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Accommodating religion and belief in healthcare: Political threats, agonistic democracy and established religion

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Abstract

This paper considers what concept of accommodation is necessary to identify and address discrimination, disadvantages and disparities in such a way that the plurality of religious people with their beliefs, values and practices may be justly accommodated in healthcare. It evaluates threats to the possibility of such accommodation pertaining by considering what beliefs and practices might increase the risk of unjust discrimination against and disadvantage for religious people, whether as individuals or as groups; and the risk of disparities between the care provided to religious people. The claim is that there is an important cluster of risks that are political in kind and emergent within philosophical bioethics. While not amounting (yet) to a trend, they are sufficiently threatening to a just civic life for patients and healthcare staff as to warrant scrutiny. After an Introductory Section 1, Section 2 evaluates a criticism of 'accommodation' and the apparently additional health-related requirements that those of religious faith demand, when compared with other people. It does so by comparing Lori Beaman's idea of agonism with that of a distinct and somewhat complementary approach in Jonathan Chaplin's political philosophy, before examining the role of established religion in setting the conditions for the accommodation of religion and belief in healthcare. Section 3 examines risks to such accommodation by engaging critically with three health-related instantiations of political philosophy that differ radically from both Beaman and Chaplin. A concluding Section 4 focusses on appropriate modes of communicating about religious and other beliefs in healthcare.

KEYWORDS
accommodation, clinical ethics, conscience, public reason, religion, secularity

1 | INTRODUCTION

This paper considers whether a specific concept of accommodation might be necessary to identify and address discrimination, disadvantages and disparities in such a way that religious people, with their beliefs, values and practices, may be justly treated in healthcare. It identifies an important cluster of risks to the possibility of such a concept of accommodation taking effect in practice, emergent within philosophical bioethics and rooted in controversial political philosophy. While not amounting (yet) to a

trend, they are sufficiently threatening to a just civic life for patients and healthcare staff to warrant scrutiny.

Section 2 examines the contested meaning of 'accommodation' and evaluates Lori Beaman's criticism of one concept of accommodation, a concept which suggests that the health-related requirements that those of religious faith demand should be considered *additional*, when compared with other people. This criticism of 'accommodation' is interrogated by contrasting Beaman's ideas with Jonathan Chaplin's positive proposal regarding 'agonism' and 'accommodation', and by examining the role of established religion in defining and making practicable the accommodation of religion and belief in healthcare. Section 3 examines risks to such accommodation by engaging critically with three health-related instantiations of political philosophy which differ radically from Chaplin's view. A concluding Section 4 focusses on how accommodation relates to communication about religious and other beliefs in healthcare.

2 | ACCOMMODATION, AGONISM AND 'ADDITIONAL' CARE

In this section, two concepts of 'accommodation', those discussed by Lori Beaman and Jonathan Chaplin, will be contrasted and evaluated. These two are chosen because they chart key definitional and practical problems which surround 'accommodation' and offer differing modes of resolving those problems while focussing on similar phenomena in English-speaking contexts such as Canada and the United Kingdom. The argument is that Chaplin's advocacy of a specific concept of accommodation is superior to Beaman's rejection of accommodation in providing a basis for identifying and avoiding injustices to people in healthcare on account of their religion or belief.

The two concepts may be differentiated by how they conceive of 'agonism' in public life and by how they address the claim that accommodation of religion requires 'additional' care to be offered to religious people, when contrasted with nonreligious people.

2.1 | Accommodation, deep equality and 'agonistic respect'

First, Lori Beaman has argued that the way that 'accommodation' in democratic life works out in practice and frequently damages religious minorities' welfare and civic participation. For Beaman, aspects of healthcare practice and philosophy concerning religion proceed on the basis that 'accommodating' individual patients' or health professionals' religious beliefs, values and practices is a problem of diversity management. She criticises tendencies to see the normal citizen as nonreligious and accommodation as necessary for those who are religious. For Beaman, this split between citizens represents

> a binary that separates 'normal' citizens and everybody else. The latter are framed as promoting 'their' interests, which are often framed as being in opposition to those of 'normal' citizens and at a cost to society.[1]

For Beaman, therefore, 'accommodation' refers to practices that regulate 'additional', self-centred, even self-indulgent claims on society. Such a notion of accommodation entrenches 'a tendency to attribute malice and greed to the requesting group, and generosity, goodwill and kindness to the dispensing group'.[2]

Such 'accommodation' biases discourse towards seeing religious people as unusual and grasping outsiders, not equal citizens; religion is seen as an 'extra' that creates *additional* perhaps onerous requirements, which 'normal' people do not have. Accommodation, understood like this, suggests that some are already at home—nonreligious healthcare staff and patients—and some need *extraordinary* provision since standard practice is not already fit for them. Such 'accommodation' risks disadvantaging religious people by creating a culture in which they are immediately seen as abnormal, with additional needs when compared with normal people. Beaman thinks that this idea of 'accommodation' is prevalent and offers evidence of its damage to religious people.[3]

Beaman's view thus marginalises the seemingly positive intent of the language of accommodation. In normal parlance, 'accommodation' signals a willingness to make room for people, perhaps with the tonality of hospitable welcome. There is perhaps more willingness to get along well with others than Beaman's critique allows. However, the risk, on Beaman's view, is that even such good intentions will not prevent 'accommodation' rendering the religious person an 'other' rather than a normal person—and thereby will tend towards a culture in which healthcare staff inhabit a conflictual narrative of greed, self-interest and conflict.

