. The latter must be understood as implying also a positive obligation to promote equality and human rights, as opposed to just providing remedy for discrimination and other human-rights violations. Among the many rights that could potentially come into play at the intersection of health and religion, three are critical: (a) the right to equality and non-discrimination;⁵ (b) freedom of religion;⁶ and (c) the right to health.⁷ All three are understood as universal and interdependent principles. However, none of the three is an absolute legal norm, able to take precedence over other rights in all circumstances. The right to freedom of religion, for example, contains many important guarantees for the individual in the healthcare system (either as a patient or as a practitioner) and carries correlative obligations for the state; nonetheless, it can be legitimately limited by competing rights or other public goods.⁸ Consequently, religious freedom is one of many competing interests that the state has to weigh in order to provide an efficient, effective and accessible healthcare system. In spite of such limitations, the freedom of religion or belief, which also includes the freedom not to have a religion, is a strong moral, political and legal consideration for the state in developing healthcare policy.

The right to equality is both a legal right and an underpinning democratic principle of European Union states.⁹ Protection against discrimination not only extends to direct and indirect discrimination, but also covers harassment,

⁵ Provided by articles 2 and 26 of the International Covenant on Civil and Political Rights, article 2 (2) of the International Covenant on Economic, Social and Cultural Rights, and article 14 and protocol 12 of the European Convention on Human Rights, as well as a number of other binding treaties. A modern synthesis of the scattered and fragmented elements of the right to equality is found in: *Declaration of Principles on Equality*, Equal Rights Trust, London, 2008. Available at www.equalrightstrust.org/endorse/index.htm.

⁶ Freedom of religion is provided across all EU member states by article 18 of the International Covenant on Civil and Political Rights and article 9 of the European Convention on Human Rights.

⁷ The right to health is provided by article 12 of the International Covenant on Economic, Social and Cultural Rights and article 11 of the European Social Charter.

⁸ See, for example, article 9 (2) of the European Convention on Human Rights, which permits 'limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or the protection of the rights and freedoms of others'.

⁹ For a definition of this right, see principle 1 of the *Declaration of Principles on Equality* (see note 5 above), which reads: 'The right to equality is the right of all human beings to be equal in dignity, to be treated with respect and consideration and to participate on an equal basis with others in any area of economic, social, political, cultural or civil life. All human beings are equal before the law and have the right to equal protection and benefit of the law.'

victimization, incitement and instruction to discriminate – terms defined in a range of European Union directives. As with freedom of religion, however, the right to non-discrimination and the broader right to equality are not absolute. Legitimate limitations are imposed on this right, and not all distinctions on prohibited grounds, such as sex, race, religion, disability, age or sexual orientation, constitute discrimination. Distinctions are permitted if they have objective and reasonable justification in pursuit of a legitimate aim. This principle applies equally where policy makes distinctions on the basis of religion in healthcare provision.

The right to health under article 12 of the International Covenant on Economic, Social and Cultural Rights¹⁰ imposes a binding obligation on states to recognize the right of everyone to the 'enjoyment of the highest attainable standard of physical and mental health' and to 'take steps' to achieve the 'full realization' of this right. The Committee on Economic, Social and Cultural Rights has advised that within the right to health, healthcare provision must contain qualities such as availability, accessibility and acceptability.¹¹ In addition it has stated that:

Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party . . . All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, ie respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements.¹²

While human rights play a central role in framing health policy issues, it should be noted that these rights themselves contain within their definitions certain limitations based on important public goods, such as the nation's economy and the basic values of a democratic society, including secularism (the division of state and religious institutions). In delivering a healthcare system, the state is tasked to provide effective, efficient and accessible healthcare to its citizens and others within the constraints of finite health economies, while at the same time ensuring and fulfilling human rights. Economic costs, such as human and financial resources and infrastructure, cannot be reduced by pure political will. Similarly, healthcare policy-makers must appreciate and take account of the competing ideas regarding the place of religion in public spaces such as hospitals and healthcare centres in a secular democratic state. Without being exhaustive, this paper takes account of some of the core tensions: (a) between fundamental equality and human-rights principles including diversity, on the one hand, and

¹⁰ All EU member states are parties to this covenant.

¹¹ See *The right to the highest attainable standard of health*, general comment 14 on article 12, UN Committee on Economic, Social and Cultural Rights, 2000; UN Doc E/C.12/2000/4 (2000).

¹² *Ibid*, para 12.

the demands of efficient and cost-effective public-service delivery on the other; and (b) within the equality and human-rights framework, weighing rights against other (people's) rights.

It would be false to assume that core public goods are always in tension and do not also play complementary roles in a number of ways. However, as policy-making is more difficult when tensions have to be resolved, this paper focuses on some of the most controversial health policy issues. For example, is it acceptable that the religious beliefs of public officials influence their decision-making activities? Or, is it acceptable that a public health establishment in a secular democratic state be allowed to promote religion by the provision of religious services, eg to patients in public hospitals?

This study is meant as a starting point to encourage discussion, research and documentation of the effects that state healthcare policy has on different religious groups' healthcare outcomes, and the effects of religions on healthcare policies. It seeks to contribute to the modern liberal understanding of the relationship between the state and religion in healthcare policy, with a view to providing high-quality healthcare, ensuring religious freedom, and realizing the right to equality for everyone within the jurisdiction of the state.

Terms, scope, methodology and structure

'Religion' and 'belief' within this paper will not be limited to any specific list of denominations and will be understood in their broadest sense, inclusive of all world religions and of belief systems such as humanism or veganism. 'Healthcare' for the purposes of the paper is given a broad definition to include healthcare in hospitals, psychiatric facilities and care homes, general practice as well as specialized services.

Geographically, the study focuses on the member states of the European Union (EU). However, some member states have come under analysis more extensively than others, either in order to illustrate important policy approaches or because of a scarcity of information regarding some states. Nonetheless, the paper attempts to do justice to the religious diversity of the European Union. In addition, where appropriate, the paper draws upon practical experiences encountered outside the European Union.

While this study puts on the policy map many issues that have been identified at the intersection of public healthcare and religion, it should be noted that the list of issues remains open. Policy-makers should be cautioned that there will inevitably be other issues that arise or become acute, and that policies should contemplate that possibility and be created in such a way as to respond to them.

For example, in countries where healthcare policies make room for chaplains and other religious persons on healthcare teams in hospitals, proselytizing will predictably become a problem as religious diversity increases across the EU.

For certain stakeholders, religion appears a liability in developing healthcare policy, while for others it is viewed as a positive force in healthcare. This study does not take sides on the question whether religion plays a positive or a negative role in society in general or with regard to specific issues related to healthcare. When the study discusses challenges to healthcare policy posed by religion, this should not be read as implying that religion is itself necessarily a source of problems in society. While remaining neutral on the question of the value of religion as such, as well as of any particular religion or belief, the study assumes the value of ensuring people's right to be treated equally in healthcare regardless of their religious or other beliefs or lack thereof.

Throughout the paper, there has been an attempt to present the influence on healthcare policy of the various religions prevalent in the EU states so as to reflect the weight of these religions relative to one another. However, this has turned out to be a difficult task, mainly as a consequence of the lack of sufficient research. Overall, there is no doubt that Catholicism has influenced European culture to a larger degree than other religions, and this is bound to be reflected also in healthcare policy. It is also clear that Islamic and Jewish institutions and some Protestant churches have had very strong opinions on some of the issues covered in the study. These opinions may have had less influence on national regulations, but as they are important for many people, they are certainly relevant to this study. However, there is hardly any specialized research on the influence of the Orthodox Church on healthcare issues in Bulgaria, Greece or Romania.

In developing this study, the Equal Rights Trust followed a four-stage information-gathering methodology. The first stage involved preliminary desk research that led to the identification and framing of relevant health policy issues. The second stage consisted of an expert roundtable discussion held by the Equal Rights Trust on 17 September 2008. Participants included religion, medical, legal, sociological, policy and other experts from 13 EU member states, as well as experts from the US (see appendix A). The purpose of the roundtable meeting was twofold: (i) to identify the major thematic issues related to religion which were of concern to healthcare policy across Europe; and (ii) to add context to these issues by gaining practical insights into how religion has affected areas of healthcare. Information gathered from the roundtable discussion was supplemented by questionnaire responses from participants.¹³

¹³ Thirteen participants provided further information through questionnaire responses.

Information gathered through the third stage included responses to a different set of questionnaires sent to the ministries of health of EU member states.¹⁴ These questionnaires focused on the law and policy in place with regard to issues of health and religion within the national context of each member state; the mechanisms available to religious groups to express their healthcare concerns and issues; and the extent to which religious institutions contribute to healthcare policy nationally. In addition, a more detailed literature review of the current academic and policy-based research on the issues was conducted at the fourth stage of information-gathering.

Part 1 of this paper presents an overview of EU and national laws that aim to prevent discrimination on grounds of religion or belief in healthcare. It also makes reference to a number of public policy initiatives that operate nationally to address this issue. Part 2 examines the challenges posed by religion with respect to some aspects of national healthcare policy development. Part 3 deals with healthcare policy accommodating religious diversity, with a special focus on the influence of religion on policies regarding the operation of the hospital as the central public health institution. Issues concerning religious diversity within sexual and reproductive healthcare are analysed in part 4. Finally, part 5 presents some policy issues relating to religion within mental healthcare.

¹⁴ Only seven detailed responses had been received by March 2009 – from Bulgaria, Germany, Hungary, Poland, Spain, the Netherlands and the UK.

Summary of recommended main policy questions for further development

- 1 Under what circumstances is it justifiable for a belief-based exemption to outweigh a healthcare provider's medical duty to the patient?
- 2 Should barriers to euthanasia be addressed by legislation or by the court system?
- 3 If a patient lacks legal capacity to make an informed choice in refusing medical treatment such as organ transplantation or blood transfusion, to what extent should his/her religious background be considered in assessing the case?
- 4 Is it acceptable for hospitals to deny religious or spiritual services on secularist grounds? What are the advantages and disadvantages of maintaining a neutral meditation space in hospitals as compared with a faith space that seeks to accommodate all faiths?
- 5 Should a patient's request for a health practitioner of a particular sex be granted as an exercise of their rights to privacy and freedom of religion, or denied as unlawful discrimination on grounds of sex?
- 6 To what extent should training on cultural and religious issues be a requirement in the ongoing professional development of healthcare practitioners?
- 7 How should anti-discrimination law be applied to ensure that religion cannot be used to promote a distinction between 'innocent' and 'guilty' sufferers of HIV/AIDS?
- 8 When should belief-based exemptions to performing abortion be granted to healthcare practitioners, and what legal medical duties should be imposed (a) to ensure access to a woman's legal right to abortion; and (b) to secure the health of the woman irrespective of the belief-based exemption?
- 9 Should infertility be recognized as a standard medical condition deserving of treatment, and if yes, what provisions should be put in place to finance this treatment and how should policy address belief-based opposition?
- 10 How should national healthcare/medical curricula be adapted to cover diagnosis and treatment of religiously/culturally specific mental conditions such as possession by *Jinn*?
- 11 How can religious institutions most effectively participate in suicide-prevention programmes and to what extent should religious organizations be involved in national healthcare policy development in this area?

1 The legal and policy context in the European Union

1.1 European Union law

At present, European Union law does not offer protection from discrimination on grounds of religion or belief in healthcare. The proposals put forth by the European Commission address some of the concerns regarding the separation of different grounds of discrimination within EU law, which contributed to the creation of a hierarchy of protection.¹⁵ In particular, there has been concern expressed regarding the fragmentation of the grounds 'religion or belief' and 'racial or ethnic origin'.¹⁶ The existing protection gap is a consequence of the difference in scope of Council Directive 2000/43/EC,¹⁷ which protects against discrimination on grounds of racial or ethnic origin in many areas including healthcare, and Council Directive 2000/78/EC,¹⁸ which protects against discrimination on grounds of religion or belief, but only within employment. Therefore, while article 13 of the Treaty of the European Union provides a legal basis to protect against discrimination in healthcare on grounds of religion or belief, no legal requirement is currently in place.

In addition, the right to freedom of religion and the right to health are not presently guaranteed by EU law itself. While these rights are guaranteed within

¹⁵ See note 4 above.

¹⁶ M Miguel Sierra, I Chopin, E Jenaro Tejada and I Carles-Berkowitz, *Towards Equal Treatment: Transposing the Directive – analysis and proposals*, European Network Against Racism, March 2002.

¹⁷ Council of the European Union, Council Directive 2000/43/EC of 29 June 2000, implementing the principle of equal treatment between persons irrespective of racial or ethnic origin.

¹⁸ Council of the European Union, Council Directive 2000/78/EC of 27 November 2000, establishing a general framework for equal treatment in employment and occupation.

the Charter of Fundamental Rights of the European Union, this charter is not in force and has no legal effect on member states. In spite of this, freedom of religion and the right to health are protected through strong international human-rights standards, which are enforced through instruments available in the Council of Europe and the United Nations.

1.2 National law and policy

At the national level, constitutional and/or statutory provisions in all EU member states guarantee freedom of religion, as well as non-discrimination. Article 14 of the Spanish constitution¹⁹ provides the right to equality before the law and protection for all persons from discrimination on grounds of religion. Similarly, the constitutions of Bulgaria,²⁰ Hungary,²¹ Italy,²² the Netherlands²³ and Poland²⁴ provide for equality before the law irrespective of religion or belief. Similar constitutional protections provide a legal basis for preventing discrimination on grounds of religion or belief in a number of areas, including healthcare in most EU member states. Article 374 of Romanian Law no 95/2006 regarding reform in the healthcare sector stipulates that medical decisions will be made on the basis of the interests and rights of patients and without discrimination. This law provides that medical aid and medical treatment in situations of medical emergency will be provided without any discrimination related to religion. Hungarian legislation aims to ensure equal access to healthcare for all members of society and to preserve their human dignity and identity.²⁵ Interestingly, article 11(6) of Act CLIV of 1997 on Health ensures the rights of patients to be able to keep in contact with a representative of the church corresponding to their religious belief and to freely engage in acts of worship. More generally, Hungarian law requires that the principle of equal treatment is observed by entities providing healthcare.²⁶ The Hungarian and Romanian legal provisions are not unique. A broad range of EU member

¹⁹ Enacted on 29 December 1978 after a referendum on 6 December 1978.

²⁰ Article 6 of the Constitution of Bulgaria.

²¹ Article 70/A of the Constitution of Hungary.

²² Article 3 of the Constitution of Italy.

²³ Article 1 of the Constitution of the Kingdom of the Netherlands.

²⁴ Article 32(2) of the Constitution of Poland, which states: 'No one shall be discriminated against in political, social or economic life for any reason whatsoever.'

²⁵ Act CLIV of 1997 on Health (promulgated on 23 December 1997).

²⁶ Article 4 of Act CXXV of 2003 on Equal Treatment and Promotion of Equal Opportunities (promulgated on 28 December 2003). Article 8 of this Act provides that the scope of protection extends to religious or ideological conviction.

states have similar legal provisions that aim to protect individuals from discrimination in the healthcare sector on grounds of religion or belief.²⁷

A number of EU member states have implemented legislation that recognizes and guarantees the right to health. Obligations relating to the fulfilment of the right to health are guaranteed through various mechanisms within member states. Some member states have in place constitutional protections. The constitution of Belgium provides that everyone has 'the right to social security, to health care and to social, medical, and legal aid' and 'the right to enjoy the protection of a healthy environment'.²⁸ According to article 70/D of the Hungarian constitution, '[e]veryone living in the territory of the Republic of Hungary has the right to the highest possible level of physical and mental health.' Protection of the right to health is similarly guaranteed in the constitutions of, among others, Estonia (article 28), Italy (article 32), Poland (article 68), Portugal (article 64), Romania (article 33), Slovakia (article 40), Slovenia (article 51) and Spain (article 43(1)). Regarding state obligations, article 43 of the Spanish constitution establishes a state duty to protect citizens' health. The guarantees bestowed by such constitutional law transfer a state's international legal obligations into national law. While some EU member states have no similar constitutional protections, the right to health has been guaranteed through social policy and the implementation of healthcare institutions which provide free public healthcare, as in the case of the National Health Service (NHS) in the UK.

Some member states also regulate healthcare through comprehensive national policy strategies. For example, in realizing a constitutional right to health, Bulgaria has adopted a new 'National Health Strategy 2008–13', which reflects the new realities, priorities and challenges posed by the new economic order and the country's membership of the European Union.²⁹ The German Social Code (section 2, paragraph 3 of book XI) provides that the religious needs of people in long-term care have to be met; in particular, this policy stresses the importance of pastoral care and clinical support for those in residential and long-term care.³⁰ UK health policy operates through the NHS Strategy ('National Health Service Plan: A Plan for Investment, A Plan for Reform', published in July 2000). It requires that a key

²⁷ For example, in Poland article 134 of the Act on health services financed from public funds of 27 August 2004 (*Journal of Laws*, no 210, item 2135 as amended) stipulates that the National Health Fund is under the obligation to ensure equal treatment of all service providers applying for contracts to provide healthcare services. In the case of the conclusion of such contracts, service providers owned by churches or other religious organizations are under the obligation to treat all their patients entitled to healthcare services under the Act equally, regardless of their religious affiliation, in the scope of their activity connected with the execution of contracts concluded with the National Health Fund.

²⁸ Article 23 of the Belgian constitution.

²⁹ Letter from the Bulgarian ministry of health to the Equal Rights Trust, received 9 October 2009.

³⁰ Letter from the German ministry of health to the Equal Rights Trust, dated 2 October 2008.

part of reforming the NHS and social services is the need to ensure the delivery of fair, appropriate and equitable access to health services for all people. Similarly, the NHS and social services must take into account the personal needs (such as religious, cultural and dietary requirements) of the multicultural and spiritually diverse communities they serve by ensuring that all services are delivered appropriately to all service users and staff. In view of this policy requirement, the UK has developed guidelines for providers in order to help them meet the religious needs of those in their care.³¹ In contrast, the Dutch ministry of health's national healthcare policy is aimed at decreasing the 'social-economical' differences of patients, rather than addressing issues of healthcare inequalities as related to religious differences.³²

National mechanisms for implementing effective healthcare policies in the context of modern European democracies wishing to accommodate religious diversity must balance the right to health, the right to equality and non-discrimination and the right to freedom of religion with other considerations such as available resources. Both legislation and policy should be employed as parallel vehicles to achieve this balance. This dual approach is necessary to overcome emerging challenges and to ensure that the principles enshrined in legislative and constitutional provisions are supported by adequate economic and social policy resources.

³¹ Letter from the UK ministry of health to the Equal Rights Trust, dated 12 October 2008. See also Department of Health, 'NHS chaplaincy meeting the spiritual and religious needs of patients', 4 November 2003.

³² Letter from the Dutch ministry of health to the Equal Rights Trust, received 22 January 2009.

2 The influence of religion on national healthcare policy development

This section deals with some sensitive general healthcare issues that have been most strongly influenced by religion, in the context of EU member states. While it would be a considerable task to analyse in detail the many ways religion influences healthcare policy in EU member states, the focus here will be on issues encountered in empirical research that have recently bedevilled policy formulation. To be sure, in developing healthcare policy, state actors are bound by numerous commitments other than health, including other human rights, scientific progress, ethics and cost-effectiveness. Religion, too, plays a role in several ways.

Firstly, the religious or other beliefs of policy-makers influence policy. This should be acknowledged, as should the elusiveness of the ideals of neutrality and impartiality. Secondly, as a fact of communal life, religion (along with other factors) shapes the political agendas of politicians, regardless of their own religious affiliations, in their efforts to act upon people's real-life needs. Thirdly, religion often causes a polarization of certain issues in the public sphere—predominantly those issues whose very nature is so fused with existential, philosophical and religious meaning that they have come to epitomize the set of attitudes of the community. Such issues reflect the cultural, political, religious and other oppositions and diversities among contemporaries in a given culture. In a democratic society, such controversial issues should be welcomed as an invitation for deliberation and as an opportunity to negotiate sophisticated modern policies.

In practice, it is especially on the most controversial issues that the resulting policies are most influenced by religion. Lester and Uccellari illustrate the significance of religion's influence:

The religious lobby, drawn from the three Abrahamic religions, has exerted powerful pressure and successfully influenced the outcome of proposed law reforms on the termination of pregnancies, medically assisted suicide and human fertilization. The secular lobby would argue that law-making in these areas should be based on evidence and the wider public interest, not on religious ideology and dogma. They regret the concessions made to faith groups in the recent past.³³

The role of religion in a given state, the extent of freedom of religion and the specific nature of secularism are important factors to take into account when considering the influence of religion on national healthcare policy development. These factors must inform any analysis of how states have reacted to the influence of religion on healthcare policy. In light of these considerations, it is necessary to highlight the influence of religion on national healthcare policy and practice in respect of three issues: (a) conflict of duty in health-service provision; (b) euthanasia; and (c) belief-based patient decision.

2.1 Conflict of duty in health-service provision

Conflict of duty in the provision of health services³⁴ occurs where a healthcare provider refuses to treat individuals in a certain way because of an objection, based on their own religious or other belief, to (a) the treatment for which the patient has been referred to them or which the patient has requested; or (b) the patient as such—for example, because of the sex, sexual orientation or gender identity of the patient. Two immediate questions need to be asked. Does national healthcare policy across EU member states permit practitioners and other healthcare providers to refuse treatment or healthcare services for reasons of conflict of duty?

If yes, what scope, limits and safeguards underscore national healthcare policies permitting belief-based exemption from performing certain services?

³³ A Lester and P Uccellari, 'Extending the equality duty to religion, conscience and belief: proceed with caution', *European Human Rights Law Review*, no. 5, 2008, p 568.

³⁴ This issue has also been termed 'religious conscientious objection'—see, for example, EU Network of Independent Experts on Fundamental Rights, *Opinion no. 4—2005; The Right to Conscientious Objection and the Conclusion by EU Member States of Concordats with the Holy See*. To avoid confusion with the more widespread meaning of this phrase, which includes refusal to carry arms on grounds of conscience, this study uses the term 'conflict of duty'. The term is meant to express a phenomenon, not limited to the area of healthcare provision, where a public servant or a professional seeks exemption for herself/himself from personally participating in the delivery of certain services with which they disagree on grounds of religious, moral or other belief. For example, one can describe as 'conflict of duty' the refusal of administrative personnel to register a marriage between same-sex couples; or the refusal of a clinical assistant to carry out tasks related to animal testing in their workplace. In this study, 'conflict of duty' is intended, in the context of healthcare, to mean a conflict, for a person whose professional duty includes the provision of healthcare services, between performing their duty as would normally be required by their job description and their conscience, including their religious or other belief.

2.1.1 Does national healthcare policy permit belief-based exemption?

The answer to the first question is generally affirmative.³⁵ In many EU states healthcare law and policy exempt practitioners from undertaking a range of procedures which, for reasons of religious conscience, they might refuse to perform. One prominent illustration of this phenomenon, which drew widespread political attention, was the signing of a Draft Treaty between the Slovak Republic and the Holy See (the Vatican) in November 2000. Article 4 (1) (b) of the Basic Treaty stated:

- (1) The right to exercise objection of conscience shall apply to:
- (b) performing certain acts in the area of healthcare, in particular, acts related to artificial abortion, artificial or assisted fertilization, experiments with and handling of human organs, human embryos and human sex cells, euthanasia, cloning, sterilization or contraception.³⁶

This provision demonstrates the attempt by the Vatican to influence the development of belief-based exemption in Slovak healthcare policy. It also demonstrates the willingness of the Slovak authorities to accommodate the religious conscience of healthcare practitioners. It should be noted, however, that in response to international political pressure,³⁷ this Basic Treaty never came into effect.³⁸ Nonetheless, its signature by Slovakia has been interpreted as a clear departure from the principle of secularism in the public sphere, including healthcare. Slovakia's willingness to enter into what in effect would have amounted to a legally binding agreement with the Catholic Church is unique neither in terms of international relations,³⁹ nor (as appendix B shows) in terms of guaranteeing a legal right to belief-based exemption by member states of the European Union.

2.1.2 Scope and limits of belief-based exemption in healthcare

The answer to the second question is not so forthcoming. From appendix B, it appears that laws and policies permitting belief-based exemption are restricted

³⁵ See appendix B, outlining belief-based exemptions within EU member states' national law and policy.

³⁶ Text of Draft Treaty available at www.consciencelaws.org/Proposed-Conscience-Laws/International/IntI01.html.

³⁷ This includes an intervening opinion by the EU Network of Independent Experts on Fundamental Rights. See *Opinion no. 4 – 2005; The Right to Conscientious Objection and the Conclusion by EU Member States of Concordats with the Holy See*, EU Network of Independent Experts on Fundamental Rights, 14 December 2005. Available at http://ec.europa.eu/justice_home/cfr_cdf/doc/avis/2005_4_en.pdf.

³⁸ See J Plitchtova and M Petrijanosova, 'Freedom of religion, institution of conscientious objection and political practice in post-communist Slovakia', *Human Affairs*, vol 18, 2008, pp 37–51.

³⁹ For example, some EU member states, including Italy and Portugal, have similar binding agreements with the Holy See.

to certain practices and procedures. One policy approach which appears to be emerging across national policies is that a practitioner's religious belief will only give rise to belief-based exemption if the practice or procedure in question relates to the most fundamental aspect of that person's belief. Therefore, it is deemed justifiable to permit belief-based exemption in laws regulating abortion⁴⁰ or euthanasia.⁴¹ Issues such as abortion and euthanasia concern fundamental values, and as such are (i) inherently controversial – in that each such fundamental value is a common locus of opposing social-political positions in the communicative space; and (ii) powerfully emotive – arousing strong views anchored in deep-felt attitudes, lived experience and conceptions about the meaning of life. It is such value-laden issues that have usually attracted religious judgment and which, once they have entered the public discourse, have historically tended to move to the core of a generation's religious identity.

The EU Network of Independent Experts on Fundamental Rights suggests that as part of their obligations under article 9 of the European Convention on Human Rights,⁴² states can offer certain reasonable accommodations which are viewed as a 'correlative obligation' to 'religious conscientious objection'. However, these accommodations are not unlimited.⁴³ The extent to which it is legitimate to apply a policy of reasonable accommodation and the extent to which limits can be placed on belief-based exemption should be considered by states adopting this healthcare policy approach. It has been suggested, for instance, that medical and health issues that do not require an individual to violate fundamental religious tenets should not be accommodated.

One legal case which illustrates this approach is *Pichon and Sajour v. France*.⁴⁴ The applicant was a pharmacist who refused to sell contraceptives to three women who had received a doctor's prescription. The women lodged a civil-party claim. The applicant argued⁴⁵ before the Bordeaux Police Court that refusal to sell was justified on the legitimate ground that no statutory provision required pharmacists to supply contraceptives or abortifacients. The Bordeaux Police Court, however, drew a distinction between the sale of contraceptives and the sale of abortifacients – the former not being a legitimate basis for belief-based refusal to sell. Handing down its decision, the Bordeaux Police Court stated:

⁴⁰ See, for example, articles 97 (2) and 97 (3) of the Austrian Criminal Code; section 10 (2) of the Danish Consolidated Act on Induced Abortion; article 9 of Italian Law 194 (22 May 1978) on Abortion.

⁴¹ See section 14 of the Belgian Act on Euthanasia 2002.

⁴² Article 9 provides the right to freedom of thought, conscience and religion.

⁴³ See note 37 above.

⁴⁴ *Pichon and Sajour v. France*, European Court of Human Rights, application number 49853/99, judgment of 2 October 2001.

⁴⁵ Relying on article L 645 of the Public Health Code.

Ethical or religious principles are not legitimate grounds to refuse to sell a contraceptive. There is no legislation which authorizes pharmacists to refuse to supply contraceptives, unlike the provisions relating to doctors, midwives and nurses as regards the termination of pregnancy . . . Consequently, as long as the pharmacist is not expected to play an active part in manufacturing the product, moral grounds cannot absolve anyone from the obligation to sell imposed on all traders by the law.⁴⁶

Appealing to the European Court of Human Rights, the applicants argued that refusal to sell contraceptives to the women was protected by freedom of religion provided by article 9 of the European Convention on Human Rights. The Court declared the application inadmissible and explained:

[I]n safeguarding this personal domain, Article 9 of the Convention does not always guarantee the right to behave in public in a manner governed by that belief. The word 'practice' used in Article 9 (1) does not denote each and every act or form of behaviour motivated or inspired by a religion or a belief.⁴⁷

The Court's approach contrasts with the Irish approach which expressly absolves any person from having to sell contraceptives.⁴⁸

Comparative example 1: the United States

In the United States, the issue of conflict of duty is currently under debate, as President Obama is in the process of repealing what is often referred to as the 'conscience rule', ie the practice of protecting practitioners who refuse to perform certain procedures because of their religious beliefs. US courts have recently examined 'religious objection' in the decision of *North Coast Women's Care Medical Care Group, Inc, et al, v. San Diego County Superior Court S 142892. Ct App 4/1 D045438*. In this case, triggered by medical practitioners' refusal to assist lesbians in conceiving a child, the Californian Supreme Court rejected the argument that the right to religious freedom and free speech, as guaranteed by both federal and state law, exempted a medical clinic's physicians from complying with the prohibition against discrimination on grounds of sexual orientation set out in the California Unruh Civil Rights Act.

⁴⁶ Judgment of the Bordeaux Police Court of 16 November 1995. See <http://cmiskp.echr.coe.int/tkp197/viewhbkm.asp?sessionId=2936231&skin=hudoc-en&action=html&table=F69A27FD8FB86142BF01C1166DEA398649&key=24006&highlight>.

⁴⁷ See note 44 above; translated from French.

⁴⁸ Clause 11 of the Health (Family Planning) Act 1979.

Comparative example 1 illustrates how other jurisdictions have imposed limits to the right to belief-based exemption by weighing it against other fundamental rights, such as the right to non-discrimination. Recently, McColgan has argued that requiring the accommodation of practices or beliefs in employment situations which are categorized as 'religious' tends to perpetuate practices and beliefs which are problematic on equality and other grounds.⁴⁹ On this point the EU Network of Independent Experts on Fundamental Rights suggests:

[T]he right to religious conscientious objection may conflict with other rights ... In such circumstances, an adequate balance must be struck between these conflicting requirements, which may not lead to one right being sacrificed to another.⁵⁰

Thus, achieving a balance is difficult in practice and less clear when the issues at hand invoke tensions regarding non-fundamental, merely accessorial religious beliefs. In a related case of conflict of duty, a debate in the Netherlands questioned the extent to which medical students can opt out of working with people of the opposite sex. Similarly, in the UK Muslim medical students have refused to attend lectures or answer examination questions on alcohol-related topics, as well as topics concerning sexually transmitted disease, because it reportedly offended their religious beliefs.⁵¹ Rather than accepting the religious objections of these students, the British Medical Council, the General Medical Association and many Islamic scholars rebuked them.⁵² It seems that UK healthcare policy and healthcare institutions have established limits on belief-based exemption, wherein refusal to develop the necessary knowledge and capacity, which would not be possible without engaging in the objectionable activity, is not allowed. In adopting this stance UK healthcare policy, in a similar manner to the Bordeaux court approach described above, distinguishes between (a) conflict of duty related to fundamental religious beliefs which it is reasonable to accommodate, and (b) conflict of duty related to accessorial religious beliefs which it is not reasonable to accommodate. The subjectivity involved in deciding what constitutes a fundamental belief as opposed to a merely accessorial belief does not help to create clear and effective policy. What is fundamental to one believer may be different from what is fundamental to another in the same religion, or differ from the official doctrine, yet the individual right to freedom of religion or belief does not differentiate between the nature, depth or genuineness of beliefs. Within each

⁴⁹ A McColgan, 'Class wars? Religion and (in)equality in the workplace', *Industrial Law Journal*, vol 38 (1), 2009, pp 1–29.

⁵⁰ See note 34 above.

⁵¹ See D Foggo and A Taher, 'Muslim medical students get picky', *Sunday Times*, 7 October 2007. Available at www.timesonline.co.uk/tol/news/uk/health/article2603966.ece?Submitted=true.

⁵² *Ibid.*

tradition there is room for personal interpretation of religious belief and practice. When a healthcare practitioner has a bona fide religious belief that is sincerely and consistently held, it ought not to be dismissed on the ground that someone else determines that it is not 'proper' doctrine. However, this makes even more problematic the introduction of a fundamentality test in determining what beliefs can be the basis of exemptions. In any case, however complicated the issue of belief-based exemptions may be, there is an urgent need for policy solutions to these evolving challenges.

2.1.3 Safeguards

Of great significance in permitting belief-based exemption is the challenge of determining appropriate safeguards and mechanisms to ensure that those patients who are affected are not unduly disadvantaged or denied access to the healthcare services to which they are legally entitled. The inclusion of such safeguards is necessary to ensure fairness in healthcare policy and is especially important when formulating healthcare policy on issues such as euthanasia and abortion. As one commentator has written, 'Refusing to provide medical care for legitimate conscience or religious reasons may be legal, and possibly even almost ethical, but it should not be a blank check.'⁵³

The UK experience once again draws non-discrimination considerations into the analysis. Religiously motivated sex and gender discrimination is a central overarching issue in the nexus of religion and healthcare and is the common denominator of a number of practices where religion requires differentiation between the sexes. From the point of view of equality policy, the question in each case is whether the differentiation can be objectively and reasonably justified; if the answer is negative, differentiation would constitute unfair discrimination and should be prohibited.

In accordance with this assumption, sections 2.2.3 and 4.2.3 below offer a more detailed justification of the need for effective safeguards when permitting belief-based exemption.

2.2 Euthanasia

Religion, and in particular Catholicism, has been instrumental in framing the debate on euthanasia across Europe. The Vatican's position is explained in its 'Declaration on euthanasia':

⁵³ B Patsner, 'Refusing to treat: are there limits to physician "conscience" claims?', *Health Law Perspectives*, University of Houston's Health Law and Policy Institute, August 2008. Available at [www.law.uh.edu/healthlaw/perspectives/2008/\(BP\)%20conscience.pdf](http://www.law.uh.edu/healthlaw/perspectives/2008/(BP)%20conscience.pdf).

It is necessary to state firmly once more that nothing and no one can in any way permit the killing of an innocent human being, whether a foetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying. Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly, nor can any authority legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity.⁵⁴

The Vatican's objection to euthanasia, rooted in deeper concerns regarding the sanctity of life and the nature of human dignity, applies definitively to active euthanasia.⁵⁵ Less obvious is whether the Vatican equally condemns passive euthanasia.⁵⁶ A strict reading of the Vatican's doctrine suggests that passive euthanasia must also be condemned.⁵⁷ But other commentators argue that the Catholic Church rejects futile life support.⁵⁸ In any case, the strong association with the right to life which underscores Catholic opposition has shaped and influenced national policy in this area throughout Europe.⁵⁹

The Catholic position on the sanctity of life, which is central to the Vatican's position on euthanasia, puts the 'sacredness of life' over quality-of-life considerations. Quality-of-life proponents argue that life is only worth living as long as it maintains an adequate level of quality.⁶⁰ However, others have suggested

⁵⁴ Sacred Congregation for the Doctrine of the Faith, 'Declaration on euthanasia', 5 May 1980. Available at www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

⁵⁵ The term 'active euthanasia' is used to describe a type of euthanasia which consists in taking specific steps to cause the patient's death.

⁵⁶ The term 'passive euthanasia' is used to describe the withdrawal of medical treatment with the aim of ending life. The term is sometimes dismissed as misleading and 'withdrawal of life-support equipment or treatment' is used instead.

⁵⁷ Congregation for the Doctrine of the Faith, 'Responses to certain questions of the United States Conference of Catholic Bishops concerning artificial nutrition and hydration', 1 August 2007. Available at www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html. This response states that '[a] patient in a "permanent vegetative state" is a person with fundamental human dignity and must, therefore, receive ordinary and proportionate care which includes, in principle, the administration of water and food even by artificial means'.

⁵⁸ See J C Siurana, I Tamarit and L DeTienda, 'Ethical, religious and legal arguments in the current debate over euthanasia in Spain', *Human Affairs*, vol 18, 2008, pp 52–66.

⁵⁹ In 2007, for example, the then Polish deputy justice minister Andrzej Duda, acting on behalf of Poland, blocked moves for a 'European Day against the Death Penalty' and urged the promotion of the right to life and highlighting issues such as abortion and euthanasia instead. See, for example, 'Poland goes it alone: Warsaw blocks European anti-death penalty day', *Spiegel Online International*, 19 September 2007. Available at www.spiegel.de/international/europe/0,1518,506644,00.html.

⁶⁰ See note 58 above.

that this argument borrows too much from utilitarian ideology in not only viewing suffering as absurd but failing to find meaning in suffering.⁶¹ The mainstream Catholic position is also motivated by some practical concerns—for example, the fear that legalization of euthanasia may exert pressure on the terminally ill to prematurely end their life in order to lessen the pain and suffering of family members and loved ones.

Appendix C illustrates the national policy positions across several European Union states on active and passive euthanasia.

2.2.1 Active euthanasia

In the European Union, only the Netherlands,⁶² Belgium⁶³ and Luxembourg⁶⁴ permit active euthanasia; indeed, the European Court of Human Rights has rejected appeals to recognize the right to die as part of the right to life.⁶⁵ The Dutch law on euthanasia, which has been described as a law of necessity responding to the unregulated unofficial practice of euthanasia in the Netherlands, was adopted in 2002.⁶⁶ De Haan points out that both the practice of euthanasia and the subsequent law adopted in the Netherlands were fiercely opposed in religious circles.⁶⁷ Similarly, a law adopted in early 2008 on euthanasia and assisted suicide in Luxembourg was a source of bitter political contention. In a country where a high percentage of citizens are Catholic, the Catholic Church was highly critical and was reported to have wholly condemned the passing of this law.⁶⁸ In the course of its enactment, Grand Duke Henri of Luxembourg, the head of state who was vehemently opposed to euthanasia on religious grounds, said he would veto the law. However, he was stripped of certain constitutional powers that removed his executive power to veto laws passed by parliament.⁶⁹ By contrast, the Constitutional

⁶¹ Ibid.

⁶² Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002.

⁶³ Act Concerning Euthanasia 2002.

⁶⁴ Code de la Santé. Volume II, Professions de la Santé. A. Médecins, médecins-dentistes et médecins vétérinaires. II. Règlements d'Exécution. Arrêté ministériel du 7 juillet 2005 approuvant le code de déontologie des professions de médecin et de médecin-dentiste édicté par le Collège Médical. Chapitre III Les Devoirs généraux des médecins. Articles 40–4. Available at www.legilux.public.lu/leg/textescoordonnes/compilation/code_sante/17_PROFESSIONS/A_MEDECINS/II_REGLEMENTS_EXECUTION.pdf.

⁶⁵ See European Court of Human Rights, *Pretty v. the United Kingdom*, application no. 2346/02, judgment of 29 April 2002.

⁶⁶ M Adams and H Nys, 'Comparative reflections on the Belgium Euthanasia Act 2002', *Medical Law Review*, vol 11, Autumn 2003, pp 353–76.

⁶⁷ J De Haan, 'The new Dutch law on euthanasia', *Medical Law Review*, vol 10, 2002, pp 57–75.

⁶⁸ See J Ponthus, 'Luxembourg parliament adopts euthanasia law', *Reuters*, 20 February 2008. Available at www.reuters.com/article/worldNews/jidUSL2011983320080220.

⁶⁹ See D Charter, 'Grand Duke Henri of Luxembourg opposes euthanasia and loses power', *The Times*, 4 December 2008. Available at www.timesonline.co.uk/tol/news/world/europe/article5282483.ece.

Court of Hungary rejected a petition which claimed that Act CLIV of 1997 on Health restricted in an unconstitutional manner the right to self-determination of terminally ill patients by not allowing termination of their lives with the aid of a physician.⁷⁰

The Luxembourg experience illustrates the great pressure Catholic authorities were able to exert on politicians in the final stages of a euthanasia law's passage through parliament. Indeed, the Vatican urged Catholic politicians to observe their moral conscience and oppose the euthanasia law.⁷¹ The experience and debate on euthanasia in Spain has also been profoundly shaped by the Catholic Church. Siurana, Tamarit and DeTienda suggest that, even though Spain is a non-denominational country where in practice there exists a plurality of religious denominations, only the Catholic Church has spoken out on the issue of euthanasia.⁷² Currently, euthanasia is a criminal offence in Spain.⁷³ However, various cases over the past ten years have created an intense and complex social debate between those who advocate dignity and quality of life and those who advocate sanctity of life.⁷⁴

2.2.2 Passive euthanasia

National healthcare policy on passive euthanasia, or the withdrawal of life-saving treatment, is regulated in a number of ways across EU states. A number of states have a clear policy on passive forms of euthanasia. Under the French 'end of life' law, for example, doctors are permitted to avoid taking extreme measures to keep dying patients alive.⁷⁵ Similarly, in Sweden laws allow doctors to halt life-extending treatment at the patient's request.⁷⁶ Under Dutch law no one other than the individual concerned has the right to decide whether life-saving treatment should be withdrawn or maintained. According to the Dutch ministry of health, a strong Christian movement in the domestic political scene has created intense public discussion which has resulted in the development of stricter conditions for passive euthanasia.⁷⁷

⁷⁰ Constitutional Court Decision 22/2003.

⁷¹ See 'Vatican authority comments on euthanasia law in Luxembourg', *Catholic News Agency*, 11 December 2008. Available at www.catholicnewsagency.com/new.php?n=14593.

⁷² See note 58 above.

⁷³ Article 143.3 of the Spanish Penal Code.

⁷⁴ See note 58 above. It should be noted that the issue of euthanasia has been further dramatized in Spain and internationally by powerful films like Alejandro Amenábar's *The Sea Inside* (2004), featuring the true story of a man who fought a 30-year campaign to maintain the right to end his life in dignity.

⁷⁵ Law no. 2005-370 of 22 April 2005.