Beaman accordingly rejects the practice of accommodation and proposes instead a 'process' of 'deep equality', which looks for the relational transformations which occur when differences are encountered with the 'agonistic respect' that accords with the 'truly inclusive (common ground) civic space' of healthcare.[4] In 'agonistic respect…there is a willingness to engage with the Other without desire to change that person but instead engaging in a manner that takes equality as a given'.[5] Beaman thinks that such agonism will enable healthcare policy to leave behind the narrative of conflict and exclusion, which predominates when people come to think about

[1]Beaman, L. (2017). *Deep equality in an era of religious diversity* (p. 136). OUP.
[2]Ibid: 136; Cf. Beaman's comment that 'While negotiating one's own religious needs may be "good for one", it needs to be understood as embedded in sometimes disadvantageous power relations' (Ibid: 143).
[3]Beaman offers evidence, especially from Canadian case law, public debate and media coverage (Ibid: 133–149).
[4]Beaman, L., & Reimer-Kirkham, S. (2020). Creating an inclusive public sphere: Healthcare and the role of prayer. In S. Reimer-Kirkham, S. Sharma, R. D. Brown, & Calestani (Eds.), *Prayer as transgression? The social relations of prayer in healthcare settings* (pp. 37–53). McGill-Queen's University Press, p. 49. 'Deep equality is a vision of equality that transcends law, politics, and social policy, and that relocates equality as a process rather than a definition, and as lived rather than prescribed' (Beaman, op. cit. note 1, p. 13).
[5]Ibid: 55.

religious diversity. This is a controversial solution as the contrast of Beaman's view with Chaplin's will show.

2.2 | Issues arising from Beaman's critique

Beaman's critique of 'accommodation' raises three issues.

First, there is the question of what counts as 'additional care'. This is hard to assess but cannot plausibly be solely associated with religion. On the one hand, what is 'additional' might derive from person-centred care in which the goal is to provide an experience of healthcare that fits a person's circumstances, including their values and beliefs as well as possible. Clearly, there will be variation in many cases, which are not necessarily religious in kind—perhaps more staff time spent with a patient who strongly desires reconciliation with their family members prior to death than with a dying patient for whom family relationships are already peaceful. On the other hand, there is the outworking of how more strictly clinical treatment should be personalised in respect of a specific health need—for example, the stratification of a patient to a particular pathway appropriate to the molecular subtype of their specific form of cancer, which would require 'additional' care in a certain sense, when contrasted with a patient who receives more standard care.[6] Both are forms of personalisation, offering something 'additional' when compared with another patient, on grounds of the benefit such care is likely to offer. The point is that what counts either as standard or additional care is not easy to assess. This observation coheres with Beaman's concern that religious belief is being singled out, by the language of 'accommodation', as particularly abnormal, requiring 'additional' care.

Second, the scale of any problem with 'accommodation', as Beaman critiques it, is unclear. Evidence from a multi-site study of the role of prayer in Canadian and British hospitals offers some validation of her concerns about what is counted as 'normal'. The researchers found that some staff believed prayer to be inappropriate in the 'secular' culture of healthcare[7] and rejected any 'facilitatory' role for the NHS in respect of chaplaincy or religion at all.[8] However, the evidence is mixed and may cast doubt on Beaman's claims. Many interviewees in the study provided evidence in favour of the benefits of chaplaincy and prayer, for staff as well as patients. Their rationale included the claim that 'setting the healthcare domain apart from other social institutions and public spaces are the immediacy and unpredictability of access to the space, the intimacy and embodiment of the whole self in the engagement with the space'. As one patient said 'A hospital isn't a chosen private space…[W]e don't get to choose when we have times of need',[9] which may include need for facilitated spiritual and prayerful support as appropriate to a place which is a 'peculiar mix of state presence and personal intimacy'.[10]

The evidence is similarly mixed in a 2015, U.S.-based study, which examined discrimination against healthcare staff based on religious identity, focussing on Muslim physicians in their workplace against the backdrop of 9/11. It found that one in four Muslim physicians reported that they suffered religious 'discrimination sometimes or more often'. Significantly, 'respondents who indicated their religion was the most important part of their life had higher odds of experiencing greater scrutiny at work'.[11] These findings, however, need to be balanced against evidence that almost three in four Muslim physicians felt that their religion was accommodated (understood in a positive sense), with those for whom religion was the most important and most accommodated feeling. The picture is not straightforward but complex.