⁷⁶ HThornstedt, 'Euthanasia and related problems in Swedish law', *International Journal of Legal Medicine*, vol 70 (1), 1972, pp 32-5.

⁷⁷ Letter from the Dutch ministry of health to the Equal Rights Trust, received 22 January 2009.

In most other EU states, however, the national healthcare policy is less established. This lack of certainty places the decision-making function on healthcare policy in the hands of courts. This is also the case in the USA, as Comparative example 2 demonstrates.

Comparative example 2: United States

This case involved a seven-year-long successful legal effort by Michael Schiavo to have his wife, Terri Schiavo, disconnected from life-support equipment. Terri Schiavo had been diagnosed as being in a persistent vegetative state (PVS) several years before 1998, when her husband petitioned the Pinellas County Circuit Court to remove her feeding tube under Florida law section 765.401(3). He was opposed by Terri's parents, Robert and Mary Schindler, who argued that Terri was conscious. Michael Schiavo later ceded authority over the matter to the court, which determined that Terri would not wish to continue life-prolonging measures.

On 24 April 2001 Schiavo's feeding tube was removed and then several days later reinserted as legal decisions were made. Increasing media attention led to involvement by politicians and advocacy groups, particularly those involved in the pro-life movement and disability rights, including members of the Florida Legislature, the United States Congress, and the president of the United States. In total, the Schiavo case involved 14 appeals and numerous motions, petitions and hearings in the Florida courts; five suits in the Federal District Court; Florida legislation struck down by the Supreme Court of Florida; and four denials of *certiorari* from the Supreme Court of the United States.

On 18 March 2005 the local court ruled again to remove Schiavo's feeding tube, and she died of the effects of dehydration at a hospice on 31 March 2005.

Italy has also recently dealt with the issue of passive euthanasia through the court system, in the matter of the withdrawal of life-saving treatment from Eluana Englaro. Ms Englaro's case triggered significant public debate in which both the Vatican and Catholic politicians played an active role.⁷⁸ Ms Englaro suffered severe injuries in a car crash in 1992 and since then had been in a vegetative state. Following a decade-long court battle, Ms Englaro's father finally secured authorization from Italy's Court of Cassation to remove the feeding tubes keeping her alive. During the court proceedings, the Vatican argued that removing the feeding

⁷⁸ See R Owen, 'Top Italian court clears way for death of Eluana Englaro', *The Times*, 13 November 2008. Available at www.timesonline.co.uk/tol/news/world/europe/article5150260.ece.

tubes would amount to euthanasia. This position was supported by many Catholic politicians and directly reflects the mainstream Catholic doctrine on this issue.⁷⁹

A critical element of politicizing the concerns of the religious opposition to the Court of Cassation's judgment was refocusing the debate onto the issue of consent and decision-making capacity. Following the Court of Cassation decision, the Italian prime minister Silvio Berlusconi introduced an emergency bill which would have made it illegal for carers of people 'unable to take care of themselves' to suspend artificial feeding.⁸⁰ Consent and the capacity to make decisions regarding the suspension and termination of treatment have also played central roles in the jurisprudence of the Hungarian Constitutional Court. According to the Hungarian ministry of health, the Constitutional Court, by virtue of the constitutional right to self-determination, has interpreted Act CLIV of 1997 on Health as entitling a patient to decide whether she/he wishes to use medical care, and also to consent to or refuse interventions in the course of medical care. However, this Act adds the caveat that in exercising the patient's right to refuse life-supporting or life-saving medical care, a terminally ill patient may only refuse medical care (a) by a public deed or a private deed of full probative force, or (b) if a patient is incapable of writing, by declaration in the presence of two witnesses.⁸¹

The issue of consent and legal capacity must be a central consideration in any healthcare policy formulation with respect to passive euthanasia. It is extremely important that certain checks and balances are applied in the implementation of euthanasia policies. One such check must be a secure procedure to establish the consent of the patient. This may include not only the verbal or written expression of will by patients themselves, but (where the patient does not have the capacity to give consent) evidence that is taken into consideration to ascertain the will of the patient. Adopting such an approach ensures that the will of the patient concerned is respected. Furthermore, it also supports practitioners by providing direction and certainty in carrying out functions which will inevitably encounter religious and other scrutiny and criticism.

2.2.3 Conflict of duty and safeguards related to euthanasia

The wider notion of implementing safeguards has been a key component of national policies that permit active euthanasia. As noted above, at the national level there is a complex set of religious, ethical and political considerations that

⁷⁹ See note 57 above.

⁸⁰ However, Ms Englaro died on 9 February 2009, as the emergency legislation was being debated in the upper house of the Italian parliament. See R Owen, "'Right to die' coma woman Eluana Englaro dies', *The Times*, 10 February 2009. Available at www.timesonline.co.uk/tol/news/world/article5697099.ece.

⁸¹ Letter from the Hungarian ministry of health to the Equal Rights Trust, received 22 October 2008.

have to be balanced when a law-maker decides to allow euthanasia. In implementing a national policy that permits euthanasia, such as the laws applying in Belgium and the Netherlands, two concerns must be addressed. First, should this law accommodate healthcare providers who would refuse to carry out euthanasia as a consequence of their religious or other ethical objections? Second, what safeguards should be in place to ensure that people who are refused euthanasia as a consequence of a belief-based exemption granted to healthcare providers can nonetheless access their full legal rights?

The practical answer to the first question is that a healthcare practitioner should be able to refuse to perform euthanasia. However, the rationale behind this answer varies depending on the social perception of euthanasia. In the Netherlands, for example, euthanasia is not regarded as a 'standard medical act': it is viewed as a socially regulated act in which physicians happen to be involved.⁸² Therefore, it has been argued, the right of the doctor to refuse to perform or participate in euthanasia is legitimate. By contrast, in Belgium, some have argued that euthanasia *is* a 'standard medical act', as the legislation requires a *physician* to perform it. However, as Adams and Nys point out, this argument is unpersuasive: the fact that it must be performed by a physician does mean that it is an act carried out by a medical professional, but this does not necessarily make it a 'standard medical act'.⁸³ If the legislation merely requires a physician to perform euthanasia, this does not mean that *every* physician has to perform euthanasia – this is reflected in section 14 of the Belgian Euthanasia Act, in which a physician is not required to consent to a patient's request for euthanasia. Therefore, where euthanasia is permitted, it is clear that practitioners do not face an automatic obligation to perform euthanasia and can exercise a right to belief-based exemption.

This approach needs to be balanced, however, in order to achieve a fair system. Belgian and Dutch legislation aims to achieve this balance by requiring that physicians who refuse to perform euthanasia must hand over the patient's medical records to another physician appointed by the patient or their representatives. The practical application of these safeguards, however, and their effectiveness have been questioned. In the Flanders region of Belgium, for example, where 80 per cent of hospitals are associated with Catholic organizations, there are *de facto* barriers for patients wanting access to euthanasia due to the greater likelihood that physicians working in Catholic-associated hospitals will refuse to perform euthanasia on grounds of religious belief. To be sure, the overwhelming majority of Catholic hospitals in Flanders, and in the whole of Belgium, apply euthanasia law. Patients can have access to euthanasia, even if their own

.....
⁸² See note 66 above.

⁸³ *Ibid.*

physician will not perform it. However, in many Catholic hospitals additional safeguards are built in before euthanasia is performed.⁸⁴

In circumstances such as these it is necessary to put in place robust safeguards and systems to counterbalance the belief-based exemption of physicians who legitimately refuse to perform euthanasia. Policy should ensure that everyone can have access to their legal right to euthanasia. In addition, the right to equality must be respected and balanced with health economy considerations, to ensure that where euthanasia is legal, those who wish to exercise their right to it can do so on an equal basis with others, and not be disadvantaged by social, economic, cultural or religious barriers. Whether such a balance should be struck through legislation or through the court system is an open question.⁸⁵ A clear advantage of the former is that economic and social considerations would be factored into any safeguarding mechanism, thereby enabling such barriers to be circumvented. An advantage of the latter is that any decision would be highly influenced by notions of justice. What is plain, however, is that any country which permits euthanasia must operate within a system of legal certainty to ensure that both patients and healthcare practitioners know their legal rights and that subsequent challenges in accessing euthanasia can be foreseen and addressed.

2.3 Belief-based patient decisions

One essential area of healthcare policy at the intersection with religion is the regulation of responses to belief-based decisions by patients or their representatives concerning the course of treatment. This area is dominated by the issues of personal autonomy, and the patient's right to informed consent, as well as freedom of religion. The policy issues in this area include patient decisions to refuse any medical treatment that is deemed undesirable on account of religious or other belief, such as organ transplant, organ donation, blood transfusion, etc. This section maps different religious viewpoints and looks at policy trends related to belief-based patient decisions.

2.3.1 Organ transplant and donation

Organ transplant and donation systems play a critical role not only in saving lives, but also in achieving a better quality of life for many people throughout Europe. Most major religions, including Christianity and Judaism, view organ transplant

⁸⁴ J Lemiengre, B Dierckx de Casterlé, G Verbeke, C Guisson, P Schotsmans and C Gastmans, 'Ethics policies on euthanasia in hospitals: a survey in Flanders (Belgium)', *Health Policy*, vol 87, 2007, pp 170–80.

⁸⁵ As a result of its already developed jurisprudence, the Dutch legislation on euthanasia is less prescriptive and more concise than the respective Belgian legislation.

and donation in positive terms. The Vatican position was formulated by Pope John Paul II, who stated that:

Transplants are a great step forward in science's service of man, and not a few people today owe their lives to an organ transplant. Increasingly, the technique of transplants has proven to be a valid means of attaining the primary goal of all medicine—the service of human life . . . It must first be emphasized, as I observed on another occasion, that every organ transplant has its source in a decision of great ethical value: the decision to offer without reward a part of one's own body for the health and well-being of another person.⁸⁶

However, in this address John Paul II also stressed that of great ethical importance to the process of organ transplantation is the need for informed consent. According to one authority, the Vatican's position is consistent with all major religions in the UK – although within each religion different schools of thought exist.⁸⁷ Regarding Islam, while the Muslim Law (*Shari'a*) Council of the UK supported organ transplant and donation through a 1995 opinion on the basis of the Islamic principle of *al-darurat tubih al-mahzurat* (necessity overrules prohibition), many Muslim scholars believe that organ donation is not permissible and hold the view that it does not fall under the criteria of the above principle as a consequence of other overruling Islamic principles.⁸⁸ Studies suggest that Muslims in Belgium believe that organ donation is acceptable and represents a gift from the donor.⁸⁹ Nevertheless, certain limitations are placed on what constitutes a permitted donation. For example, a donation cannot come from a minor or a person with a mental disability.⁹⁰

In the UK, the question of whether the current opt-in donations system should be replaced with a compulsory opt-out system has been the subject of much conjecture. Medical authorities are keen to see the UK adopt a system of 'presumed consent', where it is assumed that an individual wishes to be a donor unless they have 'opted out' by registering their objection to donating.⁹¹ Such a policy approach is likely to cause alarm among some religious communities,

⁸⁶ See 'Address of the Holy Father John Paul II to the 18th International Congress of the Transplantation Society', 29 August 2000. Available at www.vatican.va/holy_father/john_paul_ii/speeches/2000/jul-sep/documents/hf_jp-ii_spe_20000829_transplants_en.html.

⁸⁷ See 'Organ donation and religious perspectives', *UK Transplant*, February 2005. Available at www.uktransplant.org.uk/ukt/newsroom/fact_sheets/religious_leaflets/general_religious_lflet-2005.pdf.

⁸⁸ Ibid.

⁸⁹ C Vassart, 'Les soins de santé face aux défis de la diversité: le cas des patients musulmans', Fondation Roi Baudouin, August 2005.

⁹⁰ Ibid.

⁹¹ See 'Opt in or opt out', *UK Transplant*, November 2008. Available at www.uktransplant.org.uk/ukt/newsroom/statements_and_stances/statements/opt_in_or_out.jsp.

concerned over the matter of obtaining informed consent. It is unclear whether, in view of the urgent demand for organs, it is acceptable to implement an 'opt-out' national healthcare approach. At present, this scenario seems unlikely in the UK. The major practical difficulty is meeting the high standards for informed consent in a system that automatically includes everyone as a donor. In practice, healthcare policy across the European Union today is consistent with the religious concern to ensure that informed consent from both living and deceased donors is given prior to transplant.⁹² However, significant differences exist with respect to the procedure required by national law for obtaining donor consent.⁹³

2.3.2 Refusal of medical treatment

Within the issue of refusal of medical treatment, the issue of refusing blood transfusion has had a long-standing association with the religious beliefs of Jehovah's Witnesses.⁹⁴ In 2000 the Watch Tower Society – the authoritative source on the beliefs, teachings and activities of Jehovah's Witnesses – issued a directive stating that the organization would no longer 'disfellow' members who did not comply with the policy of refusal of blood. Their policy regarding blood transfusion, however, remained substantively unchanged. The directive provides that if one does not refuse a blood transfusion, one in effect 'disfellow' oneself from membership of the Church of Jehovah's Witnesses.⁹⁵

One solution to this policy issue has been the use of 'artificial blood', based on haemoglobin extracted from outdated human blood, which could serve as a substitute for blood in certain treatments. Some commentators have noted that the original position of the Watch Tower Society, which was critical of the use of artificial blood, is starting to change in recent times. It appears that they may now accept fractions of blood components.⁹⁶ But one obvious drawback of using artificial blood is the high cost of producing it.

Another policy solution which has been suggested is that healthcare practitioners should adopt a 'don't ask, don't tell' policy in respect of administering blood transfusions to suspected Jehovah's Witnesses. It was argued that this

⁹² In 2003 the European Union emphasized that consent is required from both the living and the deceased donor in all member states. See European Commission, *Human Organ Transplantation in Europe: An overview*, Directorate-General Health and Consumer Protection, 2003.

⁹³ European Commission, 'Consultation document: organ donation and transplantation policy at EU level', 27 June 2007. This document recommends (p 7): 'Member States should ensure that there is a legal basis for ensuring valid consent or objection to organ donation.'

⁹⁴ The basis of Jehovah's Witnesses' refusal to give and receive blood is Acts 15:20, referring to the command to 'abstain from blood'.

⁹⁵ O Muramoto, 'Bioethical aspects of the recent changes in the policy of refusal of blood by Jehovah's Witnesses', *British Medical Journal*, 2001, vol 322, pp 37–9.

⁹⁶ D J Doyle, 'Jehovah's Witnesses and artificial blood', *Canadian Medical Association Journal*, vol 163 (5), 2000, pp 495–6.

policy would enable patients to remain silent about the blood transfusion treatment they had received to avoid religious sanction.⁹⁷ Such proposals, however, have been rejected by both the Watch Tower Society and the medical profession generally.⁹⁸

Consequently, the policy change by the Watch Tower Society does not appear to offer any significant improvement to the difficult circumstances faced by Jehovah's Witnesses as patients and the healthcare practitioners who treat them. Nonetheless, it reopened the debate over the appropriate treatment of Jehovah's Witnesses in respect of blood transfusions and enabled healthcare authorities to explore further policy options.

Blood transfusion is a case in point illustrative of a broader policy area: namely, how to deal with refusal of life-saving medical treatment motivated by religious or other beliefs. Two separate issues related to such refusal must be addressed: personal refusal and refusal by a patient's representatives, such as parents making decisions on behalf of their child.

Personal refusal

In some EU member states regulation and guidance exist with respect to blood transfusion policy and Jehovah's Witnesses. In the UK, the General Medical Council has published medico-ethical guidance which states that:

You should not make assumptions about the decisions that a Jehovah's Witness patient might make about treatment with blood or blood products. You should ask for and respect their views and answer their questions honestly and to the best of your ability.⁹⁹

Likewise in Sweden, the patient's treatment must be mutually agreed by both the healthcare provider and the receiver. Romania has also confronted this issue. The main challenge relates to practitioners' experiences of treating Jehovah's Witnesses and having to gain consent to blood transfusion or surgery. This challenge is exacerbated by the fact that in Romania patients are not asked to state their religion or belief in medical records. As a result statistical data regarding the religion of patients does not exist and information regarding whether the patient is a Jehovah's Witness (and may therefore refuse a blood transfusion) remains unknown to the healthcare practitioner. As a matter of policy, therefore, if there is

⁹⁷ See note 95 above.

⁹⁸ See 'Blood transfusion plan for Jehovah's Witnesses', BBC News, 7 December 1999. Available at <http://news.bbc.co.uk/1/hi/health/552606.stm>.

⁹⁹ *Personal Beliefs and Medical Practice: Supplementary guidance*, General Medical Council, March 2008. Available at www.gmc-uk.org/guidance/ethical_guidance/personal_beliefs/Personal%20Beliefs.pdf.

no consent regarding the course of treatment, the patient must – if possible – be referred to another healthcare provider.

Research suggests that the policy approach requiring medical practitioners to respect a patient's refusal to receive blood has been endorsed through the courts, which have consistently upheld Jehovah's Witnesses' decisions to refuse transfusions on the grounds that any adult of sound mind has the right to determine what shall be done with his or her own body.¹⁰⁰ Wicks argues that what such cases clearly demonstrate is that the personal decision must be respected regardless of the fact that it is rarely shared by other people concerned, including healthcare staff. She contends that:

A refusal of treatment based on religion may appear irrational to others . . . and, although it has been clearly stated that this will not vitiate a refusal of consent, it may cause a reluctance to accept the decision of others.¹⁰¹

Refusal by patient's representatives

A more difficult ethical question is to what extent healthcare policy should accommodate the religious belief of a person who refuses to authorize a blood transfusion for a family member. In August 2004, the Constitutional Court of the Czech Republic considered an application by the parents (both Jehovah's Witnesses) of a six-year-old boy.¹⁰² The boy was suffering from cancer and chemotherapy was necessary. The parents gave their consent to chemotherapy but protested against a blood transfusion. According to the treating doctors, a blood transfusion was necessary to protect the health and life of the child. The doctors turned to the courts, which suspended the parents' rights and the boy was put into the care of the hospital. The parents appealed to the Constitutional Court following unsuccessful appeals against the decisions of lower courts. The Constitutional Court, however, held that the limitation of the parents' rights was proportionate as there was no alternative to the treatment.

This case illustrates the difficulties healthcare practitioners experience, in the absence of a clear policy. Medico-ethical questions have to balance the competing human rights such as freedom of religion and the right to health. While consent, as a consequence of its link to personal autonomy and personal agency, plays a fundamental role in cases where the decision-maker is the patient, it becomes problematic where the consent of a parent (or next of kin) is needed in situations where the patient does not have full legal capacity and cannot give

¹⁰⁰ See D Busuttill and A Copplestone, 'Management of blood loss in Jehovah's Witnesses', *British Medical Journal*, vol 311, 1995, pp 1115–16. Available at www.bmj.com/cgi/content/full/311/7013/1115.

¹⁰¹ E Wicks, 'The right to refuse medical treatment under the European Convention on Human Rights', *Medical Law Review*, vol 9, spring 2001, p 32.

¹⁰² Case no. III. US 459/03.

informed consent. Under such difficult circumstances it appears that every effort should be made to ascertain whether the individual has consented to a procedure. If this is impossible (or if guardianship laws transfer consent requirements to the parents), then it seems that practitioners and courts across EU states agree that the patient's right to life should outweigh other considerations, including freedom of religion.

Comparative example 3: United States

According to media reports, the need for states to protect children who are suffering from life-threatening diseases is increasingly colliding with religious choices of parents, including one case where a child died. As a Wisconsin woman stood trial in May 2009 for the death of her daughter, authorities nationwide were searching for a Minnesota mother who vanished with her cancer-stricken 13-year-old son, refusing chemotherapy that doctors said could save his life.

Colleen Hauser and her son Daniel, who had Hodgkin's lymphoma, apparently left their southern Minnesota home sometime after a doctor's appointment and a court-ordered X-ray, which showed his tumour had grown. A Brown County district judge had ruled a week earlier that Daniel's parents were medically neglecting him. The judge had stated that the risk of death to Daniel Hauser compelled him to overrule the parents' constitutional right to religious freedom and to raise their child as they saw fit. The judge had ordered the teenager to undergo an immediate X-ray and to undergo chemotherapy and radiation treatments. Reacting to the news of the disappearance of mother and son, the judge issued an arrest warrant for Colleen Hauser and ruled her in contempt of court. The judge also ordered that Daniel be placed in foster care and immediately evaluated for treatment by a cancer specialist.

Meanwhile, Leilani Neumann, 41, of Weston, Wisconsin, was on trial on a charge of second-degree homicide for the death of her daughter, Madeline Kara Neumann, on 23 March 2008. The 11-year-old died as a result of untreated juvenile diabetes.

In both the Minnesota and the Wisconsin cases, the families believed religion would save their children. The Hausers belong to a religious group that believes in 'natural' healing methods. They follow the 'do no harm' philosophy of the Nemenhah Band, a Missouri-based religious group that believes in natural healing methods advocated by some American Indians. Its motto is: 'Our religion is our medicine.' Colleen Hauser testified earlier that she had been treating Daniel's cancer with herbal supplements, vitamins, ionized water and other natural alternatives. Daniel testified that he believed chemotherapy would

kill him and told the judge that if anyone tried to force him to take it, 'I'd fight it. I'd punch them and I'd kick them.' The Neumann family believed prayer would save their daughter.

In both cases the children's illnesses were treatable. Daniel's Hodgkin's lymphoma, diagnosed in January 2009, is considered highly curable with chemotherapy and radiation, but the boy gave up chemotherapy after a single treatment. The judge said that Daniel, who had a learning disability and could not read, did not understand the risks and benefits of chemotherapy and did not believe that he was ill. Madeline Neumann's autopsy showed that she lacked insulin, which would have allowed glucose, a simple sugar, to go from her blood to her tissue. Instead, the glucose built up in her body, which began to break down fat and produced acid.

A non-profit group called Children's Healthcare Is a Legal Duty is tracking five criminal prosecutions around the US, all cases that involve children being denied healthcare because of religious beliefs. Apart from the Wisconsin case, there are two cases in Oregon, one in Tennessee, and one in Pennsylvania. Since 1983 the group, which says it works to stop abusive religious and cultural practices, has tracked 66 similar prosecutions. Rita Swan, the group's executive director, stated that in many cases religious exemptions in state law have discouraged prosecutors from filing charges and police from investigating cases. According to the group, only five states – Hawaii, Nebraska, Massachusetts, Maryland and North Carolina – have no religious exemptions for child abuse and neglect in state civil or criminal codes. Swan, a former Christian Scientist, lost her son to meningitis, a treatable disease, after forgoing medical care in favour of spiritual treatments practised by her church. 'The Christian Science practitioners were pooh-poohing our fears and telling us that our fear was a sin and showed a lack of trust in God and a lack of faith in them, that our fears were causing our baby to be sick,' she said. Swan left the church after her son's death and became an activist on the issue.

Wisconsin state senator Lena Taylor plans to introduce legislation that would eliminate the state's current exemption. The bill would replace the exemption with an 'affirmative defence' mechanism, which could protect parents from being prosecuted if they could prove they provided reasonable medical care.

Sara Sinal, a professor and physician at Wake Forest University Baptist Medical Center in Winston-Salem, North Carolina, told the media that preventable deaths were often associated with small sects in which the children did not attend public schools. (Information compiled from press reports in US media of May 2009.)

2.4 Emerging policy trends and outstanding policy questions

Healthcare policy formulation at the national level faces many difficult challenges. These challenges include managing the influence of religion in developing policy on politicized issues such as euthanasia, as well as balancing religious freedom with other considerations including equality, health economics, and the health and well-being of patients.

Emerging Europe-wide policy trends suggest that, while religion plays a significant part in national healthcare policy, it is often outweighed by other competing values. Across the European Union, the emerging policy trends can be summed up as follows:

- i The right of healthcare providers to belief-based exemption is broadly recognized by states, but within limits and subject to certain safeguards. Exemption is deemed acceptable in principle where the activities objected to challenge the healthcare provider's most fundamental beliefs. The major outstanding policy issue in this regard is the scope and nature of limits and safeguards.
- ii In states that have adopted laws which permit euthanasia, religious opposition has been strong and has secured belief-based exemptions for followers of various faiths. The major outstanding policy issues include achieving legal certainty with regard to euthanasia and ensuring that belief-based exemptions do not render the patient's right to euthanasia inaccessible. Another concern that should be addressed is that any exemption process must be managed with strong safeguards to enable full access, irrespective of the type of hospital or other factors irrelevant to the patient's rights.
- iii EU states have based policy regarding organ donation and blood transfusion primarily on the principle of informed consent. It is only when consent is unavailable or a patient's legal capacity to give consent is contested that the right to life of the patient overrides all other considerations. A major outstanding task is to regulate the policy on informed consent, which is central to patients' rights.

Recommended policy questions for further research

- 1** Under what circumstances is it justifiable for a belief-based exemption to outweigh a healthcare provider's medical duty to the patient?
- 2** Should barriers to euthanasia be addressed by legislation or by the court system?
- 3** If a patient lacks legal capacity to make an informed choice in refusing medical treatment such as organ transplantation or blood transfusion, to what extent should his/her religious background be considered in assessing the case?

3 Healthcare policy and religious diversity

Today religious diversity is a statistical fact and a highly visible reality across many EU states. Through migration, particularly immigration from other regions of the world, Europe is developing into a rich set of multi-ethnic, multicultural and multi-religious societies, in which religious diversity brings some new challenges to service provision in areas such as healthcare.

It has been argued that one's religion or belief can play a significant role in maintaining and improving one's health, by providing comfort or encouraging the pursuit of physical well-being. Religious practice and observance also have significant implications for health. However, empirical research regarding whether or not religion has a positive or negative impact on health is inconclusive. Some studies have argued that certain religious practices actually promote good health.¹⁰³ Other studies, however, suggest that belonging to a religious group, and in particular a minority religious group, can lead to negative healthcare experiences.¹⁰⁴ Wherever the truth may lie, what matters for healthcare policy at this stage of inconclusive research is to try to meet reasonable religious needs

¹⁰³ See, for example, L D Laird, J de Marrais and L L Barnes, 'Portraying Islam and Muslims in MEDLINE: a content analysis', *Journal of Social Science and Medicine*, vol 65, 2007, pp 2425–39. This study submits that western cultures can benefit from cross-cultural education and that even biomedicine can gain from integrating traditional health medicine and healers into public health efforts. See also P L Schiller and J S Levin, 'Is there a religious factor in healthcare utilization? A review', *Journal of Social Science and Medicine*, vol 27, no. 12, 1988, pp 1369–79. This study suggests that even if religious affiliation does not have a direct impact on health, it may still be a critical factor insofar as it contributes to willingness to engage in certain healthcare practices. See also J Kluger, 'The biology of belief', *Time Magazine*, 23 February 2009.

¹⁰⁴ P Weller, A Feldman and K Purdam, 'Religious discrimination in England and Wales', Home Office Research Study 220, February 2001.

through policies that are sensitive to the religious identity of both patients and healthcare providers.

While healthcare policy should be sensitive to the religious aspects of people's identity on grounds of respect for their dignity, it should be noted that an inseparable aspect of dignity is equality. Without equality of treatment and of opportunity, the experience of unfairness is damaging to one's dignity. At the empirical level, it has been demonstrated that people who are the victims of discrimination and inequality, including on grounds of religion, often suffer negative health outcomes. Research in the UK has shown that in both Scotland and Northern Ireland Roman Catholic populations suffer greater health inequalities than other religious groups and that this situation is compounded by their unequal socio-economic position generally.¹⁰⁵ Equal access to healthcare for people of different religions is not a reality in today's EU societies.

To realize full and effective equality for everyone in healthcare, irrespective of one's religion, it is necessary to treat people differently according to their different circumstances, to assert their equal worth, and to enhance their capabilities to participate in society as equals.¹⁰⁶ This means that healthcare policy in a democratic society committed to equality and diversity must attempt to accommodate religious difference.

Religion-based inequalities may be exacerbated by gender inequalities and gender bias. The latter has been extensively documented with respect to health and medical research; one example is the practice of excluding women from the clinical trial process in pharmaceutical and drug development, which may lead to the results and outcomes of such trials being imposed on women.¹⁰⁷ Although multiple discrimination, where both religion and gender are grounds of discrimination, is particularly detrimental to the victims, current legal systems in the EU display a gap in the legal protection against such discrimination.

This section of the study focuses on how healthcare policies accommodate religious diversity inside and outside the hospital setting.

¹⁰⁵ See J Abbotts, R Williams and G Ford, 'Morbidity and Irish Catholic descent in Britain: relating health disadvantage to socio-economic position', *Journal of Social Science and Medicine*, vol 52, 2001, pp 999–1005. See also D O'Reilly and M Rosato, 'Religious affiliation and mortality in Northern Ireland: beyond Catholic and Protestant', *Journal of Social Science and Medicine*, vol 66, 2008, pp 1637–45.

¹⁰⁶ See *Declaration of Principles on Equality*, Equal Rights Trust, London, 2008, p 5.

¹⁰⁷ See K Ramasubbu, H Gurm and D Litaker, 'Gender bias in clinical trials: do double standards still apply?', *Journal of Women's Health Gender-Based Medicine*, vol 10 (8), 2001, pp 757–64. In the USA, there is a legal requirement that the different effects of pharmaceutical products are known according to gender and ethnicity of the patient. See L Schiebinger, 'Women's health and clinical trials', *Journal of Clinical Investigation*, vol 112 (7), 2003, pp 973–7.

3.1 Healthcare policy and accommodating religious needs in hospitals

Hospitals, like other public spaces such as schools and universities, have been the subject of dispute regarding the level of association they should have with religion. In one significant recent example, a government-appointed panel in France recommended adopting a charter to keep religion out of hospitals.¹⁰⁸ Although softer than policies France has adopted in order to keep religion out of schools and universities, the proposal demonstrates that concerns exist over the influence religion has within hospitals. This influence is partly due to the fact that in a number of states hospitals are, or have been in the past, administered by religious associations.¹⁰⁹

This section will examine policies with respect to four hospital provisions in particular: religious assistance and faith space; medication and dietary needs; hospital clothing; and after-death issues – post-mortem and burial.

3.1.1 Religious assistance and faith space

Religious assistance and faith space within hospitals is a significant focus of local-level healthcare policy in EU countries. Within hospitals it is common that patients may wish to participate in religious rituals and worship.¹¹⁰ This wish tends to be more urgent with patients who are suffering from terminal illness or are nearing the end of their life. Noting the importance that access to religious assistance has for patients of religious belief, either through a chaplain or faith rooms, the policy question is, should hospitals afford a right to religious assistance as part of hospital policy? According to the Dutch ministry of health, in the Netherlands any patient in a hospital has a right to spiritual assistance.¹¹¹ Similarly, the UK has published guidance on the religious needs of patients and recommends that NHS Trusts provide accessible and suitable spaces for prayer, reflection and religious services which are open to patients and staff 24 hours a day.¹¹² While NHS Trusts are given autonomy in determining precisely how they

¹⁰⁸ See 'French panel recommends measures to keep religion out of hospitals', *International Herald Tribune*, 29 January 2009. Available at www.iht.com/articles/2007/01/29/news/france.php.

¹⁰⁹ Belgium, Hungary and the Netherlands are examples.

¹¹⁰ See P Weller, A Feldman and K Purdam, 'Religious discrimination in England and Wales', Home Office Study 220, February 2001; P Bay, D Beckham, J Trippi, R Gunderman and C Terry, 'The effect of pastoral care services on anxiety, depression, hope, religious coping, and religious problem-solving styles: a randomized controlling study', *Journal of Religion and Health*, vol 47, 2008, pp 57–9.

¹¹¹ Letter from the Dutch ministry of health to the Equal Rights Trust, received 22 January 2009.

¹¹² See 'Meeting the religious and spiritual needs of patients and staff: guidance for managers and those involved in the provision of chaplaincy-spiritual care', NHS Chaplaincy, UK Department of Health, November 2003. Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4073108?IdcService=GET_FILE&IdID=2305&Rendition=Web.

should implement such a recommendation, they are expected to implement it.¹¹³ Therefore, while it appears that religious assistance in hospitals has been provided in some countries as a matter of national policy, local hospitals are permitted, on a regional basis, a certain amount of autonomy over whether and how to use their resources to provide religious assistance.

It is unclear what proportion of hospitals in EU member states feature some kind of faith space. A recent study reveals that in Romania, during 2007, the ministry of public health paid for priests to provide religious assistance in hospitals, but while access to hospitals for priests is ensured, there are usually no suitable faith spaces in them for religious services.¹¹⁴ An essential consideration to ensure an inclusive and accommodating policy on religious assistance is whether or not such spaces should be single-faith, multi-faith (representative of targeted religions) or neutral. For example, if the faith space is a chapel, is there space within the chapel for minority faiths such as Islam or Judaism? As a result of local-level autonomy, approaches differ from hospital to hospital and from region to region. In Spain multi-faith spaces are rare.¹¹⁵ UK national policy encourages pluralism in hospital worship spaces and recommends that in the process of appointment of chaplains the appointment panel should be representative of the local area the hospital serves.¹¹⁶ The UK approach focuses on two issues: the need to consult the community; and the need to carry out research into how the needs of each religious community can be accommodated without offending any other community.

Interestingly, not all UK hospitals have discharged their obligations in respect to the national guidelines by facilitating multi-faith provisions; many hospitals have chosen a different approach, providing neutral, non-religious artwork in meditation or prayer rooms rather than religious symbols, with a view to creating a more inclusive environment. Given the nature of this religious demand, local-level decision-making has been viewed as essential with respect to the provision of faith space, in order to ensure that the beliefs of the local community – those most directly affected by any hospital policy – are accommodated. Furthermore, local-level autonomy enables hospitals to manage their limited resources.

A final concern to note regarding religious assistance and the appropriate provision of faith space is the need to strike a balance between the provision

¹¹³ Letter from the UK ministry of health to the Equal Rights Trust, dated 12 October 2008.

¹¹⁴ *Romania's State and Religions: A transparent relationship?*, Association for the Defence of Human Rights in Romania/Helsinki Committee, 2008. Available at www.apador.org/en/publicatii/stat_si_religii.pdf. According to this work, out of a total of 182 employed priests, 165 belong to the Romanian Orthodox Church, five to the Romano-Catholic Church, four to United Romanian Greek-Catholic Church, six to the Reformed Church of Romania and two to the Unitarian Church of Transylvania.

¹¹⁵ Testimony provided to the Equal Rights Trust by Bárbara Navaza, 17 September 2008.

¹¹⁶ See note 113 above.

of religious assistance and proselytizing in hospitals. In reality achieving and managing this balance can be difficult.

It appears that a good practice in managing faith-space policies would be to introduce national-level principled guidelines which are allowed to be implemented flexibly at local level. This would enable hospitals to recognize the needs of their communities through research and consultation and to provide more effective and accessible religious assistance and faith space, without discrimination on grounds of religion or belief.

3.1.2 Medication and dietary needs

Some religions, for example Islam and Judaism, place dietary restrictions on their adherents. Beliefs regarding alcohol consumption, halal meat, pork, vegan food, etc influence not only the type of food a person is willing to consume, but also – as medicines often contain alcohol or animal-related products – the medication they are willing to take. The influence of religion on the willingness of people to eat certain foods and to take certain medications has been a matter of concern to hospitals.

In principle, hospitals have been expected to make reasonable accommodation regarding diet and medication, allocating adequate resources to meet religious needs. The issue here is one of equality, with policy aimed at delivering public healthcare services accessible to everyone. The matter of equal access is particularly important in building confidence in the healthcare system, especially for people with express religious needs related to health services. Even in the UK, which has done a great deal to accommodate the religious demands of patients, there is still widespread distrust regarding the provision and possible contamination of food and medicine. Similar concerns have been documented in Belgium. According to one study, Muslims in Belgian hospitals preferred vegetarian food options rather than running the risk of eating meat that is 'unclean'.¹¹⁷

Policy considerations regarding diet and medication include proper handling during periods of fasting, such as Ramadan for Muslims. Healthcare risks due to dietary regimes during Ramadan are especially heightened for pregnant women who are fasting. Not only is the provision of plural services seen as necessary to ensure the rights of minority religious patients who may already be from a disadvantaged group, but healthcare policy must prepare healthcare providers to advise patients on how to diet safely, whether in hospital or during Ramadan outside hospital. Within some UK hospitals, for example, if safe fasting is

¹¹⁷ CVassart, 'Les soins de santé face aux défis de la diversité; le cas des patients musulmans', Fondation Roi Baudouin, August 2005, p 17.

not possible, healthcare practitioners in cooperation with imams issue a signed letter warning that fasting is unsafe in particular conditions.

In most places policies regarding diet and medicines have reflected the religious composition of the community served by the health establishment. Where religious groups with special dietary and medicine requirements are absent, there has been no need for a detailed policy. But even in this case, equal access to healthcare requires that procedures are in place to ensure the provision of special diets and medication if and when the need arises. The underlying principle is that healthcare policy should attempt to satisfy religious dietary and medication requirements, in so far as this does not pose an undue burden on the establishment and provided that measures have been taken to prevent or reduce harm to the patient's health.

3.1.3 The sex of the health practitioner and hospital clothing

It frequently happens that patients of certain religions or beliefs refuse to be seen or treated by a doctor, nurse or other healthcare practitioner of the opposite sex. There are two common scenarios: (a) opposition on the part of a patient to being treated by a practitioner of a particular sex; and (b) opposition on the part of a patient's family or spouse to the sex of the practitioner. In the UK, cases have been reported where husbands have verbally and even physically assaulted medical staff who referred their wives for emergency caesarean sections. This aggression was motivated by opposition on the part of the husbands to male doctors and surgeons performing such medical procedures on their wives during childbirth.¹¹⁸ In the Netherlands, guidelines are now in place indicating that individual patients should be given the opportunity to express a preference on the sex of the practitioner, although in cases of emergency the guideline may be overridden.¹¹⁹

However, providing an opportunity to choose the sex of a healthcare provider, or recognizing a patient's right to do so, raises concern that such a policy may violate the right of others – namely the right of healthcare providers to non-discrimination on grounds of sex. The policy issue in this regard is not, however, found only at the intersection of religion and health; a request for women to be treated by female doctors is part of a wider attitude that goes beyond religiously based demands.

Nevertheless, of greater concern from the perspective of equality is the fact that women of minority religious backgrounds, including in particular migrant women, face the most serious challenges in accessing healthcare treatment

¹¹⁸ Testimony provided to the Equal Rights Trust by Imam Yunus Dudhwala, 17 September 2008.

¹¹⁹ Testimony provided to the Equal Rights Trust by Walter Devillé, 17 September 2008.

such as perinatal examinations,¹²⁰ cervical screenings and breast-surgery consultations. Any solution to this policy challenge should require that religious/cultural minority women are provided access to services in a manner that does not violate their dignity or create an overly uncomfortable environment for them. At the same time, this concern must be balanced both with pragmatic economic considerations such as the limited number of female practitioners available, and with the principled consideration that if one can choose a service provider's sex, one might try to extend this right to choose a healthcare provider's ethnicity, religion or other characteristic – a position that would strike at the heart of equality principles and lead to segmentation rather than social cohesion.

Another issue related to exposing one's body in front of others is that of appropriate hospital clothing. In all situations, including hospital, clothing is among the most sensitive issues, particularly for religious minorities in Europe. A report by the UK Home Office, for example, indicated that many British Asian women did not feel comfortable wearing the standard hospital nightdress during the daytime and preferred to wear their saris.¹²¹ In fact, in 2005 the UK hospital system introduced new 'inter-faith gowns', which aimed to cover up more of the body.¹²² However, the introduction of these gowns received negative publicity in the UK media, stoked up particularly by Conservative politicians who criticized the measure as a waste of money and pandering to religious minority communities.¹²³

3.1.4 After-death issues: post-mortem and burial

Hospital policy has reportedly been at odds with religious observance with respect to post-mortem examinations of deceased patients of certain religions. Muslims and Jews, who share common beliefs on this issue, have voiced two concerns.¹²⁴ First, Islam and Judaism require a funeral to take place close to the day of death, but autopsy causes delays to funeral arrangements and proceedings. Second, autopsy as such is unacceptable as it is a bodily invasion. With regard

¹²⁰ B Essen, 'Perinatal mortality among immigrants from Africa's Horn', doctoral dissertation, Department of Obstetrics and Gynaecology, Malmö University, Sweden, 2001.

¹²¹ P Weller, A Feldman and K Purdam, 'Religious discrimination in England and Wales', Home Office Research Study 220, February 2001.

¹²² B Marsh, 'Muslims and healthcare in the United Kingdom', *European Hospital*, Issue 4, 2008, p 6; available at www.european-hospital.com/topics/article/4296.html. See also 'Muslim women get their own NHS burka-style gown', *Mail Online*, 5 September 2006; available at www.dailymail.co.uk/news/article-403693/Muslim-women-NHS-burka-style-gown.html.

¹²³ See 'The new look for Britain's hospitals', *Daily Express*, 5 September 2006. Available at www.express.co.uk/posts/view/1179/The-new-look-for-Britain%3Bs-hospitals.

¹²⁴ A R Gatrad, 'Muslim customs surrounding death, bereavement, post-mortem examinations, and organ transplants', *British Medical Journal*, vol 309, 1994, pp 521–3. Available at www.bmj.com/cgi/content/full/309/6953/521.

to the second concern, one option that has been put forward is to use emerging technologies that enable minimal-invasive autopsy (virtopsy), such as MRI (magnetic resonance imaging) scans. These procedures have been adopted in the UK following specific requests from Jewish communities,¹²⁵ as they mitigate the level of bodily invasion imposed on the deceased.

Respect for religious identity in general healthcare also affects policies with respect to burial.¹²⁶ For some minority religions, including Islam and Judaism, burial needs to take place as soon as possible after death, but delays in the issuing of death certificates have reportedly interfered with this observance.¹²⁷ When the death certification office is closed over weekends, burial is delayed, and this causes anguish among the relatives of the deceased.