Third, Beaman's positive proposal hinges on the key issue of what respect requires with respect to religious reasoning in public decision-making and resource usage. However, her analysis of 'agonistic respect' completely ignores the central significance of respect in debates about religion in public life, in which critics and defenders of Rawlsian political liberalism have focussed on what reasons should and should not be given to justify decisions in public institutions.[12] Giving religious reasons which are largely or entirely deemed inaccessible or unintelligible would be a mark of *disrespect*. Beaman fails to attend to this sharp end of decision-making difficulties in public institutions. Technical and political discussions of what counts as 'reasonable' are ignored. Beaman's preference for informal cooperation rather than competition is seriously under-equipped to provide the apparatus to discuss disagreements about just resource usage faced by public institutions.

Engaging with 'respect' on these terms matters for understanding what counts as 'additional' care, assessing whether accommodation should be understood wholly negatively and determining the limits of flexibility concerning what should not be afforded to people on account of their values and beliefs (religious or otherwise). Consider, in the study of prayer to which Beaman contributes, the fascinating but inconclusive account of management decision-making in allocating human resources and physical space for prayer in an NHS hospital. The way that a hospital's mission and values determine the meaning of 'person-centred care' are inevitably intertwined with difficult decisions about deploying space, time and personnel.[13] These are almost always at a premium, and so it must be a management level decision as to whether it is a reasonable use of (often public) resources to, for example, deploy physical space for chaplaincy rather than to serve direct clinical needs or provide, for example, a refreshment area for hard-pressed healthcare staff. For example, the project's evidence found that 'a patient held up surgery,

[6]For discussion, see Feiler T., Hordern, J., Gaitskell K., & Maughan T. (2017). Personalised medicine: The promise, the hype and the pitfalls. *The New Bioethics, 23*(1), 1–12.
[7]Beaman & Reimer-Kirkham, op. cit. note 4, p. 39.
[8]Ibid: 44–45.
[9]Ibid: 49–50.
[10]Ibid: 37.

[11]Padela, A., Adam, H., Zahra Hosseinian, A., & Curlin, F. (2016). Religious identity and workplace discrimination: A national survey of American Muslim physicians. *AJOB Empirical Bioethics, 7*(3), 149–159. This study built on a variety of other smaller studies and reports indicating similar findings.
[12]See, for example, Quong, J. (2011). *Liberalism without perfection*. OUP.
[13]Reimer-Kirkham, S., De Bono, C., & Quinn, B. (2020). Organisational practices in the management of prayer. In S. Reimer-Kirkham, S. Sharma, R. D. Brown, & M. Calestani (Eds.) *Prayer as transgression? The social relations of prayer in healthcare settings* (pp. 71–85). McGill-Queen's University Press.

in the pre-surgery area, because he insisted he first had to have prayer'.[14] In itself, a single event like this is not very significant. However, multiplied many times over it is an activity which, Rawlsian public reason thinkers might argue, slows down the proper business of healthcare, transgressing, without any public justification, into space which is technical and scientific. A patient praying in their own head as they are wheeled into an operating theatre is one thing; a patient accompanied by a chaplain or other appropriate religious or cultural figure is another; *waiting* for such a figure to arrive—'holding up' surgery—and therefore placing pressure on operating room time is, for many, unjust.

A Rawlsian critic of Beaman would say that her notion of 'agonistic respect' provides no way of resisting religious people who think that their reasons are more important than those of the nonreligious and should be given special weight in decision-making about resources—justifying, for example, holding up surgery until a chaplain arrives. Accordingly, religious people might mistakenly think it worse for them to experience healthcare or a workplace environment which is not in accordance with their wishes—the ready availability of chaplaincy for example—just because their wishes are informed by religious beliefs. Religious patients or healthcare workers would expect more fitting kinds of personalised care or tailored working conditions to be afforded to them than to other people, with correlative costs for everyone. Such an expectation suggests a ranked order of beliefs, a sense of the superiority of religious reasons which is likely to lead to the kind of binary and narrative of conflict, which Beaman rejects. This is fundamentally disrespectful, the Rawlsian might say, and likely to make Beaman's 'agonistic respect' less likely to characterise institutions.

By contrast what is needed, so the complaint might go, is a neutral, genuinely respectful decision-making procedure which avoids such difficulties by excluding religious beliefs and values from justifications of resource usage altogether. To such a criticism, Beaman's commitment to the 'dejudicialization of religious diversity'[15] in favour of informal processes of deep equality is unlikely to be convincing. As noted, for consensus public reason liberalism, the issue is centrally around what respect for one's fellow citizens requires. The claim is that, in healthcare as in other zones of public life, requiring people to engage with 'agonistic respect' in religious (or any other nonpublic) reasoning to resolve resource allocation matters justly is itself disrespectful. To such approaches—and the risks attendant on them—we will turn in Section 3.

2.3 | Accommodation, 'secular faith' and 'confessional silence'

While Beaman's account identifies a difficulty with the rhetoric of 'additional' care, there are problems with the concept of accommodation she rejects, including uncertainty about the scale of harm which accommodation discourse allegedly effects and the plausibility of her account of 'respect'.

By contrast, consider how Jonathan Chaplin's approach to the complexities of religious and other beliefs in society addresses these problems, and thereby endorses a specific concept of 'accommodation' of religious diversity in public affairs, including healthcare. For Chaplin, 'the core purpose of the political community'[16] is so to conceptualise and frame the laws and policies which govern public institutions that we 'avoid putting fellow citizens into the posture of supplicants for exceptional treatment'.[17] Chaplin's recommendation is that citizens work exceptionally hard to avoid any paternalism with respect to people's religion or belief. He advocates that laws and policies should be so well framed as to avoid even any impression of the binary which Beaman perceives between an allegedly 'normal' majority culture and a minority (especially religious) belief, value or practice. Chaplin seeks to avoid a culture of ad hoc exemptions or special additional measures with the supplicant status such a culture entrenches.

Applied to a definition of 'accommodation', this view would entail that accommodating religion and belief requires a steadfast determination to fit healthcare and working conditions to people's desire to manifest publicly what Cecile Laborde calls their 'identity-protecting commitments'.[18] Much healthcare policy and practice has rightly moved away from the paternalism, whereby patients become supplicants, dependent on the goodwill of a (normally) medical gatekeeper, towards patient–partnership in which the equal citizenship of patients with healthcare staff is recognised in policy and practice.

Such culture can only be grown, Chaplin claims, if it is also recognised that, underpinning all laws and policies are some kind of belief or 'faith'. Such 'faith' can be either 'secular' or 'religious' in kind; for beneath all reasons given for decisions in (for example) public institutions are the (often) controversial doctrines about life in which people place confidence.[19] Focussing mainly at the level of representative legislative decision-making and court judgements, he observes and endorses the practice of 'confessional silence' in ultimate public justifications given for any such decisions or judgements. Such silence entails, for religious and nonreligious people, that they do not insist on their doctrine being written into the public record as the justification for the decision.[20]

The terms 'religious' and 'secular' need some clarification. Chaplin claims that.

[14]Calestani, M., Sharma, S., & Beardsley C. (2020). Mapping geographies of prayer. In S. Reimer-Kirkham, S. Sharma, R. D. Brown, & M. Calestani (Eds.) *Prayer as transgression? The social relations of prayer in healthcare settings* (pp. 54–70). McGill-Queen's University Press, p. 67.

[15]Beaman, op. cit. note 1, p. 142.

[16]Chaplin, J. (2020). *Faith in democracy: Framing a politics of deep diversity* (p. 136). SCM Press.

[17]Ibid: 149.

[18]Laborde, C. (2017). *Liberalism's religion* (pp. 203–204). Harvard University Press; Cf. Chaplin, op. cit. note 16, pp. 132–133.

[19]Chaplin, op. cit. note 16, pp. 59–60.

[20]Ibid: 120; Cf. Oliver O'Donovan's coinage of the term and criticism of the political doctrine inherent within it (Bartholemew, C., Chaplin, J., Song, R., & Wolters, A. I. (Eds). (2002). *A royal priesthood? The use of the Bible ethically and politically. A dialogue with Oliver O'Donovan* (p. 313). Paternoster Press.

> the fact that ultimate religious reasons are not articulated during deliberation does not thereby make the reason or the policy conclusion actually offered 'secular', in the sense of being uninfluenced by or indifferent to or antithetical to faith.[21]

Instead, there are most likely a mix of 'secular' and 'religious' beliefs at work in any group—such as a multidisciplinary team and a patient—who together endorse a decision. With this in mind, he considers it 'needlessly exclusionary' to deny a public place to a belief in 'dignity' as 'a divine gift' but permit such a place to 'dignity' grounded in a belief in 'the supreme moral autonomy of the rational individual'.[22] The claim that the former kind of statement, in contrast to the latter, is unintelligible or inaccessible to people (as Rawlsian public reason liberals would suggest) confuses, Chaplin says, an 'epistemological question' for a 'sociological question', the answer to which, in any given circumstance 'depends on what the audience happens to know or understand or be willing to accommodate'.[23] Section 3 will show that this sociological critique of proposals to limit religion's role in public life has purchase in health-related contexts.

Chaplin observes that 'British democracy seems to have more problems accommodating religious faiths than it does secular ones'.[24] But this is a matter of happenstance. For Chaplin, the question of what care or working conditions should be facilitated for patients or healthcare staff—in short what should be 'accommodated'—neither assumes a set of secular beliefs nor assumes that religious beliefs are intrinsically special. Democracy should take an interest in what is important to citizens and, given the right conditions and with appropriate protection against risks to those conditions, can develop the competence to do so. A wide range of beliefs could be intrinsically special to people, including religious beliefs. For patients, a commitment to accommodation is a commitment to adjusting care to people's personal beliefs in the context of an agreed standard of care. If the standard is 'personalised care' then the task is to be competent in personalising the accommodation which is provided.

2.4 | What kind of 'agonism'?

Chaplin's argument therefore provides a rationale, complementary to Beaman's, for not construing 'additional' care in terms of what is fitting for those who are religious over against those who are (allegedly) 'normal', that is, not religious. If Chaplin is right, much of the problem lies with the often unrecognised nature of the disagreements citizens have with each other in society: one side denying that arguments based in (religious) faith should play any part in public justification of decisions because they are inaccessible and unintelligible; the other side claiming that, since controversial doctrines are ultimately behind all reasons, we would do better to make that plain and respectfully enter the robust debate which inevitably follows.