It is clear that not all of these issues can be addressed by implementation of a more inclusive hospital policy. A good starting point, however, would be greater recognition not only of the needs of religious minorities adversely affected by existing healthcare policy, but also of the need to investigate further the different ways such issues are managed both locally and nationally.

3.2 Healthcare policy and accommodating religion outside hospitals

3.2.1 Training of healthcare professionals

Strong communication skills and appropriate training to develop such skills are fundamental to providing effective healthcare services to diverse religious and cultural groups. As Hendriks has recently written: 'In fact, without good communication, it is virtually impossible to obtain a patient's consent for treatment.'¹²⁸

At the national policy level of EU member states, training of healthcare personnel on religious diversity matters is insufficient and fragmented, and in most countries there is no clear national policy. Rather than training healthcare practitioners themselves, some countries rely on external mediators with special knowledge and skills to address religious, ethnic, cultural and related difference.

¹²⁵ See R A L Bisset, N B Thomas, I W Turnbull and S Lee, 'Post-mortem examinations using magnetic resonance imaging: four year review of a working service', *British Medical Journal*, vol 324, pp 1423–4, available at www.pubmedcentral.nih.gov/articlerender.fcgi?artid=115853; and *Virtobot – mobile and stationary systems for a minimally invasive autopsy*, available at www.forim-x.com/docs/5542_virtobot_A4_S24.pdf?PHPSESSID=e5beb00aa62148f86984b08816c8ebc4.

¹²⁶ See note 124 above.

¹²⁷ M Wolfe, 'Muslim death in England and the constraints encountered', paper presented at the third postgraduate conference of the Association of University Departments of Theology and Religious Studies, June 2000. Available at www.multifaithcentre.org/images/content/seminarpapers/MuslimDeathinEnglandandtheConstraintsEncountered.htm.

¹²⁸ A Hendriks, 'Ethnic and cultural diversity: challenges and opportunities for health law', *European Journal of Health Law*, 15, 2008, p 292.

In Belgium, for example, the ministry of health funds the appointment of 'intercultural mediators' in hospitals, and regional authorities finance similar positions in other care institutions.

Part of the reason why no clear policy patterns exist may be uncertainty about where to assign training to capacitate dealing with religious diversity in healthcare, as the issue cuts across several areas of government, including education, health and justice. Training for healthcare workers in religious and cultural diversity may also have to be linked to training on the need to overcome language barriers in cases where patients are not fluent in the national language. In France, for example, poor communication by healthcare professionals has been an issue highlighted by litigation before the European Court of Human Rights in the case of *Vo v. France*.¹²⁹

Communication and training have been highlighted as a fundamental issue in the Spanish context. According to the Spanish ministry of health, a major challenge is the provision of training for healthcare professionals which can integrate diversity, sensitize professionals, and make them aware of the different ways of understanding health depending on the culture and religion of the patient.¹³⁰ This echoes the experience in the US, where reportedly practitioners often feel they lack the expertise and training to seek information on their patients' spiritual beliefs – or lack thereof – and to assess the impact of beliefs on healthcare delivery.

In addition, it has been pointed out that healthcare policy on this issue should not be limited to training in verbal communication. Some good practices in UK hospitals illustrate the skilful use in difficult situations of communication beyond simply verbal communication. One such situation is where husbands attend consultations with their wives. While the presence of the husband may arguably play a supportive role, it can also have the effect of suppressing relevant communication and can conceal issues of domestic abuse. A practice in some UK hospitals, known as the 'dot on the pot', consists of placing posters in toilet

¹²⁹ Application no. 53924/00, judgment of 8 July 2004. The case concerned a pregnant woman of Vietnamese origin, Mrs Vo (the applicant), who attended an examination at Lyons General Hospital during the sixth month of her pregnancy. Another patient, Mrs Van Vo, was due to have a contraceptive coil removed at the same hospital. The doctor called for Mrs Vo, and the applicant answered. Following a brief interview in which the applicant's limited French was noted, the doctor, believing the applicant to be Mrs Van Vo, sought to remove the coil without examining her beforehand. In doing so the doctor pierced the amniotic sac, causing a loss of amniotic fluid, and eventually the pregnancy had to be terminated for health reasons. While the case could be perceived merely as one of medical error due to lack of language skills, it has a broader significance, alerting healthcare professionals to the very high probability of making mistakes in similar situations. In the current case, medical professionals could have benefited from training to teach them to pay special attention to identifying persons by a name, as in many cultures a last name is not sufficient to determine individual identity – eg the name Singh is common among Sikhs.

¹³⁰ Questionnaire response to the Equal Rights Trust received from the Spanish ministry of health, undated.

cubicles which inform women, when they are giving a urine sample, that if they are suffering domestic abuse, they can alert hospital and medical staff by taking the dot off the poster and sticking it on the urinal pot.

Consequently, robust training to enable practitioners to develop strong communication skills when dealing with religious patients – and with patients of religious/cultural minorities in particular – is a need that has been recognized by health practitioners, religious leaders and the state. Fulfilling this need is essential if equal access to healthcare irrespective of religion or belief is to be guaranteed. However, translating the need into effective healthcare policy faces a number of challenges, such as the lack of research identifying good practices from which others could learn; healthcare practitioners' time constraints; and financial constraints on healthcare budgets. Healthcare policy should seek to overcome these challenges by integrating training into existing professional development schemes for healthcare practitioners.

3.2.2 Substance abuse

Smoking cannabis has been identified as an issue relating to the religious observance of Rastafarians in the UK, who claim it as an 'aid to worship'.¹³¹ It is also well known that mind-altering drugs are used among adherents of some tribal cults and New Age religious movements. As to cannabis, there are significant healthcare implications. Studies have shown that smoking cannabis increases the likelihood of (a) developing smoking-related illness;¹³² (b) negative consequences on male reproductive functions, as cannabis has been shown to adversely affect male fertility;¹³³ and (c) mental-health problems.¹³⁴

However, the case of Rastafarians is somewhat exceptional in Europe, and while mind-altering substance use as part of religious or quasi-religious practice may be an issue in Europe at this time, the main policy challenge related to the link between religion and substance abuse lies rather in the opposite direction. There are certain strongly negative attitudes in religious communities

¹³¹ In November 2000, the *Guardian* newspaper reported that in the United Kingdom a Rastafarian, charged with possession of cannabis with intent to supply, appealed to have his case reconsidered under article 9 of the Human Rights Act. The applicant argued that the smoking of cannabis should be considered as 'an aid to worship, medicine, and as a source of income'.

¹³² Smoking-related illness is caused by cannabis smoke itself and when cannabis is mixed with tobacco. See D R Tashkin, G C Baldwin, T Sarafian, S Dubinett and M D Roth, 'Respiratory and immunologic consequences of marijuana smoking', *Journal of Clinical Pharmacology*, vol 42, 2002, pp 715–815; and R Melamede, 'Cannabis and tobacco smoke are not equally carcinogenic', *Harm Reduction Journal*, 2005, vol 2:21.

¹³³ 'Sperm from marijuana smokers move too fast too early, impairing fertility, UB research shows', University of Buffalo, 13 October 2003. Available at www.buffalo.edu/news/6427.

¹³⁴ See *Cannabis and Mental Health*, leaflet published by the Royal College of Psychiatrists, August 2006. Available at www.rcpsych.ac.uk/mentalhealthinfo/problems/alcoholanddrugs/cannabisandmentalhealth.aspx.

towards tobacco,¹³⁵ alcohol and illicit mind-altering drugs. Condemnation can be directed at users or addicts in ways that fail to appreciate the medical aspects of dependency and stress the moral aspects, presenting addicts as sinners deserving punishment.

3.3 Emerging policy trends and outstanding policy questions

This section has shown that religious diversity places a broad range of demands on healthcare systems. In turn, the hospital as a local-level institution regulated by the state faces huge challenges in accommodating the needs of religious patients. Outside hospitals, challenges also exist and include, among other things, training for practitioners and various health issues related to life styles and patterns of behaviour such as substance abuse. The demand to accommodate religious patients is particularly acute when patients are from religious minority groups. Furthermore, the task of reasonable accommodation is made increasingly difficult by competing factors such as lack of knowledge of issues, insufficient training, finite resources and imperatives of religious observance, which require different modes of operation within hospitals.

Nonetheless, the policy principle that the healthcare system should accommodate religious difference is an aspect of the positive duty of the state to fulfil human rights, and is based on a range of human rights, including the rights to health, religious freedom and non-discrimination. People of diverse religious backgrounds, including minority religions, are citizens of the state or non-citizens under its jurisdiction, and as such are entitled to equal access to healthcare. Therefore, national healthcare policy should take into consideration the needs of religiously diverse groups and accommodate them where accommodation is reasonable.

One important factor to consider when deciding whether accommodation of religious needs is reasonable is the needs of patients without religion, who might feel uncomfortable in an environment saturated with religiously oriented policies. At the local level, where such policies will be rolled out, hospitals should be given the flexibility to develop nationally enforced policies and to tailor them to their local area, and this will include taking account of the non-religious parts of the community. This should not supplant any national strategy but should build upon existing principles.

¹³⁵ See, for example, K Singh Sehmi, 'Patterns and distribution of tobacco consumption in India: impact of religion was not considered', *British Medical Journal*, vol 328, 2004, pp 1498–9; available at www.bmj.com/cgi/content/full/328/7454/1498-b. This article explains that Sikh Punjabis have the lowest tobacco consumption rates both in the United Kingdom and in India on account of a decree set on 13 April 1699 (Baisakhi) in the Sikh Commonwealth of North India, which banned tobacco use through a baptism ceremony called the Amrit ceremony.

Across the European Union, emerging policy trends include:

- i** Recognition of the importance of access to religious assistance is leading to the introduction within hospitals of religious counselling and faith space, in order to facilitate worship and to meet patients' religious needs in access to healthcare. Decisions regarding the most appropriate method to organize faith space are increasingly being made at the level of local policy. Trends in EU states suggest that a space which accommodates all local religions and a neutral meditation space are the two main policy approaches taken by hospitals.
- ii** Healthcare policy in hospitals has sought to determine whether a patient's refusal to be treated by a practitioner of the opposite sex should be respected. If adopted, such a policy must ensure that the right to equality and non-discrimination of the healthcare provider is balanced with the patient's preference. Policy-makers are also seeking to factor in further considerations, including human resources in hospitals, social cohesion and the quality of the health service.
- iii** Healthcare policy increasingly involves identifying the training needs of healthcare practitioners and medical staff. The provision of religiously and culturally sensitive training which enables effective communication with religiously diverse patients is a major challenge across EU states. The outstanding concern is whether training of health professionals, which incorporates training on religious and cultural issues, is undertaken nationally through ongoing professional development or locally through the hospital, where the needs of the surrounding community can be better assessed.
- iv** Healthcare policies are trying to ensure that the link between religion and substance abuse is addressed on the basis of the principle of harm reduction; and that such policies discourage religiously motivated stigmatization of the victims of substance abuse.

Recommended policy questions for further research

- 1** Is it acceptable for hospitals to deny religious or spiritual services on secularist grounds? What are the advantages and disadvantages of maintaining a neutral meditation space in hospitals as compared with a faith space that seeks to accommodate all faiths?
- 2** Should a patient's request for a health practitioner of a particular sex be granted as an exercise of their rights to privacy and freedom of religion, or denied as unlawful discrimination on grounds of sex?
- 3** To what extent should training on cultural and religious issues be a requirement in the ongoing professional development of healthcare practitioners?

4 Religion and sexual and reproductive healthcare

The cluster of issues surrounding religion and sexual and reproductive healthcare is highly charged. From a human rights point of view, the discourse in this area is marked by tensions among the competing rights of freedom of religion or belief, health, equality and non-discrimination, and it also involves the rights to life, privacy and freedom of expression, among others. Furthermore, on account of the essential gender dimension of sexual and reproductive health, this area of policy is also strongly influenced by women's rights movements. Indeed, in Europe advocacy organizations have repeatedly urged EU member states to guarantee, maintain and promote the sexual and reproductive rights of all women without religious or cultural distinction.¹³⁶ This section examines how religion and healthcare policy have interacted on a number of sexual and reproductive issues, including contraception, HIV/AIDS, sexually transmitted disease, abortion, sterilization, fertility treatment and reproductive techniques, circumcision, and female genital mutilation.

4.1 Contraception, HIV/AIDS and other sexually transmitted disease

In most religions, the attitude to contraception is a critical issue on which a particular religion's perspective on a range of other reproductive, sexual and moral issues depends. The evolving positions of the major religions on contraception

¹³⁶ See, for example, *Religion and Women's Human Rights*, European Women's Lobby, position paper, adopted 27 May 2006.

inevitably affect policy approaches to HIV/AIDS and sexually transmitted diseases (STDs), among other issues. In comparison to other regions, Europe has a relatively low percentage of HIV/AIDS infection.¹³⁷ However, in many European states religion has a clear impact on access to treatment for people with HIV/AIDS. Similarly, religion influences attitudes and policies related to other STDs.

4.1.1 The influence of religion on contraception policy

Regarding contraception, in the European policy context the most influential opinion-shaper among religions in the last few decades has been Catholicism. According to the official Vatican doctrine of 1968, the only morally acceptable contraception is 'recourse to infertile periods' and the natural cycle method of contraception.¹³⁸ Other methods of contraception are viewed as illicit. The 1968 encyclical letter of the Vatican on this issue states:

We are obliged once more to declare that the direct interruption of the generative process already begun and, above all, all direct abortion, even for therapeutic reasons, are to be absolutely excluded as lawful means of regulating the number of children. Equally to be condemned, as the magisterium of the Church has affirmed on many occasions, is direct sterilization, whether of the man or of the woman, whether permanent or temporary. Similarly excluded is any action which either before, at the moment of, or after sexual intercourse, is specifically intended to prevent procreation – whether as an end or as a means.¹³⁹

However, it should be noted that in reality many people who identify themselves as Catholic do not necessarily follow all of the Vatican's positions or teachings, and that, as within all major religions, different interpretations of contraception exist among the Catholic parts of different EU states. On the whole, it appears that the influence of religion on contraception policy in EU states has diminished in recent years. Robust mechanisms are now in place to enable those who wish to access contraception to do so.

In the recent past, despite the Vatican's official doctrine on contraception, Catholic organizations have not been so stringent in their criticism of the use of

¹³⁷ *Population and HIV/AIDS*, United Nations Department of Economic and Social Affairs, Population Division, March 2008. Available at www.un.org/esa/population/publications/AIDS_Wallchart_web_2007/HIV_AIDSchart_2007.pdf.

¹³⁸ Encyclical Letter *Humanae Vitae* of the Supreme Pontiff Paul VI to his Venerable Brothers the Patriarchs, Archbishops, Bishops and other Local Ordinaries in Peace and Communion with the Apostolic See, to the Clergy and Faithful of the Whole Catholic World, and to all Men of Good Will, on the Regulation of Birth, 25 July 1968. Available at www.vatican.va/holy_father/paul_vi/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae_en.html.

¹³⁹ *Ibid*, para 14.

contraception such as condoms.¹⁴⁰ A 2003 United Nations report demonstrated that most European states provided either direct or indirect support for contraceptive methods.¹⁴¹

However, there has been a degree of influence from religion. Ireland, for example, was the last country in Europe to permit the use of modern contraception. This reflects the dominant position of Catholicism in Ireland and the wider influence it has had on many health policy considerations, as compared with other European countries.¹⁴² Clause 11 of the Irish Family Planning Act 1979 enables individuals to use religious freedom arguments to refuse the sale, importation into the state, manufacture, advertising or display of contraceptives. In Ireland, because of the historic influence of the Catholic Church, such a provision could substantially limit the accessibility of contraceptives. The increase in other methods of sale, such as vending machines, may alleviate, though not remove, the problem of access to contraception.

4.1.2 The influence of religion on HIV/AIDS education and prevention policies

According to recent research, religion has had a significant influence on the spread of HIV/AIDS among Evangelical and Pentecostal African immigrants. Researchers indicated that there were high levels of HIV/AIDS sufferers among these communities in London.¹⁴³ Doctors treating these immigrants, and in particular pregnant immigrant women, have reported that patients had been receiving conflicting advice and direction from their religious leaders, who were telling them that they should not take medication during pregnancy. This resulted in pregnant women's refusal of HIV/AIDS treatment. No guidance is provided to professionals in these fields of healthcare, in stark contrast with other socially significant health issues such as procedures for treating Jehovah's Witnesses, where guidance is supplied to healthcare professionals.

In Spain, local-level research revealed that some migrants did not believe that HIV/AIDS even existed: about 15 per cent of a sample of 800 African migrants in Spain maintained this belief. Furthermore, in one HIV/AIDS prevention

¹⁴⁰ For example, the Spanish Bishops Conference, the body representing all of Spain's bishops, issued a statement saying that condoms have a place in global prevention of AIDS. See S Arie, 'Crusading for change', *British Medical Journal*, vol 330, 2005, p 926. Available at www.bmj.com/cgi/content/full/330/7497/926.

¹⁴¹ *Fertility, Contraception and Population Policies*, United Nations Department of Economic and Social Affairs, Population Division, 25 April 2003. Available at www.un.org/esa/population/publications/contraception2003/Web-final-text.PDF.

¹⁴² See O McDonnell and J Allison, 'From biopolitics to bioethics: church, state, medicine and assisted reproductive technology in Ireland', *Sociology of Health and Illness*, vol 28, no. 6, 2006, pp 817–37.

¹⁴³ Testimony provided to the Equal Rights Trust by Birgitta Essén, 17 September 2008.

programme, it was established that 77 per cent of respondents perceived faithfulness as being more effective than contraception in preventing the spread of HIV/AIDS. Of those who held this view, 81 per cent belonged to a religious group.¹⁴⁴

In both the Spanish and the UK context the predominant identifiable policy trend is recognition of the need for education. It is necessary to educate people about HIV/AIDS and about the efficiency of each preventive method of contraception. While religion may play its part in the final decision of the patient on which contraceptive method to use, it should not be allowed to shape the information that healthcare practitioners give to patients. Such information should provide adequate scientifically based guidance, allowing patients to make an informed choice as to which method to use to protect their health.

Policy development would benefit from further research into useful initiatives made by religious groups or organizations in Europe which provide advice and guidance to sexual minorities with respect to HIV/AIDS. The evidence at hand suggests that such initiatives are not well known. But in one positive example, in the UK, religious leaders and religious community facilities launched supportive initiatives at the local level, to educate and raise awareness of HIV/AIDS.¹⁴⁵

Another issue that deserves attention is the complicity of religion in the stigmatization of people living with HIV/AIDS. According to the World Health Organization (WHO), conservative policy-makers have used religiously motivated arguments to distinguish between 'innocent' and 'guilty' HIV/AIDS sufferers:

Claiming a distinction between [people living with HIV/AIDS] who were 'innocent' (HIV-infected children or recipients of contaminated blood and blood products) and those who were 'guilty' (such as gay men and injecting drug users (IDU)), conservative policy-makers used moral and religious grounds to effectively erect barriers to public health measures that would have saved thousands of lives.¹⁴⁶

Furthermore, in the same study WHO suggest that Italy and Spain were slow to introduce needle exchanges for injecting drug users, as a consequence of socio-cultural and religious pressures on healthcare policy-makers.¹⁴⁷

¹⁴⁴ Testimony provided to the Equal Rights Trust by Bárbara Navaza and Anne Guionnet, October 2008.

¹⁴⁵ See, for example, the initiative taken by Camden Council in London: www.camden.gov.uk/ccm/content/press/2007/november/mosque-opens-doors-to-all.en.jsessionid=B17F409E4148B87B64DFD5D02AA33D92.node1.

¹⁴⁶ *HIV/AIDS in Europe: Moving from death sentence to chronic disease management*, World Health Organization Europe, 2006. Available at www.euro.who.int/document/e87777.pdf.

¹⁴⁷ *Ibid.*

As pointed out above, the reservations held by religious organizations about healthcare policies that seek to combat HIV/AIDS are based on fundamental positions regarding contraception. From the perspective of the official Roman Catholic Church, the strong reservation regarding condom use is based on the church's understanding that sexual activity should largely serve a procreative function. Such reservations may, however, start to be challenged, as recent comments from prominent Catholic officials suggest that the life-saving functions that contraception can perform should be recognized in the fight against HIV/AIDS. Furthermore, such sentiments are shared by some prominent members of the Catholic Church, who are influential leaders of opinion.

4.1.3 The influence of religion on other STD policy

Although there have been exceptions, religion has reportedly played a largely negative role in sexual education policies, as well as in the stigmatization of 'guilty' STD (sexually transmitted disease) sufferers. Even without necessarily having been instructed by their religious authorities, some devout religious people refuse to accept sex education because it allegedly violates their religious preference – even though there is overwhelming evidence that shows the spread of STDs and the rates of STDs (as well as teenage pregnancy) are lower when comprehensive sex education is taught in place of abstinence-only education.