However, Chaplin does much better than Beaman specifically on just what respect requires in connection to accommodation. A distinction between persons and reasons helps. In 'political debate, persons should be accorded proper respect, but reasons should be prepared to take whatever drubbing (or praising) they deserve in the bear pit of democratic contestation'.[25] This is the practice of what Chaplin calls an 'agonistic' or 'argumentative' democracy.[26] Herein, lies a key distinction in the two concepts of accommodation. Chaplin's agonism within accommodation is very different from Beaman's idea of agonism in 'deep equality' which rejects accommodation. This is principally because, for Chaplin, respect for persons is not incompatible with seeking to persuade that person to think differently—to change that person's mind (and be ready to have one's own mind changed in turn). While for Beaman, respect 'is 'agonistic' because it requires an abandonment of 'rightness' and the conviction that one is imbued with the truth through some sort of transcendent authority'[27] in order to 'support [a neighbour] in her commitment',[28] Chaplin takes agonism to be a practice that 'resists the lure of easy consensus that risks silencing dissenting minorities'.[29]

Chaplin's recommendations for analysing and engaging in the difficulties of our deep diversity therefore differ sharply from Beaman's with respect to opposing disadvantage to religious minorities in healthcare. With regard to religious people's beliefs, Beaman's analysis is that to 'frame such interests as 'special interests' shifts the burden to the group who is being disadvantaged or who is making the identity-based claim'. She argues that 'Recasting the dialogue or discourse as being about differing interests allows an entry point on a more even footing'.[30] In contrast, Chaplin's account places all *reasons*—religious and secular—on level ground, in hope that an agonistic approach might shape the practices of legal and political culture. In such 'argumentative democracy',

> citizens openly and honestly deliberate with one another on the basis of their full belief-value sets, before voting on the basis of their best judgment of the overall balance of (moral) reasons. Such deliberation includes seeking to understand and respond to others' reasons and arguments, and trying to persuade others of the merits of one's position, while being open to persuasion.[31]

[21]Chaplin, op. cit. note 16, p. 93.
[22]Ibid: 95.
[23]Ibid: 97.
[24]Ibid: 129.
[25]Ibid: 89.
[26]Ibid: 222.
[27]Beaman, L. (2014). Deep equality as an alternative to accommodation and tolerance. *Nordic Journal of Religion and Society*, *27*(2), 89–111.
[28]Ibid: 98.
[29]Chaplin, op. cit. note 16, p. xiv.
[30]Billingham, P. & Chaplin, J. (2019). Law, religion and public reason. In R. Sandberg, N. Doe, B. Kane, & C. Roberts (Eds.), *Handbook of the interdisciplinary study of law and religion* (pp. 128–148). Edward Elgar, p. 143.
[31]Beaman, op. cit. note 1, p. 136.

Just how such agonism does or does not fit within healthcare's specific forms of communication is addressed in Section 4.

2.5 | The character of accommodation

Chaplin's account differs from Beaman's both by rejecting an idea of 'accommodation' as specifically focussed on the additional and costly needs that a *religious* person might have; and by rehabilitating 'accommodation' as a positive proposal via his notion of agonistic democracy. Chaplin's view, that there are multiple faith commitments operating in decision-making, argues in favour of forms of 'accommodation' in which no particular comprehensive doctrine is *seen* to triumph. Agnosticism rather than atheism would be the *perceived* character of public decision-making. Nonetheless, in agonistic democracy, people with multiple doctrinal commitments are, more-or-less explicitly, in contestation with each other, seeking compromises which facilitate decision-making. No controversial 'social ontology'[32]—that human personhood is best summarised in terms of either rational autonomy or the image of God—should assume rightful predominance over another just because the one in power, perhaps the doctor, happens to be secularly or religiously minded. Healthcare would not be a "secular" activity' in which only certain nonreligious reasons count for public justification but rather a public activity in which multiple reasons are at work, whether jostling alongside each other or conversing in more irenic fashion. Such is the proper character of our complexly religious and secular civic life in general, including the practice of healthcare. This is very different than the process of deep equality that Beaman recommends to replace any practice of 'accommodation'.

2.6 | The practice of accommodation

What follows for defining the practice of 'accommodation' in healthcare? Chaplin's approach, sharpened by contrast with Beaman, would suggest that while everyone should ideally feel 'at home' in healthcare—for example in the U.K. NHS—no one person or group with a particular doctrinal commitment should claim to own the housekeys so as to control the doctrinal terms on which people must enter and talk to each other within it. The practical effects of this view will be somewhat uneven in their application, although not necessarily unjustifiably so.