State policies to combat some STDs have also been challenged by religious institutions. Reportedly, in both the UK and the Netherlands the Catholic Church has opposed the provision of a vaccination against the Human Papilloma Virus (HPV) for pre-teenaged girls. A reasoned opinion by the UK's Catholic Bishops' Joint Bioethics Committee justified their objection to the vaccination policy with the concern that it would have to be made clear (which it was not) that promoting the vaccination did not result in young people engaging in sexual activity at an earlier age.¹⁴⁸ Additionally, the Catholic Bishops released a statement which urged that efforts be made to change behavioural patterns which accept or encourage early sexual activity. Muslim organizations have also expressed reservations about the application of the UK policy on HPV vaccines, although their reservations are motivated not by the substance of the policy but by the idea of administering the vaccine during Ramadan.¹⁴⁹

¹⁴⁸ See D Fitzpatrick, 'Ethical considerations in the use of Human Papilloma Virus (HPV) vaccines', Catholic Bishops' Joint Bioethics Committee. Available at www.catholic-bioethics.org.uk/documents/CervicalcancervaccinepaperforCBJBC.doc.

¹⁴⁹ C Santry, 'Cervical cancer immunisation plans may exclude Muslim girls', *Health Service Journal*, 4 September 2008. Available at www.hsj.co.uk/news/2008/09/timing_of_hpv_vaccine_during_holy_month_criticised.html.

It appears that religious viewpoints have been used by political conservatives to argue against the introduction of facilities and services to provide support for sufferers of STDs (including HIV/AIDS) across Europe. In spite of this, religion has in general been expected to play a role in combating STDs, particularly by serving a positive educational function. While at present the involvement of religious institutions in education and awareness-raising initiatives is limited, a trend seems to be emerging in religious discourses, and Catholic discourses in particular, that contraception should be used to combat the spread of STDs.

More research is needed into the influence on STD policies of other religious organizations and religious doctrines in the European Union, such as Christian Orthodox, Jewish, Muslim and Hindu.

4.2 Abortion and sterilization

4.2.1 Some religious positions on abortion

Religious beliefs regarding abortion vary from religion to religion. Nonetheless, abortion remains a highly sensitized issue and a point of contention for most. In European countries, it is once again Catholicism that has been particularly vocal in its opposition to abortion. The Vatican doctrine is set out in the 1974 'Declaration on procured abortion':

It must in any case be clearly understood that whatever may be laid down by civil law in this matter, man can never obey a law which is in itself immoral, and such is the case of a law which would admit in principle the licity [sic] of abortion.¹⁵⁰

Thus the Vatican position, based on the sanctity of life, whereby life is viewed as starting from the moment of conception, considers procured abortion morally illicit. Jewish law is ambiguous on abortion; a single position is not forthcoming from research. Some traditions of Judaism generally accept abortion, whereas in others abortion is only permitted if the life of the mother is in danger.¹⁵¹ In Islamic law abortion is subject to much debate at present. Within Islam, there are generally three different opinions. According to some scholars, abortion is forbidden altogether after insemination of the ovum. Others state that it is only forbidden after the 120th day of pregnancy (the moment the soul allegedly enters the foetus) and allow it for any reason before this time. A third interpretation is that abortion is permitted before the 120th day but only for important reasons. All three

¹⁵⁰ Sacred Congregation for the Doctrine of the Faith, 'Declaration on procured abortion', para 22, 18 November 1974. Available at www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19741118_declaration-abortion_en.html.

¹⁵¹ See www.bbc.co.uk/religion/religions/judaism/jewishethics/abortion_1.shtml.

positions, however, agree on the possibility of an abortion after the 120th day, if the life and health of the mother is at stake.¹⁵²

4.2.2 National policy positions

As appendix D (National policy on abortion in some EU states) shows, the influence of the official Catholic (Vatican) doctrine on abortion is reflected in the national policy of states where the Catholic presence has traditionally been strong. From appendix D, laws and policies can be classified as follows:

- abortion banned (Malta)
- abortion permitted only to save the life of the woman (Ireland)
- abortion permitted to save the life of the woman, to preserve the woman's mental or physical health, for reasons of rape or incest and for foetal impairment (Poland, Spain)
- abortion permitted as above and also for economic or social reasons (UK and Finland)
- abortion available on request before the end of a specified term of pregnancy (Bulgaria, France, Czech Republic, Sweden)

Malta, Ireland, Spain and Poland – all states with traditional ties to Catholicism – have the strongest restrictions on abortion. The Irish case is particularly worthy of note. A 1983 referendum in Ireland secured the Eighth Amendment to the Irish Constitution, 'the right to life of the unborn'. This amendment, which essentially serves to limit abortion to instances where the life of the mother is in danger, was motivated by a fundamentalist Catholic social movement and the birth of the ideal of a pro-life nation.¹⁵³ States with the most liberal abortion policies, such as Bulgaria, the Czech Republic and France, are deeply secular. Thus it seems that abortion policy across Europe is heavily influenced by religious considerations, and Catholicism in particular.

In addition to shaping policy with regard to circumstances in which abortion is permitted, religion has also attempted to influence policy regarding timescales for abortion. One pertinent example was the recent parliamentary vote in the UK regarding the permissible gestational limit of the foetus. The gestational limit – the point up until which an abortion can be performed – varies across EU states. Following a call for a review and reduction of the 24-week limit by the

¹⁵² See, for example, K Aramesh, 'Abortion: an Islamic ethical view', *Iranian Journal of Allergy, Asthma and Immunology*, vol 6 (5), February 2007, pp 29–33.

¹⁵³ See note 142 above.

head of the Catholic Church of England and Wales and Conservative politicians,¹⁵⁴ the UK parliament voted to reject a proposal to reduce the gestational limit to 22 weeks.¹⁵⁵ Moreover, it has been reported that in the UK, when faced with the issue of foetal deformities, families often seek guidance from religious leaders to ensure that their actions are in accordance with their religious faith.¹⁵⁶ This research accords with a German study concluding that religion was an important variable in what women said about aborting a foetus diagnosed as disabled.¹⁵⁷

4.2.3 Safeguards when abortion is denied

Analogies have been drawn between abortion and euthanasia with respect to the demand for safeguards if medical practitioners invoke a right to belief-based exemption from performing abortion. Often laws which permit abortion are nuanced by the caveat that healthcare practitioners who express a religious reservation to performing it can be exempt. As pointed out above with regard to euthanasia, some have argued that exemption from euthanasia is legitimate as it has no function in reducing the level of pain or harm to a person and is not in itself a standard medical procedure. One must consider whether this same approach should apply to abortion.

A strong religious ethical consideration – the sanctity of life – links conflict of duty regarding abortion and euthanasia. However, abortion can also serve a harm-reducing function, for example in the case of a therapeutic abortion. As such, it is generally accepted that in certain strictly defined conditions, medical practitioners should never be permitted to refuse to perform an abortion. This reflects the law across European states (see appendix B), where greater exemption is afforded in cases of conflict of duty when the abortion is procured or voluntary.¹⁵⁸

Policy difficulties remain in determining what level of permissible belief-based exemption should be tolerated when there is a serious risk to the health of the woman. National policies on this issue are less well defined across

¹⁵⁴ See 'Cardinal urges abortion rethink', BBC News Channel, 21 June 2006. Available at <http://news.bbc.co.uk/1/hi/health/5099362.stm>.

¹⁵⁵ See 'MPs back 24-week abortion limit', BBC News Channel, 20 May 2008. Available at http://news.bbc.co.uk/1/hi/uk_politics/7409696.stm.

¹⁵⁶ Testimony provided to the Equal Rights Trust by Imam Yunus Dudhwala, 17 September 2008.

¹⁵⁷ S L Erikson, 'Post-diagnostic abortion in Germany: reproduction gone awry, again?', *Journal of Social Science and Medicine*, vol 56, 2003, pp 1987–2001.

¹⁵⁸ For example, only Germany and Ireland exempt practitioners from undertaking an abortion in any circumstances (see appendix B). A much broader range of EU member states, however, permit belief-based exemption in cases of voluntary or procured abortions.

the EU and decisions of this nature are often left to courts.¹⁵⁹ What is more certain is that, irrespective of whether a right to belief-based exemption is still permissible if only the health and not the life of the woman is in danger, robust and effective mechanisms must be in place to safeguard the right of the woman swiftly to obtain an abortion by another practitioner.

One example which illustrates the seriousness of this scenario and the need for all healthcare systems to have effective policies in place is the case of *Tysi c v. Poland*.¹⁶⁰ This case concerned a Polish woman who had suffered for many years from severe myopia. When she discovered that she was pregnant for the third time, she consulted several doctors in Poland to determine what impact this might have on her sight. Although the doctors concluded that there would be a serious risk to her eyesight if she carried the pregnancy to term, they refused to issue a certificate authorizing termination. She secured a referral for a termination on medical grounds, but the gynaecologist refused to perform it. There was no procedure through which Ms Tysi c could appeal this decision and she gave birth to a child in November 2000. Her eyesight deteriorated further following the delivery and she now risked going completely blind. In its judgment the European Court of Human Rights criticized the lack of effective mechanisms that would have been capable of determining whether the conditions for obtaining a lawful abortion had been met in her case. Consequently, Polish abortion law 'created for the applicant a situation of prolonged uncertainty. As a result, the applicant suffered severe distress and anguish when contemplating the possible negative consequences of her pregnancy and upcoming delivery for her health.'¹⁶¹

The Court's judgment establishes a clear need for safeguard mechanisms. In EU states where access to abortion is limited, women who wish to access their right to termination may face increasingly negative experiences. Furthermore, challenges such as the negative perceptions of the community and the task of finding a doctor willing to perform an abortion (which may involve serious travel, time and financial costs) compound the difficulties faced by women seeking their right to a termination. If such safeguards are not ensured, it will inevitably lead to

¹⁵⁹ See, for example, *Personal Beliefs and Medical Practice: Supplementary guidance*, General Medical Council, March 2008. This guidance explains that UK courts have set limits on the ability of a practitioner to refuse to participate in an abortion. It sets out that a practitioner has no legal or ethical right to belief-based exemption if pre- or post-abortion patients need medical assistance, as the definition of 'participation in abortion' has been interpreted to mean 'actually taking part in treatment designed to terminate a pregnancy' in the case of *Janaway v. Salford Health Authority*, All England Law Report 1998 Dec 1; [1988] 3:1079–84.

¹⁶⁰ Application no. 5410/03, judgment of 20 March 2007.

¹⁶¹ *Ibid*, para 124.

an unacceptable position where women are forced to seek underground illegal abortions.¹⁶²

4.2.4 Sterilization

Within EU member states national health policy on sterilization takes three forms.¹⁶³ Sterilization is legal within a number of EU member states,¹⁶⁴ but laws regulating the practice impose restrictions and limits to access. Age is one major factor which the law regulates with respect to sterilization. Swedish law, for example, permits people over 25 years of age to have a sterilization for contraceptive purposes and people between 18 and 25 years of age for health reasons. In a number of states sterilization is not available.¹⁶⁵ Finally, in a number of states the national policy on sterilization remains unclear.¹⁶⁶

In spite of the plurality of approaches by states, it appears that countries with strong ties to secularism have legalized sterilization, whereas those states which have historical bonds to religion do not have significant laws in place permitting access to sterilization. Indeed, this is unsurprising, as traditional interpretations of the Catholic religion, for example, oppose voluntary sterilization on the same grounds on which they oppose contraception.¹⁶⁷ In both cases, it is the right of the person to choose the number and spacing of their children that is at stake. Despite the inherent difficulties to be faced by public policy-makers, sterilization as a method of contraception should also be a matter of health policy, where a balance should be sought between personal rights to bodily autonomy and the right to belief-based exemption.

4.3 Fertility treatment and reproductive techniques

Developing technology has empowered healthcare practitioners to overcome reproductive barriers that inhibited fertility in the past. In the European Union, the EU Tissues and Cells Directive¹⁶⁸ now regulates many standards relating to safety and quality involved in undertaking assisted reproduction and fertility

¹⁶² See 'Concluding observations to Poland's periodic report under the International Covenant on Civil and Political Rights', UN Human Rights Committee, CCPR/CO/82/POL, 2 December 2004.

¹⁶³ See *Sterilization Laws and Government Funding for Family Planning Services in EU Countries*, Astra Network, 2006. Available at www.astra.org.pl/sterilization.pdf.

¹⁶⁴ For example, Austria, Czech Republic, France, Germany, Hungary, Spain and Sweden.

¹⁶⁵ Estonia and Latvia are examples.

¹⁶⁶ Ireland, Poland and Malta fall within this group.

¹⁶⁷ See note 138 above, para 14.

¹⁶⁸ Directive 2004/23/EC of the European Parliament and of the Council of 31 March 2004 on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells.

treatment.¹⁶⁹ It sets minimum standards for safety and quality in relation to the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells, including reproductive cells. At present, national policies on fertility and reproductive treatment are inconsistent and fragmented. In response to this, experts have called for the removal of barriers such as the lack of medical reimbursement policies in order to improve the accessibility of such treatment.¹⁷⁰ Recent studies suggest that the reimbursement and funding of fertility treatment differ from country to country in Europe.¹⁷¹ One illustration of this is the contrast between Italy and France. In Italy the financing of such services is characterized by a high level of personal payment, whereas in France such services are normally funded through the national health service. Within national health policy on fertility treatment, whether infertility is defined as an illness similar to other medical conditions is often a material factor in reimbursement and funding.¹⁷²

It has been argued that the influence of religious institutions on national policy has left some states out of step with European standards on fertility treatment and reproductive techniques, in particular where Catholicism is strong in the culture. The Vatican doctrine on this issue is well developed and rejects medical techniques which seek to secure procreation that (a) may destroy embryos; and (b) dissociates procreation from 'the integrally personal context of the conjugal act'. Therefore, the Catholic doctrine rejects as illicit reproductive techniques such as in vitro fertilization (IVF) or intracytoplasmic sperm injection.¹⁷³ At the level of practice, Comparative example 1 (see section 2.1.2 above) illustrates how religious doctrine can cause discrimination not only for unmarried couples but also for gay and lesbian couples. Just as significantly, at the level of policy, religious doctrine has sought to influence the development of healthcare regulation in this area.

Throughout Europe countries have enacted laws to regulate fertility treatment and assisted reproduction. Some countries, eg France, permit fully comprehensive and liberal access, while others such as the UK are more moderate but

¹⁶⁹ RA Fenton, 'Catholic doctrine versus women's rights: the new Italian law on assisted reproduction', *Medical Law Review*, vol 14, spring 2006, pp 73–107.

¹⁷⁰ 'Good clinical treatment in assisted reproduction', position paper of the European Society of Human Reproduction and Embryology, *The Parliament*, issue 274, 29 September 2008, pp 84–9.

¹⁷¹ 'Between politics and clinics – the many faces of biomedical policy in Europe: analysis of drivers and outcomes of Assisted Reproductive Technologies policy', vol 1: Synthesis report, RAND Europe, 2008.

¹⁷² *Ibid.* This study shows that the absence of the label 'illness' has meant that funding of assisted reproductive technology is patchy in both Italy and the UK.

¹⁷³ See Congregation for the Doctrine of the Faith, 'Instruction *dignitas personae* on certain bioethical questions', 8 December 2008. Available at www.vatican.edu/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html.

are moving towards liberalizing access. Others still, typified by Italy, have highly restrictive regulations.¹⁷⁴ The Italian process of adopting a law on assisted reproduction¹⁷⁵ was noteworthy for the influence exerted by the Catholic Church.¹⁷⁶ Fenton states that:

In Italy, the domination of patriarchal ideology is undisguised. The law uses coercion to undermine freedom of choice. It presumes incapacity to make the 'right' choice and assumes a protectionist role in the name of ethics. The Roman Catholic Church may have been concerned about lack of regulation leading to damaging consequences for civil society. By its obeisance to Catholic doctrine, inappropriate to address scientific and technological advances in reproduction, and unfitted for secular democracies, the Italian legislature has arguably done more damage.¹⁷⁷

Thus, whilst under the previous legal regime there existed a vacuum, under current Italian law respective provisions include a ban on the use of donor gametes – ie egg, sperm or embryo donation.¹⁷⁸ In addition, under article 4 (1) of Law 40/2004, access to reproductive technologies requires an infertility certificate; and under article 1 (2), only when other methods of combating infertility or sterility have proved ineffective is assisted reproduction to be considered as a last resort. In these and other ways Italian law reflects the Vatican's doctrine.¹⁷⁹ The effects that the law will have on people's access to fertility treatment are significant, and there are growing concerns that they will lead to fertility tourism by Italian women.¹⁸⁰

Ireland, too, has been slow to develop policy on assisted reproduction and currently has no law to regulate this field. In Ireland, which like Italy is closely associated with Catholicism, techniques such as IVF are not available through the public health system, although some private clinics provide this service.¹⁸¹ But even there, the use of reproductive techniques is regulated by restrictive guidelines issued by the Irish Medical Council, which according to McDonnell and Allison were meant to appease the Catholic Church.¹⁸²

Restrictive guidelines, especially if unregulated by law, cannot be trusted to effectively balance religious, political and health interests and can create

¹⁷⁴ See note 171 above.

¹⁷⁵ Law 40/2004.

¹⁷⁶ See note 169 above. See also J A Robertson, 'Protecting embryos and burdening women: assisted reproduction in Italy', *Human Reproduction*, vol 19 (8), 2004, pp 1693–6.

¹⁷⁷ See note 169 above, p 106.

¹⁷⁸ Article 5 of Law 40/2004.

¹⁷⁹ See note 169 above.

¹⁸⁰ *Ibid.*

¹⁸¹ See 'In Vitro Fertilization (IVF) in Ireland', *Irish Health*, 29 January 2003. Available at www.irishhealth.com/article.html?con=528.

¹⁸² See note 142 above.

space where malpractice spreads. In Greece, for example, research has demonstrated how urban Greek couples and clinical practitioners in the 1990s proceeded with IVF in the absence of government regulations, and did so with reference to cultural beliefs and social relations consistent with Greek Orthodox religious practice.¹⁸³ Researchers have also contrasted the position within European legal systems and the practices operating in Middle Eastern states under Islamic law, observing that in Iran, where the legal system restricts fertility treatment to heterosexual couples, the role of Islam is central.¹⁸⁴

Research on European policy has shown that various religions, in particular Christianity,¹⁸⁵ have influenced policy-makers, practitioners and patients in the field of fertility treatment and reproductive techniques. This influence affects not only the practices of practitioners who may refuse to perform fertility treatment on religious grounds, but also the prospects of patients receiving fertility treatment, as well as the development of law and policy by European states on regulating fertility treatment and reproductive techniques.

States in the European Union that have strong ties to Catholicism have deliberately been slower to adopt and implement laws that help infertile people to get medical help. Religious institutions have sought to have national policy reflect religious doctrine and thereby to promote a system of restrictive regulation. In countries with traditionally secular histories, legal provisions are more liberal and encouraging, treating infertility as an illness that requires medical treatment.

4.4 Circumcision

Within Europe there remains a continuing sensitivity to the issue of male circumcision. This practice is commonplace for members of religious groups such as Jews and Muslims. Both faiths stress that male circumcision does not impair male sexuality and is a positive undertaking. Some national health systems, for example the French, have no provisions for male circumcision. Other systems afford autonomy to local hospitals and healthcare providers to accommodate the needs of the local community if they require circumcision. In Germany circumci-

¹⁸³ H Paxson, 'Reproduction as spiritual kin work: Orthodoxy, IVF, and the moral economy of motherhood in Greece', *Culture, Medicine and Psychiatry*, 2006, vol 30, no. 4, pp 481–505.

¹⁸⁴ R O Samani, AVT Dizaj, MRR Moalem, ST Merghati and L Alizadeh, 'Access to fertility treatments for homosexual and unmarried persons, through Iranian law and Islamic perspective', *International Journal of Sterility and Fertility*, vol 1 (3), 2007, pp 127–30. Available at www.ijfs.ir/files/127-130.pdf.

¹⁸⁵ According to the Dutch ministry of health, there has been a strong Christian movement in the politics of in vitro fertilization; letter to the Equal Rights Trust, 22 January 2009.

sion is funded by the state, if it is not otherwise affordable.¹⁸⁶ In the UK, while male circumcision is not widely available on the NHS,¹⁸⁷ certain health authorities do provide this service.¹⁸⁸ In fact, despite the differences that exist between Jewish and Muslim practices, Muslims in the UK are reportedly keen to pay for the procedure to be undertaken by a Jewish practitioner. Finally, a number of states including Sweden have placed strict regulations on male circumcision.¹⁸⁹

Policy-makers have been asking whether circumcision should be provided for by the national healthcare system, and whether the Swedish approach of detailed regulation should be followed. Many factors are critical to this consideration; primary among them is freedom of religion. Consent also has a crucial role in this debate. If a child is of age to consent, his informed consent should be secured before any procedure takes place.¹⁹⁰

An opposing argument to permitting publicly funded circumcision is that public hospitals as institutions of the state and secular entities should not be required to adopt procedures that have specifically religious benefits. Recent research, however, which suggests that circumcision can reduce HIV infection and HPV,¹⁹¹ has been invoked to refute this charge.¹⁹²

At the same time, in formulating health policy, it is necessary to recognize that whatever the health benefits or drawbacks, ultimately the demand for public funding for male circumcision throughout Europe is religiously motivated. Taking stock of this fact, as well as claims that circumcision has some positive health benefits and economic considerations, one possible approach is for national policy to be flexible over male circumcision. This would mean that, within a set regulatory framework, hospitals were allowed to have their own policies and resources

¹⁸⁶ Testimony provided to the Equal Rights Trust by Nina Mühe, 17 September 2008.