As to working conditions, there will be the messy process of identifying 'reasonable accommodations', a well-trodden, if fraught, path down which Chaplin (though not Beaman) would go. To consider an adjustment to working conditions as 'additional' to a norm, just because of the doctrines which an individual or group holds, would deny the deep plurality which actually characterises democratic society and what may need accommodating within it. The extent of what is reasonable is, naturally, the core challenge but, on Chaplin's account, is largely a sociological and pragmatic consideration, allowing 'no final resolution to…discursive plurality, only ongoing political and legal contestation issuing in a series of shifting, partial settlements of different duration'.[33]

As to patient–healthcare staff relationships, Chaplin's focus, namely legislative decision-making, voting and court judgements, may offer the most plausible context for the mix of agonistic debate and confessional silence he advocates. What Beaman notices in referring to 'the intimacy and embodiment of the whole self in the engagement with [healthcare] space'[34] is the peculiar experience of existential vulnerability in which 'accommodation' is worked out in healthcare. With this in mind, it would seem eccentric to suggest that a religious (or nonreligious) person should frame their reasons for the care they want in ways that do not draw on their deepest sources of value and belief on account of the sensitivities of some secular (or religious) medical staff. Even if they knew the internal mental world of such staff, it would seem a return to paternalism to suggest that they should conceal their most significant reasons and proffer only those reasons which are likely to be accepted by healthcare staff in order both to respect the autonomy *of those staff* and to secure the kind of confessional silence Chaplin recommends in other aspects of democratic practice. It seems hard to believe that defenders of respect for autonomy—normally referring to *patients'* autonomy—might think that this is what a just civic life requires.[35]

On the other hand, compassionate person-centred care should not require that healthcare staff simply acquiesce in an individual's understanding of their own condition and automatically comply with what a patient says should follow[36]—for example, that a chaplain be present to pray throughout a surgical procedure; or that a doctor should be expected to concur (or at least not demur) publicly with a religious way of justifying a decision; or that a member of healthcare staff can choose not to work with those with whom they disagree about doctrinal matters. As Chaplin notes, religious people should not expect to get all that they may want, since politics is necessarily a matter of compromise.[37] This is so for good theological reasons, at least for Christian believers who distinguish the contested peace of this time with the settled peace of the age to come—an assumption which clearly many such as Beaman will not share. In the meantime, an agonistic democracy will be characterised by a compassion which may, in principle, ask difficult questions of religious (and secular-minded) people as to the quality of their reasoning and how it relates to their values and practices.

By the same token, nonreligious people—including healthcare staff—should not be understood monolithically as if all secular-minded people were opposed to or incurious about the role for

[32]A social ontology refers to 'what exists in the social world…rooted in social interpretations of…institutions and relationships' (Laborde, C. (2018). Abortion, marriage and cognate problems. *The American Journal of Jurisprudence*, *63*(1), 33–48, p. 43.

[33]Chaplin, op. cit. note 16, p. 148.

[34]Beaman & Reimer-Kirkham, op. cit. note 4, p. 50.

[35]Ibid: 91.

[36]Hordern, J. (2020). *Compassion in healthcare: Pilgrimage, practice and civic life* (pp. 39–41). OUP.

[37]Chaplin, op. cit. note 16, p. xiii.

religious beliefs and values in healthcare; or as if real individuals' decision-making was not sometimes a complex mix of religious *and* nonreligious reasoning. Beaman's account of the possibility of discovering surprising commonalities and workable *modi operandi* should chasten any merely conflictual account of religion's role in healthcare.[38] What is needed, therefore, if either of Chaplin's or Beaman's concerns are to be addressed is a sufficient competence, especially among healthcare staff, to be able to engage in religious *and* secular diversity appropriately.

Here, there are significant challenges, the chief of which concern healthcare workers' confidence and literacy regarding religion. A 2016 systematic review of evidence found that, while spiritual care was considered important by many physicians and by patients, there were significant barriers to physicians providing or enabling the provision of spiritual care. While lack of time was one factor, it was not the only nor necessarily the most important one in effecting change to address disadvantage. The evidence showed that physician discomfort with and uncertainty about spiritual care was also significant, linked to 'insufficient knowledge and training, lack of clarity regarding whether [providing spiritual care] is part of a physician's professional role and concern that patients would be offended'.[39] A key aspect of this challenge concerns religious diversity. For example, while antisemitism clearly persists as a pernicious element in society, one study has shown that U.S. Jewish physicians, compared with other religiously affiliated physicians, are less likely to believe in the importance of spiritual care for health and place less emphasis on physicians' role in spiritual care. Reasons postulated for this were complexly related to the interface of ethnic, cultural and religious identity as well as to specific historic and doctrinal matters.[40] Addressing questions of disparity in the way religious values and beliefs are accommodated *will* require reckoning with prejudicial discrimination such as antisemitism. However, precisely because of the plurality of religious belief, other factors less susceptible of governmental or institutional policy influence will also matter, such as healthcare staff's literacy about the diversity of self-understandings, characterising people sharing the same broad religious tradition as well as diversity between religious traditions. Enabling a healthcare culture which is intelligently accommodating to people's forms of religion is a difficult task.

2.7 | Accommodation and establishment

How might such problems be addressed? Here, a rejoinder to Chaplin's advocacy of 'confessional silence' is occasioned by consideration of Beaman's concern about the impact on public services of 'a society that is institutionally set up on the basis of a Christian understanding of religion'.[41] She thinks that the notion of reasonable accommodation itself is inherently 'embedded in the social practices, structures and institutions' of Christianised societies, notwithstanding the decline in religious participation.[42] Others have critiqued a bias towards a Judeo-Christian understanding of spirituality in Western healthcare as cultural imperialism.[43] It is, although, also reasonable to expect that a nonreligious view of the accommodation of religious beliefs and values would introduce its own kind of bias, which would itself call for critical examination. Chaplin's account places such views—alongside religious 'faiths'—on a level playing field.

On the other hand, a civilizational or cultural bias may or may not be concerning depending on the actual effects it has on accommodation of both those from plural religious traditions and those of secular faiths. For example, a Judaeo-Christian understanding of spiritual care which has a bias in favour of marginalised or vulnerable people would seem commendable. Similarly commendable would be a Judaeo-Christian, theologically grounded commitment to high quality, tailored spiritual care accommodating a society's variety of religious traditions, such as indigenous spiritual traditions.

In short, there is no one *monolithic* Judeo-Christian understanding of spirituality or of what should be accommodated. To think this would be to overlook the variety in forms of religious belief, a mistake which can itself entrench disadvantage and discrimination. In light of such diversity, it is implausible to claim that any one religion's interpretation of spirituality or accommodation would necessarily introduce a negative bias. It is therefore not implausible to claim, over against both Chaplin and Beaman, that an established religion might appropriately enshrine a way of conceiving the lives of human persons that gives institutional recognition to their existential weight and, in doing so, encourages among citizens practices of curiosity and patience which are fitting to person-centred healthcare. This represents a positive view of accommodation, reframing the agonism Chaplin recommends within an established religion. Nigel Biggar comments that

> Anglicanism is essentially humanist in its credal affirmation of the special dignity of human beings made in the image of God—a dignity intensified by God's assumption of human flesh in the Incarnation.[44]

In England at least, instead of confessional silence, there is a doctrine-based public avowal of human dignity. Equality is not

[38]Note that Beaman's interest in celebrating the nonevents where difference is informally reconciled through 'citizen negotiation' into a shared plan might cohere with Chaplin's support for nonlegal civic negotiation wherever possible, thereby avoiding a judicialisation of speech, conscience and association (Beaman, op. cit. note 1, p. 141).

[39]Best, M., Butow, P., & Olver, I. (2016). Doctors discussing religion and spirituality: A systematic literature review. *Palliative Medicine*, *30*(4), 327–337, p. 334.

[40]Stern, R., Rasinski, K., & Curlin, F. (2011). Jewish physicians' beliefs and practices regarding religion/spirituality in the clinical encounter. *Journal of Religion and Health*, *50*(4), 806–817.

[41]Beaman, op. cit. note 1, p. 143. Note that some of Beaman's reasoning is motivated by the observation that those of minority religious faith are being 'accommodated' (in her negative sense) by those of majority religious faith, or the culture influenced by such majority faith.

[42]Ibid: 150.

[43]Ellis, M., Campbell, J., Detwiler-Breidenbach, A., & Hubbard, D. (2002). What do family physicians think about spirituality in clinical practice? *Journal of Family Practice*, *51*(3), 249–254; Cf. Best, M., et al., op. cit. note 39, p. 331.

[44]Biggar, N. (2020). Anglican establishment: How is it liberal? *Studies in Christian Ethics*, *33*(2), 205–214, p. 209.

understood here as a process but as a given reality coincident with the dignity of each person, interpreted as an ineliminable divine bestowal.[45] The implications for healthcare—which Biggar does not draw—are manifold, not least in the precise form of chaplaincy which is available in the NHS. Although a far fuller account would be necessary, they would include the continued importance of an established Church of England to secure chaplaincy services, broadly conceived to include those which make provision for those of all religious beliefs and secular philosophies.[46]

3 | RISKS TO ACCOMMODATION

Chaplin recommends an approach to accommodation which differs significantly from Beaman, and is more compelling with respect to what agonism and respect require. The concept of accommodation recommended here not only incorporates Beaman's critique of what counts as normal or additional but also reframes Chaplin's in recognition of the benefits of a form of established religion. This concept, applied to healthcare, conceives accommodation as marked by a charitable, patient but robust interchange about patients' and staff's beliefs and values.

An important cluster of risks to this specific concept of accommodation are bound up with a certain kind of political philosophy which aims, for principled reasons, to render religion irrelevant to healthcare practice as far as possible. Examining this political philosophy closely provides a way to analyse risks to accommodation, to diminish the prevalence of religion-based disadvantage and disparity and (in Section 4) to discern what form 'agonism' should take in healthcare.

Attitudes which reflect such philosophy have already shown up empirically in Beaman et al.'s research on prayer in Canadian and U.K. health services. Critically evaluating such philosophy and attitudes in three further aspects of healthcare—conscientious objection, clinical ethics and resource allocation—will enable a deeper analysis of accommodation. These are not randomly chosen but track key dimensions of how accommodation can work in practice, focussing first on doctors' professional identity; second, on patient–clinician relationships; and third, on resource-allocation. Crucially, each of them bears on the chief challenge identified above, namely that healthcare workers may lack both the confidence that engaging with people's religious values and beliefs (as well as secular beliefs) is part of healthcare work and the literacy to engage well. The goal here is not to adjudicate on all the elements of these debates but rather to focus on the political philosophical issues which bear on this important concern of civic life. The practical significance of the argument for issues of communication will be considered in Section 4.