¹⁸⁷ See P Weller, A Feldman and K Purdam, 'Religious discrimination in England and Wales', Home Office Research Study 220, June 2001, p 74.

¹⁸⁸ S Abbott and S Shahriar, 'An NHS religious and cultural male circumcision service: service users' views and experiences', *Community Practitioner*, vol 80, no. 3, March 2007, pp 20–3.

¹⁸⁹ See Y Hofvander, 'New law on male circumcision in Sweden', *The Lancet*, vol 359 (9306), p 630. Available at [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(02\)07737-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)07737-1/fulltext). Similarly, in 2008 news reports suggested that Finland was preparing legislation to legalize circumcision, provided that the procedure was undertaken by a doctor with the child's consent; see www.yle.fi/uutiset/news/2008/07/finland_considers_legalising_male_circumcision_311435.html.

¹⁹⁰ For example, the UK's General Medical Council has stated that it does not have a position on this issue, and if a practitioner is asked to circumcise, they must proceed on the basis of the child's best interests and with consent. An assessment of the child's best interests will include the child's or his parents' cultural, religious or other beliefs and values. See *Personal Beliefs and Medical Practice: Supplementary guidance*, General Medical Council, March 2008.

¹⁹¹ See *Operational guidance for scaling up male circumcision services for HIV prevention*, World Health Organization and Joint United Nations Programme on HIV/AIDS, 2008. Available at www.who.int/hiv/pub/malecircumcision/who_hiv_mc_opguide.pdf.

¹⁹² On the other hand, there have been reported instances of severe injury and ill health resulting from malpractice in relation to circumcision; see *Male Circumcision and HIV Prevention: Policy and programme implications*, technical consultation, WHO/UNAIDS, March 2007.

to fund a male circumcision programme, if a business case for it could be made and it operated with due consideration to standards of consent. This approach would allow hospitals flexibility in situations where there is an articulated social need and would enable religious minorities to access their basic religious/health needs.

4.5 Female genital mutilation

The debate over whether female genital mutilation (FGM) is religiously motivated or a culturally specific practice in some African communities has taken place in recent years. Some have charged Islam with requiring FGM, a charge that has been vigorously refuted by numerous Islamic scholars.¹⁹³ Yet the erroneous public perception that FGM is associated with Islamic practice still persists. One reason for this may be the overlap between the geographic spread of Islam in Africa and of FGM among certain African communities. The misperception is compounded by the fact that some Muslim immigrants carry with them both their culture and their religion in their journey to Europe, and the distinction between the two gets blurred in transit. The lack of association with Islam is evidenced by the fact that in some countries, including Italy, for example, certain non-Muslim groups allegedly practise FGM.¹⁹⁴

Religious scholars and broader academic literature¹⁹⁵ have strongly insisted on decoupling male circumcision, which is viewed as good for health,¹⁹⁶ and FGM. For example, one study of the subject states that within Islamic scholarship some view male circumcision as obligatory while others view it as recommended, whereas FGM is viewed as neither required nor recommended.¹⁹⁷

While FGM has long been recognized as a severe violation of human rights and has been unanimously condemned by the human-rights community (despite strategic differences on how to address the issue), national legislation on FGM across EU member states suffers from a lack of direction by European

¹⁹³ For example, the Mufti of Egypt declared FGM a crime against humanity in 2007. See also M al-Sabbagh, *Islamic Ruling on Male and Female Circumcision* (The Right Path to Health: Health Education through Religion, no. 8), WHO, Alexandria, Egypt, 1996.

¹⁹⁴ FTao, 'Italy continues crackdown on FGM', *China View*, 21 August 2007. Available at http://news.xinhuanet.com/english/2007-08/21/content_6574143.htm.

¹⁹⁵ L D Laird, J de Marrais and L L Barnes, 'Portraying Islam and Muslims in MEDLINE: a content analysis', *Journal of Social Science and Medicine*, vol 65, 2007, p 2434.

¹⁹⁶ The positive effects of circumcision on male health are not beyond doubt and have been questioned. See, for example, G Boyle and G Bensley, 'Adverse sexual and psychological effects of male infant circumcision', *Psychological Reports*, Missoula, vol 88, pp 1105–6.

¹⁹⁷ M al-Sabbagh, *Islamic Ruling on Male and Female Circumcision* (The Right Path to Health: Health Education through Religion, no. 8), WHO, Alexandria, Egypt, 1996.

law. Nevertheless, many European states have national laws which criminalize FGM. Two distinct national approaches can be identified:

- specific anti-FGM legislation (Austria, Belgium, UK)
- FGM punishable under penal code (Finland, France, Germany, Greece, Italy and the Netherlands, among others)¹⁹⁸

Policy should encourage education within Muslim and non-Muslim communities alike, sending the plain message about the harm of FGM. In Germany there are initiatives involving mosques and groups of Muslim doctors and nurses who provide information to clarify that FGM cannot be justified on religious grounds.

4.6 Emerging policy trends and outstanding policy questions

Policy regulating different aspects of sexual and reproductive healthcare is significantly influenced by religion, at both the national and the local level. In many European states, Catholicism has had the strongest influence on some policy developments, particularly in relation to abortion and assisted reproduction. Islam and Judaism have also played an important role.

Across the European Union, the emerging policy trends include:

- i The impact of religion on contraception policy is weakening in recent years, and access to contraception is improving across EU states.
- ii Identifying a positive role for religion in HIV/AIDS education and prevention policy is in progress. It has been broadly agreed that religion should not be invoked as a justification for conservative policy-making which restricts HIV/AIDS healthcare services for those who are perceived as 'guilty' sufferers. The outstanding policy issue which needs to be considered is the extent to which health or anti-discrimination law should intervene to prevent religious stigmatizing and discrimination between 'innocent' and 'guilty' HIV/AIDS sufferers by health organizations, policy-makers and practitioners.
- iii Every EU state's healthcare laws except one (Malta) permit abortion in at least one set of circumstances (usually several). Throughout EU states, religious opposition to abortion law has been strong in placing limits on legal abortion and ensuring belief-based exemptions for followers of their faith. Policy in this area is moving in the direction of ensuring that

¹⁹⁸ RA Powell, E Leye, A Jayakody, F N Mwangi-Powell and L Morrison, 'Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda', *Health Policy*, vol 70, 2004, pp 151–62.

permitting belief-based exemptions will not render the patient's right to abortion inaccessible.

- iv** Healthcare policy on fertility has been influenced by religion in states with a strong culture of religious observance. In the field of health, common EU standards are being diluted in such countries by the implementation of regressive national law. In addition, funding and reimbursement policies tend to be influenced by whether infertility is perceived as a condition that merits medical treatment. An outstanding policy issue is whether belief-based exemptions should be granted to medical practitioners unwilling to provide any form of assistance to infertile couples.

Therefore, it appears that both at the level of policy and in practice religion has been extremely influential in decision-making in relation to sexual and reproductive healthcare.

Recommended policy questions for further research

- 1** How should anti-discrimination law be applied to ensure that religion cannot be used to promote a distinction between 'innocent' and 'guilty' sufferers of HIV/AIDS?
- 2** When should belief-based exemptions to performing abortion be granted to healthcare practitioners, and what legal medical duties should be imposed (a) to ensure access to a woman's legal right to abortion; and (b) to secure the health of the woman irrespective of the belief-based exemption?
- 3** Should infertility be recognized as a standard medical condition deserving of treatment, and if yes, what provisions should be put in place to finance this treatment and how should policy address belief-based opposition?

5 Religion and mental healthcare

A broad range of academic studies have investigated the relationship between religion and mental health.¹⁹⁹ However, existing studies of religion and mental health have largely been conducted in Christian contexts and there is an urgent need for future studies to examine other religious groups. Furthermore, the question of the role of churches, mosques and synagogues in the provision of mental healthcare similarly warrants further investigation.

Research suggests that the impact of religiosity on psychological well-being is substantially moderated by the cultural context.²⁰⁰ But very few definitive generalizations can be made regarding the exact relationship. Much social research has focused on identifying the effects of religion on the mindset of individual believers. For example, one Belgian study examined the effects of membership of new religious movements (NRMs) on a person's mindset and autonomy. It concluded that NRM members were less prone to value autonomy, more submissive to authority, and more submissive to unjustified and meaningless requests and recommendations.²⁰¹

Hartz and Everett describe the problems experienced by people who have left what the authors call 'fundamentalist religions', which are often closed

¹⁹⁹ See, for example, J Abbotts, R Williams and G Ford, 'Morbidity and Irish Catholic descent in Britain: relating health disadvantage to socio-economic position', *Journal of Social Science and Medicine*, vol 52, 2001, pp 999–1005; and H G Koenig, 'Religion and medicine II: religion, mental health, and related behaviours', *International Journal of Psychiatry in Medicine*, vol 31 (1), 2001, pp 97–109.

²⁰⁰ M Lavric and S Flere, 'The role of culture in the relationship between religiosity and psychological well-being', *Journal of Religion and Health*, vol 47, 2008, pp 164–75.

²⁰¹ C Buxant and V Saroglou, 'Feeling good, but lacking autonomy: closed-mindedness on social and moral issues in New Religious Movements', *Journal of Religion and Health*, vol 47, 2008, pp 17–31.

communities with a tendency towards absolutist beliefs and strict codes of behaviour. Leaving such a community can cause distress, stigma, a sense of displacement and various other mental-health issues. The authors suggest that mental-health professionals need to receive training about the religious environments experienced by their patients in order to help them integrate into the wider community. They also argue against labelling all fundamentalists as being mentally impaired.²⁰²

In some religions a tension or resistance to psychiatry is prevalent. An extreme case is the Church of Scientology, which has vehemently opposed psychiatry and the pharmaceutical industry producing psychotropic drugs, presenting both as fake sciences that have disastrous impacts on health.

This section will focus on the ways in which religion has influenced policy in the area of mental health. First it will examine European policy trends in this area; then it will look at some elements of mental-health policy on which the influence of religion has been particularly significant. These include issues of diagnosis in religiously grounded experiences such as possession by demons and *Jinn*; and issues of therapy in selected conditions, including suicide and depression.

5.1 The European policy context and the influence of religious institutions

At this stage a more general discussion of the link between religion and mental health in Europe would be useful. According to the European Public Health Association, 450 million people suffer from a mental disorder globally and mental-health problems account for approximately 20 per cent of the total burden of ill health in Europe.²⁰³ However, as the European Commission has observed, mental-health services are underfunded in many EU countries, where on average 6 per cent of health expenditure is dedicated to mental health.²⁰⁴ The diversity in mental-health policy approaches across the EU motivated the European Commission to draft a green paper on a more comprehensive strategy for mental health in 2005.²⁰⁵

²⁰² GW Hartz and HC Everett, 'Fundamentalist religion and its effect on mental health', *Journal of Religion and Health*, vol 28 (3), 1989, pp 207–17.

²⁰³ *Briefing on the European Commission Green Paper on Mental Health*, European Public Health Association, January 2006. Available at www.eph.org/IMG/pdf/mental_health_briefing_20060111final.pdf.

²⁰⁴ *The State of Mental Health in the European Union*, European Commission, Directorate-General Health and Consumer Protection, 2004.

²⁰⁵ 'Improving the mental health of the population: towards a strategy on mental health for the European Union', green paper, European Commission, Directorate-General Health and Consumer Protection, 10 October 2005. Available at http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf.

Within a broader social context, religion has been alleged to have both positive and negative implications for mental health. One initial question that must be asked is how religion affects sufferers of mental illness – although at this stage the jury is still out on the issue. There is an almost complete lack of any definitive empirical research based on representative samples of believers and non-believers. It has been argued that at a personal level religion can be significant as it negatively influences individual attitudes towards mental health. Studies have found that people brought up in rigid religious settings express a greater sense of stigma towards mental illness.²⁰⁶

On the other hand, research has also indicated that the social benefits of being part of a religious community, such as positive interpersonal interactions, social participation and social responsibility, act as protective factors which create positive mental-health outcomes.²⁰⁷ In this sense religion has been alleged to have a positive correlation with mental health in that it promotes the family unit and the centrality of parents to a child's mental well-being. It has also been argued that religion helps avoid isolationist tendencies which may lead to negative mental-health outcomes.

It must be pointed out, however, that the religious family unit is not necessarily a better model than any other for encouraging good mental health. Under certain circumstances the evangelical methods used by some religions to promote the family unit have led, for some, to isolation and subsequent negative mental-health outcomes. For example, the social and psychological burden religious doctrine may impose on gay or lesbian people, same-sex couples or their children has been revealed as a source of guilt and social isolation, which in turn foster a whole range of neuroses and psychoses.

Bereavement has also been associated with the development of psychiatric problems which are mitigated by religious belief. Pandarakalam states that: 'In bereavement, religion enhances the ability to move on, provides a sense of transcendence, decreases the individual's anxiety about death and reduces depression.'²⁰⁸ Similarly, religion, and in particular religious assistance within hospitals, have been shown to help people cope with trauma and to aid recovery

²⁰⁶ See, for example, D Rosen, D Greenberg, J Schmeidler and G Shefler, 'Stigma of mental illness, religious change, and explanatory models of mental illness among Jewish patients at a mental-health clinic in North Jerusalem', *Mental Health, Religion and Culture*, vol 11, issue 2, March 2008, pp 193–209.

²⁰⁷ 'Prevention of mental disorders: effective interventions and policy options', summary report, World Health Organization, Geneva, 2004, p 21.

²⁰⁸ J P Pandarakalam, 'Aspects of religion relevant to psychiatry'. Available at www.rcpsych.ac.uk/pdf/Aspects%20of%20religion%20relevant%20to%20Psychiatry%20Dr.%20James%20Pandarakalam.pdf.

after serious illness.²⁰⁹ However, the positivity of religion in this regard applies mostly to people who had already been religious prior to traumatic events.

In general, stressful life events, including death of a loved one, are an important factor that affects a person's mental health. This is particularly true with respect to immigrants belonging to minority religions, where the disadvantage of being an immigrant is combined with that of following a minority religion. Events related to migration, social disadvantage, exclusion, poverty, work-related stress, and racial and religious injustice and discrimination can all affect mental health.²¹⁰ Religion purports to alleviate such stress by providing coping mechanisms and giving purpose and meaning to life.²¹¹ However, membership of minority religious groups has also been identified as a cause of such stress. One serious example of this has been the victimization, stigma and negative social attitudes experienced by Muslims in the aftermath of 11 September 2001 and subsequent terrorist attacks. Some authors have claimed that in the UK, for example, Muslims and immigrant communities are over-represented in the mental healthcare system. It is argued that this is the result of a culture shock, an inability to integrate into a completely foreign system, and may be due to healthcare professionals not being sensitive enough to distinguish between the mentally ill and those who are just having a hard time.²¹²

Notably, many recent initiatives associated with religious institutions focus on mentally disabled children and adults and aim to facilitate their community integration,²¹³ or support suicide-prevention programmes.²¹⁴ Indeed, this is part of a wider function that religion aims to perform throughout Europe.²¹⁵ Research has indicated that a number of patients' rights organizations (including

²⁰⁹ See S J Vellenga, 'Longing for health: a practice of religious healing and biomedicine compared', *Journal of Religion and Health*, vol 47, 2008, pp 326–37; and L Culliford, 'Spirituality and clinical care', *British Medical Journal*, 2002, pp 1434–5.

²¹⁰ See note 205 above, p 22.

²¹¹ G H Boswell, E Kahana and P Dilworth-Anderson, 'Spirituality and healthy lifestyle behaviours: stress counterbalancing effects on the well-being of older adults', *Journal of Religion and Health*, vol 45, 2006, pp 587–602.

²¹² H Irfan, 'Religion in mental health: the soul under pressure', Islam Online, 17 September 2002. Available at www.islamonline.net/english/Science/2002/09/article09.shtml.

²¹³ One example of this is the Faith and Light initiative run by the Catholic Church throughout Ireland.

²¹⁴ In Finland, for example, churches have helped to implement national suicide-prevention programmes. See KWahlbeck and M Mäkinen, 'Prevention of depression and suicide', consensus paper, European Commission, Directorate-General Health and Consumer Protection, 2008.

²¹⁵ According to the Conference of European Churches and Eurodiaconia, 'Churches and diaconal organizations implement strategies to prevent mental ill health, and provide services at the local and national level to children, youth, families, old people and excluded groups. They offer social support and human networks, pastoral care, counselling for risk groups, and health and rehabilitation services.' See 'Mental health from the perspective of European Churches and Diaconal Organisations', contribution to the green paper 'Improving the mental health of the population: towards a strategy on mental health for the European Union', Conference of European Churches and Eurodiaconia, 2006. Available at www.cec-kek.org/pdf/GreenPaperMentalHealth.pdf.

organizations for people with mental disabilities) are faith-based and play an important role in rehabilitation.

5.2 The influence of religion on mental illness

Religion can have a significant influence on the understanding and subsequent diagnosis of some mental diseases. Spirits and demons play a prominent role in the belief systems of many religions. Mental impairments are also often associated with issues of sin or spirituality. A lack of understanding of the religious and/or cultural context of patients from certain religious backgrounds may affect diagnosis. This is especially the case if the situation is obstructed by language barriers. Similarly, religion has been shown to interfere with therapeutic decisions and to alter health outcomes in both positive and negative ways.

5.2.1 Diagnosis of mental illness

Several studies suggest that contact with religious providers represents a key entry point into the formal mental healthcare system. This is because many people turn first to local religious leaders for help with their mental or emotional problems. The role of religious leaders depends on the presence and severity of mental-health problems, while as a rule members of the clergy are not trained to know how to recognize the symptoms of mental illness and how to direct the person into contact with the care system.²¹⁶

In the case of a person with an intense religious inner life, who experiences phenomena of a religious nature such as epiphanies, visitations and possessions, it may be difficult both for the religious leader and for the mental healthcare practitioner to draw a clear line between what is viewed as 'normal' within a certain religious culture and actual or emerging mental illness. Among western psychiatrists, there has been a temptation to regard religious fanaticism in its extreme forms as a medical rather than a moral phenomenon.

For some within Islam, the possession of persons by *Jinn* is an example of the misunderstanding of a religious experience which leads to mistakes in diagnosing a patient's mental state.²¹⁷ In Belgium and the Netherlands the influence of *Jinn* among Moroccan immigrants is reported to be significant, and many

²¹⁶ K M Harris, M J Edlund and S L Larson, 'Religious involvement and the use of mental health care', *Health Services Research*, April 2006.

²¹⁷ In Islam and pre-Islamic Arabian folklore, *Jinn* is a supernatural creature which possesses free will. *Jinns* are mentioned in the Qur'an, a whole *sura* of which is named after them (*Al-Jinn*). They can be either good or evil. Iblis (Satan) is the main evil *Jinn*, who refused to bow down to Adam when ordered by Allah. It is of great significance that certain strands of Islam deny that *Jinn* has existence or can possess people, and treat the belief in *Jinn* as a culturally based superstition rather than as part of Islam.

Moroccans attribute mental illness to *Jinn*.²¹⁸ Sheikh explains that the experience of *Jinn* is similar to experiences of possession that all world religions have encountered.²¹⁹

Mental healthcare experts have pointed out that while treating patients who believe that an angel, demon or *Jinn* is the cause of their ailment, sensitivity to religious identity is critical. Doctors have been urged to be open-minded and non-judgmental, and to recognize that possession is a common indicator of a wider mental-health issue. Although the patient and possibly their relatives have misdiagnosed themselves, beliefs based on personal religious experience are strongly held and will be hard to alter at a time when anxiety is running high.²²⁰

The example of *Jinn* possession in Muslim patients has been used to illustrate a cultural divide leading to misdiagnosis, and to argue for mental-health reform that would be more accommodating to religious difference.²²¹ It has been suggested that Muslim psychiatrists are more likely to understand the concept of *Jinn* and would enjoy greater trust from the Muslim community.

The possession phenomenon, and for European countries the *Jinn* phenomenon in particular, represents a distinct difficulty for practitioners in accurately diagnosing the mental-health status of persons of different religious, national and cultural backgrounds. There is a need, therefore, for sensitivity and understanding on the part of the practitioner, not only in order to discern and identify the real mental issue at hand but also in order to impart advice and guidance in a religiously and/or culturally sensitive way. Such guidance will provide direction for the patient and his or her family and achieve the best health outcomes possible.

5.2.2 Treatment of mental illness

Unsurprisingly, there have been numerous claims that religious practices such as prayer and meditation have cured not only physical ailments but also mental illness.²²² Also unsurprisingly, the plausibility of such reports has been consist-

²¹⁸ C Vassart, 'Les soins de santé face aux défis de la diversité: le cas des patients musulmans', Fondation Roi Baudouin, August 2005.

²¹⁹ A Sheikh, 'Jinn and cross-cultural care', *Journal of the Royal Society of Medicine*, vol 98, 2005, pp 339–40. See also N Khalifa and T Hardie, 'Possession and Jinn', *Journal of the Royal Society of Medicine*, vol 98, 2005, pp 351–3. This article describes a number of practice examples where practitioners have had to deal with migrant Muslims experiencing *Jinn*.

²²⁰ A Sheikh, 'Jinn and cross-cultural care', *Journal of the Royal Society of Medicine*, vol 98, 2005, pp 339–40.

²²¹ In Germany, Muslim men are reportedly reluctant to go to a psychiatrist as it is often considered a taboo. Also issues of distrust of the psychiatric profession are reported in regard to the Muslim community. Testimony provided to the Equal Rights Trust by Nina Mühe, 17 September 2008.

²²² Much discussion of the issue has been caused by a recent bestselling book, which tells the true story of a severely autistic boy healed by Mongolian Shamanic practices involving communication with horses. See Rupert Isaacson, *The Horse Boy: A father's quest to heal his son*, Little Brown, 2009.

ently questioned by scientists. The policy issue, therefore, is not whether to allow religion to work its alleged miracles on mental-health patients, but how to harness both the negative and the positive potential of religious experience in order to achieve the best possible health outcomes.

Reynolds suggests several ways in which religious institutions can contribute to mental healthcare policy. These include congregation-based sharing groups, lay caring teams, counselling centres, and distribution of educational publications.²²³

Exorcism

Exorcism as a 'therapy' for possession involves a religious ritual designed to evict demons or evil spirits from a person they have allegedly possessed. Exorcism as a method of treating mental-health issues has been scrutinized in the recent past. Across European states and within a variety of religions, the practice of exorcism has taken place in overzealous circumstances and been adopted to treat people suffering from mental disorders. Research has demonstrated that exorcism can be dangerous and cause further trauma to people who are suffering from identified mental illnesses, such as mania, schizophrenia and psychosis, but who are treated for demon possession. In a survey carried out by the Mental Health Foundation, several respondents said that they had been damaged by exorcism. The charity warned that exorcism and notions of demonic possession are 'conflating notions of evil and ill health'.²²⁴ A recent example which illustrates the dangerous consequences exorcism can have for mental-health sufferers was the widely reported exorcism of a nun in Romania by an Orthodox priest, the outcome of which was fatal.²²⁵

In 1999 Pope John Paul II revised the rite of exorcism within the Catholic doctrine and cautioned that exorcists must not consider people to be vexed by demons if they suffered from some form of mental illness.²²⁶ The Vatican's revision of the rite was a response to the concern that sickness and ailments which should be properly diagnosed as mental-health issues had been submerged

²²³ Mildred M Reynolds, 'Religious institutions and the prevention of mental illness', *Journal of Religion and Health*, vol 21, no. 3, 1982, pp 245–53.

²²⁴ See D Batty, 'Exorcism: abuse or cure?', *Guardian*, 2 May 2001. Available at www.guardian.co.uk/society/2001/may/02/socialcare.mentalhealth1.

²²⁵ See 'Priest jailed for exorcism death', BBC News, 19 February 2007. Available at <http://news.bbc.co.uk/1/hi/world/europe/6376211.stm>.

²²⁶ See 'Presentation of the rite of exorcism', 26 January 1999. Available at www.vatican.va/roman_curia/congregations/ccdds/documents/rc_con_ccdds_doc_1999-01-26_il-rito-degli-esorcismi_it.html (Italian only).

within the rite of exorcism. In spite of the efforts of the Vatican to urge caution in the assessment of a person's condition, exorcism can still be found in Europe.²²⁷

Policies should be aimed at educating people about the dangers of exorcism and training healthcare professionals to provide impartial advice and care to patients involved or wishing to be involved in such practice.

Comparative example 4: United States

In 2004 a court in the US state of Wisconsin heard how an autistic boy died while being held down by worshippers and a priest during an exorcism. Terrance Cottrell, aged 8, died in 2003 in a service at the Faith Temple Church of the Apostolic Faith in Milwaukee. The minister, Ray Hemphill, who had no theological training, was charged with felony child abuse. He denied abuse, and is said to have thought the boy was possessed by demons and to have offered to banish them.

Terrance's severe autism meant that he could talk little and had difficulties in communicating and relating to people around him. In 2003 his mother took him to the Faith Temple Church, where members prayed over the young boy. Hemphill lay across the boy's chest for more than an hour during the exorcism. Several worshippers, including Terrance's mother, were said to have held his legs and hands to stop him from moving. When Hemphill stood up, he was told that Terrance was not breathing. In August 2004 Hemphill was found guilty of abusing the child and sentenced to two-and-a-half years in prison.²²⁸

Depression and the prevention of suicide

Depression is a mental-health issue that can have strong links to religion. An interesting study has noted that in the Netherlands immigrants living in mixed neighbourhoods have a higher chance of schizophrenia than immigrants living in 'black' neighbourhoods. In comparison to other immigrants, the Moroccans (largely Muslim) exhibited the highest incidence rates of psychotic disorders. The study indicates that discrimination might be a possible cause of the higher stress to which immigrants are exposed. Moroccan immigrants' confused social identity was proposed as another possible explanation of their poor mental health.²²⁹

²²⁷ The media have recently reported an emerging trend in Germany for people to see exorcists; the establishment of an exorcism centre in Poland has also been reported. See J Paulick, 'Planned Polish exorcism centre sparks interest in Germany', *Deutsche Welle*, 22 January 2008. Available at www.dw-world.de/dw/article/0,2144,3082751,00.html.

²²⁸ Hemphill's conviction was subsequently upheld on appeal. For further details and background see www.wicourts.gov/ca/opinion/DisplayDocument.html?content=html&seqNo=26207.

²²⁹ See W Veling, E Susser, J van Os, J Mackenbach, J P Selten and H Hoek, 'Ethnic density of neighbourhoods and incidence of psychotic disorders among immigrants', *American Journal of Psychiatry*, vol 165, 2008, pp 66–73.

Similarly, a recent Belgian study showed that there was a tendency for higher risks of psychological distress, depression and generalized anxiety in foreign-born Turkish and Moroccan immigrants, as compared to those born in Belgium.²³⁰

It is also important to recognize the multiplication of disadvantage for women of certain religious backgrounds. This is because, as studies have suggested, women across the world are more likely than men to suffer from depression, as well as generally being more religious. Gender differences and roles imposed by religion can bring feelings of guilt, shame and anxiety.²³¹ It has been found that women suffer more from stress, anxiety and depressive disorders, whereas men suffer more from substance abuse. Leyla Gülçür claims that gender inequality has in its turn produced very negative mental-health outcomes for women. Gender inequality is of course caused by many factors, but religiously defined gender roles are certainly among them.²³²

Suicide and depression are two mental-health issues that are significantly influenced by religion. The religious objections to suicide are similar to objections to euthanasia (see section 2.2 above). In addition, religion has affected public perceptions of people who have attempted suicide as a consequence of mental-health issues. The World Health Organization highlights the importance of the cultural context in attitudes to suicide:

Suicide has long been a taboo subject and is still surrounded by feelings of shame, fear, guilt and uneasiness. Many people have difficulties discussing suicidal behaviour, which is not surprising since it is associated with extremely powerful religious and legal sanctions. Ideas about suicide being noble or detestable, brave or cowardly, rational or irrational, a cry for help or a turning away from support contribute not only to confusion but also to ambivalence towards suicide prevention. In many countries, it was not until as late as the twentieth century that religious sanctions were removed and suicidal acts ceased to be considered criminal. Suicide is often perceived as being predestined and even impossible to prevent. Such taboos and emotions are important factors hindering the implementation of suicide prevention programmes.²³³

In Berlin, suicide is reportedly the second-most common cause of death among immigrant men under 65 (after lung cancer, which is equal for all groups),

²³⁰ K Leveque, I Lodewyckx and P Bracke, 'Psychological distress, depression and generalized anxiety in Turkish and Moroccan immigrants in Belgium: a general population study', *Social Psychiatry and Psychiatric Epidemiology*, vol 44 (3), 2009, pp 188–97.

²³¹ K M Loewenthal, *Religion, Culture and Mental Health*, Cambridge University Press, 2007, pp 67–70.

²³² L Gülçür, 'Evaluating the role of gender inequalities and rights violations in women's mental health', *Health and Human Rights*, vol 5, no. 1, 2000, pp 46–66.

²³³ *Mental Health: Facing the challenges, building solutions*, World Health Organization, 2005. Available at www.euro.who.int/document/e87301.pdf.

whereas among non-immigrant men of this age group heart disease and alcohol abuse are the second-most common causes of death.²³⁴ The high proportion of non-Christians among the demographic of immigrant men suggests that cultural and religious integration can have a significant effect on mental health.

Thus there is a need for healthcare policy to engage with religious organizations to help them actively participate in suicide-prevention programmes, as has happened in Finland.²³⁵ This will serve to break down perceptions of guilt and provide assistance and support for those driven to suicide as a result of poor mental health.

5.3 Emerging policy trends and outstanding policy questions

The European Union has sought to stimulate action by harmonizing mental-health standards across Europe. In light of the interaction of religion and health in a number of fields of mental health, a system of minimum standards would be welcome.

However, there is a gap in both research and policy with respect to non-Christian religions and their link to mental health. There is little more than anecdotal information on the influence of Islam, for example, on mental-health issues. There is also widespread conflation of religion and culture when it comes to interpreting phenomena such as possession by *Jinn*.

In particular, clear policy is absent across Europe regarding practitioner standards in dealing with religious minority immigrants' mental-health problems. In other areas, for example the positive role that church organizations could play in combating depression and preventing suicide, there appears to be little coordination nationally or Europe-wide.

Consequently, there is a clear need for healthcare practitioners and religious organizations to engage in open dialogue in which challenges can be addressed and experiences shared. At the practitioner level, such dialogue would promote the educational role that needs to be filled in order to meet emerging developments across Europe. At the level of policy, national healthcare systems and religious organizations should both contribute to facilitating the improvement in access and quality of mental-health services.

Across the European Union, the emerging policy trends include:

- i Policies take account of the fact that religious experiences such as the presence of *Jinn* are widely misinterpreted and consequently

²³⁴ Testimony provided to the Equal Rights Trust by Nina Mühe, 17 September 2008.

²³⁵ See note 215 above.

mental illness is often overlooked. The outstanding policy challenge is to provide proper training and awareness-raising for doctors and psychiatrists regarding the cultural and religious sensitivities of their patients. The emerging concern that religious minority patients may be misdiagnosed is beginning to be addressed.

- ii Policies recognize that suicide may be a taboo that is subject to religious sanction. Religious institutions have engaged positively in suicide-prevention programmes. An emerging challenge is to increase the participation of religious institutions and organizations in suicide-prevention programmes.

Recommended policy questions for further research

- 1 How should national healthcare/medical curricula be adapted to cover diagnosis and treatment of religiously/culturally specific mental conditions such as possession by *Jinn*?
- 2 How can religious institutions most effectively participate in suicide-prevention programmes and to what extent should religious organizations be involved in national healthcare policy development in this area?

.....

Conclusion

This paper has shown that religion and healthcare interact across Europe in a broad range of ways. Interaction is observed in national healthcare policy, hospital policy, sexual and reproductive healthcare and mental healthcare. The strategies and policies that operate across European healthcare systems are rarely consistent. Consequently they cause difficulty and represent a significant challenge not only to people of minority religions but generally to people who hold religious or other beliefs. In addition, the demands that religious observance places on people creates a number of healthcare concerns, including negative healthcare outcomes for people themselves and operational and procedural difficulties for healthcare providers.

While contextual differences may exist from one EU member state to another, it is clear that the majority of member states have encountered a broad range of healthcare issues with religious overtones. This national experience may relate to a national legal policy setting out the law on abortion, euthanasia or removal of life-saving or life-prolonging treatment; or it may merely relate to hospital policies on faith space, food or clothing. In either case, the influence of healthcare on religion and religion on healthcare is both undeniable and unavoidable.

In order to balance the rights to freedom of religion, equality and health, both with one another and against other factors such as the secular character of the state and finite human and capital resources, it is clear that there needs to be greater discussion within the European Union of the genuine challenges, needs and concerns that exist in relation to the various issues identified in this

paper. The proposals put forward by the European Commission which would put in place an EU directive implementing the principle of equal healthcare treatment on grounds of religion and belief represent a starting point. Nonetheless, greater legal harmony is needed not only to inform national legal frameworks but more importantly to inform the local-level policy and practice that delivers healthcare on the ground. Difficult issues in healthcare, such as communication and training, conflict of duty, and safeguards to ensure access to abortion, need considerable policy attention to address the ambiguous and inconsistent practices in EU member states and to define a strategic direction to overcome challenges.

Appendix A

Roundtable participants

<i>Name</i>	<i>Organization/profession</i>	<i>Country</i>
Dr Georgette Bennett	Tanenbaum Center for Interreligious Understanding	USA
Jarlath Clifford	The Equal Rights Trust	Ireland
Emil Cohen	Bulgarian Helsinki Committee	Bulgaria
Dr Walter Devillé	European Public Health Association	Belgium
Joyce Dubensky	Tanenbaum Center for Interreligious Understanding	USA
Imam Yunus Dudhwala	Newham University Hospital NHSTrust	UK
Professor Birgitta Essén	University of Uppsala	Sweden
Gita Feldhune	Country expert for the European Network of Legal Experts in the non-discrimination field	Latvia
Ivan Fišer	The Equal Rights Trust	UK
Rabbi Hershel Gluck	Chairman of the Muslim Jewish Forum	UK
Anne Guionnet	Tropical Medicine Unit of the Hospital Ramón y Cajal, Madrid	Spain
Professor Aart Hendriks	Leiden University	Netherlands
Heather Hunt	Equality and Human Rights Commission	UK
Tuomas Martikainen	Åbo Akademi University	Finland
Nina Mühe	Cultural anthropologist	Germany
Bárbara Navaza	Tropical Medicine Unit of the Hospital Ramón y Cajal, Madrid	Spain
Georgiana Pascu	Centre for Legal Resources	Romania
Katherine Perks	The Equal Rights Trust	UK
Professor Alessandra Sannella	Sapienza University of Rome	Italy
Sukhvinder Singh	Equality and Human Rights Commission	UK
David Zahumensky	The Human Rights League	Czech Republic

Appendix B

Belief-based exemption from healthcare provision

<i>Country</i>	<i>Area of permitted belief-based exemptions for healthcare providers</i>	<i>Applicable law</i>
Austria	Refusal to perform abortion	Article 97(2) Criminal Code Article 97(3) Criminal Code
	Refusal to perform medically assisted fertilization	Article 6, Reproductive Medicine Act 1992
Belgium	Refusal to perform euthanasia	Chapter VI: Special Provisions, Section 14, Belgian Act on Euthanasia
	Refusal to perform termination of pregnancy	Article 348, al. 2, 6 Belgian Penal Code
Cyprus	Refusal to give medical treatment	Regulations of Conduct of Doctors, Article 8, Doctors (Council, Discipline and Pension Fund) Law of 1967 & 1970
Denmark	Refusal to perform abortion	Consolidated Act on Induced Abortion, Section 10(2)
France	Refusal to perform abortion	Code of Health, Article L.2212-8
Germany	Refusal to 'act against conscience'	Constitution of Germany, Article 4(1)
Ireland	Provision of family-planning service or contraceptives	The Health (Family Planning) Act 1979, Clause 11
	Giving information	Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995, Clause 13
Italy	Abortion	Article 9, Law 194 (22 May 1978)
Spain	Performance of certain medical operations	Spanish Constitution, Article 16
UK	Abortion	Abortion Act 1967, Section 4
	Fertilization and embryology	Human Fertilization and Embryology Act 1990, Section 38

Appendix C

National policy on euthanasia in some EU states

<i>Country</i>	<i>Active euthanasia</i>	<i>Applicable law</i>	<i>Passive euthanasia</i>	<i>Applicable law/ Court decision</i>
Belgium	Yes	Belgium Act on Euthanasia 2002	Yes	Belgium Act on Euthanasia 2002
France	No		Yes	Law no. 2005-370 of 22 April 2005
Germany	No	German Penal Code	Widely accepted	1994 – German Constitutional Court ruled that doctors could withdraw life-sustaining treatment.
Italy	No		Yes	July 2008 – Milan court allowed feeding tubes to be removed from a woman in a vegetative state.
Luxembourg	Yes	Bill passed on 18 December 2008	Yes	Bill passed on 18 December 2008
Netherlands	Yes	Termination of Life on Request and Assisted Suicide (Review Procedures) Act, passed on 10 April 2001, in force from 1 April 2002	Yes	Termination of Life on Request and Assisted Suicide (Review Procedures) Act, passed on 10 April 2001, in force from 1 April 2002
Spain	No	Spanish Penal Code	Unclear	In 2007 the Andalusian Ethics Committee allowed Inmaculada Echevarria to have his respirator switched off by doctors under a law that grants patients the right to refuse treatment.
Sweden	No		Yes	Medical guidelines issued by the Swedish Society of Medicine

Appendix D

National policy on abortion in some EU states

<i>Country</i>	<i>Conditions in which abortion is available</i>	<i>Law</i>
Austria	on request until three months economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Federal Law of 23 January 1974
Belgium	on request until 12 weeks economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Law of 3 April 1990, on the termination of pregnancy, amending Article 350 of the Penal Code
Bulgaria	on request until 12 weeks economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Decree No. 2 of 1 February 1990 of the Ministry of Health and Social Welfare
Czech Republic	on request until 12 weeks economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Law 63 and 77 of 23 October 1986

<i>Country</i>	<i>Conditions in which abortion is available</i>	<i>Law</i>
Denmark	on request until 12 weeks economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Law No. 350 of 13 June 1973
Finland	economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Abortion Act 1970 (Law No. 239 of 24 March 1970); Law No. 564 of 19 July 1978 (amending Section 5 of the Abortion Act 1970); and Law No. 572 of 12 July 1985
France	on request until 10 weeks economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Law No. 75-17 of 18 January 1975; Law No. 79-1204 of 31 December 1979; and Law No. 588, 2001
Germany	on request until 12 weeks economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Law of 27 July 1992 on the protection of prenatal/nascent life, the promotion of a society suitable for children, aid in conflicts involving pregnancy, and the regulation of the termination of pregnancy; Pregnancy and Family Assistance Act, 21 August 1995; Penal Code
Greece	on request until 12 weeks economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Law No. 821 of 14 October 1978 and Law No. 1609 of 28 June 1986
Ireland	to preserve life	Offences Against the Person Act 1861
Italy	on request until 12 weeks economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Law 194 of 22 May 1978
Malta	none	Criminal Code of Malta (Chapter 9 of the Laws of Malta)

<i>Country</i>	<i>Conditions in which abortion is available</i>	<i>Law</i>
Netherlands	on request until 13 weeks economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Law on termination of pregnancy of 1 May 1981; Decree of 17 May 1984 laying down provisions for the implementation of the law
Poland	foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Law on Family Planning, Human Embryo Protection and Conditions of Abortion of 7 January 1993 (new restrictive amendments introduced January 1997)
Spain	foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Organic Law 9/1985 of 5 July 1985, reforming Article 417 of Penal Code, decriminalizing abortion on three grounds; Crown Decree 2409/1986 of 21 November 1986, on accreditation of centres and pronouncements for legal practice of abortion; Order of 16 June 1986, on statistics and epidemiological information concerning abortion; Organic Law 10/1995 of 23 November; Penal Code
Sweden	on request until 18 weeks economic or social reasons foetal impairment rape or incest to preserve mental health to preserve physical health to preserve life	Swedish Abortion Law of 14 June 1974
United Kingdom (excluding Northern Ireland)	economic or social reasons foetal impairment to preserve mental health to preserve physical health to preserve life	Abortion Act of 1967, as amended by the Human Fertilization and Embryology Act of 1990

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Religion and Healthcare in the European Union

Policy issues and trends

Dimitrina Petrova
and Jarlath Clifford

The impact of religious doctrine on the law, policy and practice of healthcare is becoming increasingly significant for a whole range of issues – from euthanasia to fertility treatment; from belief-based exemption from performing abortion for doctors to the medication and dietary needs of religious patients; from organ donation to contraception; from circumcision to suicide. The relationship between religion and healthcare has a long history of evoking tension and debate in Europe. While developments in medical technologies and techniques question the religious beliefs of policy-makers, practitioners and patients across the European Union, research into the legal and policy responses by EU member states on such issues remains underdeveloped.

ABOUT THE AUTHORS

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The challenge of health policy, which is common across the European Union, is to balance fundamental human rights such as the right to equality, the right to health and the right to freedom of religion while adhering to secular principles.

This report aims to map out the major issues at stake and to initiate a broader discussion on how the religious needs of the community, religious doctrine and religious practices across the European Union affect public health policy.