3.1 | Accommodation and conscientious objection

First, consider the argument that conscientious objection (CO) based on religion should be judged unacceptable and, where possible, excluded in health professional practice. The claim by Schuklenk and Smalling is that 'arbitrary' and 'untestable' religious claims should, in liberal political society, have no standing to circumscribe the services a doctor (for example) has to provide and that permitting any such standing is liable to introduce inequities in the provision of a service.[47] On this view, as citizens of a society which has determined that a certain treatment is lawful (e.g., abortion or euthanasia), doctors should abide by that legal settlement and have no recourse to CO.

This contentious argument has been addressed elsewhere. In short, the eradication of conscientious objection on religious grounds should be resisted in favour of preserving the moral integrity of healthcare professionals, their independent critical judgement, the vibrancy of debate in healthcare as a dimension of liberal democracy and, as a product of these three, the welfare of patients.[48] While there are reasonable concerns about not allowing CO to 'run amok',[49] our present concern is more focussed: namely with the specifically political risks to accommodation which the arguments of those who completely reject conscientious objection presents. Chaplin's argument in favour of 'faithful conscience' begins with the story of Tim Nicholson whose employer is found to have failed to grant him reasonable accommodation for his conscientious objection based on his ecological beliefs, which amount to a philosophy.[50] Those beliefs have a coherence and are worthy of respect in a democratic society, so the judgement goes.[51] This exemplifies the way that secular beliefs (or 'faiths') are, on Chaplin's account, rightly being recognised as worthy of accommodation. Whereas criticism of CO seeks to exclude religious beliefs from public respectability by requiring that all doctors must perform all legally permitted procedures, obstetricians (for example) do not need to be religious to have a CO regarding abortion. Obstetricians commonly draw the line *at different points*, being unwilling, for example, to perform a termination after 12 weeks. Secular belief on this matter is not monolithic but diverse.

[45]Hordern, J. (2020). The dignity of the frail: On compassion, terror and social death. *Literature and Medicine*, *38*(2), 349–370.

[46]For assessment of the current arrangements for and 'liminal' character of chaplaincy in Canada and the United Kingdom, see Beardsley, C., Todd, A., & Reimer-Kirkham, S. (2020). Chaplaincy in Canada and the United Kingdom: Prayer and the dynamics of spiritual care. In S. Reimer-Kirkham, S. Sharma, R. D. Brown, & M. Calestani. (Eds.), *Prayer as transgression? The social relations of prayer in healthcare settings* (pp. 86–104). McGill-Queen's University Press.

[47]See, for example, Schuklenk U., & Smalling R. (2017). Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. *Journal of Medical Ethics*, *43*, 234–240.

[48]Hordern, J. (2020). Religion, culture and conscience. *Medicine*, *48*(10), 640–643.

[49]Wicclair, M R. (2019). Preventing conscientious objection in medicine from running amok: A defense of reasonable accommodation. *Theoretical Medicine and Bioethics*, *40*, 539–564.

[50]Chaplin, op. cit. note 16, p. 127.

[51]Talk of 'accommodation'—especially in the sense of 'reasonable accommodation' is often closely associated with legal judgements as to the balance of equality and religious liberty. These are focussed, in the United Kingdom at least, around the 2010 Equality Act. See Rivers, J. (2020). Is religious freedom under threat from British equality laws? *Studies in Christian Ethics*, *33*(2), 179–193.

On Chaplin's account, a commitment to CO for the variety of different beliefs operating in an institution—religious and secular—ensures 'public space for minority views that challenge mainstream assumptions, a possibility of immense importance for a healthily responsive democracy'.[52] In Biggar's terms, such challenge and debate is underpinned by the dignity of the individual who, being both worthy of a hearing and liable to error, 'is bound to listen, to enquire, to consider that she might be mistaken, to contemplate that the other might be right'.[53]

However, elimination of CO for all parties would threaten this kind of democratic culture by reducing the value accorded to the integrity of citizens in manifesting their beliefs, 'convictional diversity' and the scrutiny of controversial or marginal opinions.[54] Here again, as Beaman noted, we see how healthcare should not be perceived as a zone apart from the rest of society in which the wholeness of people's identities is attenuated but rather as a place for accommodating them, thereby making individuals visible and available for a depth of personalised engagement.

By contrast, making religion publicly unrespectable seems liable to sap energy from that civic curiosity which could lead to healthcare staff being sufficiently motivated and literate to notice religion-based disadvantage or disparity—or indeed a *religious* hegemony which fails to accommodate secular faiths. For terminating the acceptability of religiously-based conscientious objection also seems likely to reduce awareness of and tolerance for secular grounds for CO. Chaplin would remind Schuklenk, Smalling and Savulescu that 'to participate in a democracy is to be prepared to live with a degree of loss'[55] including the loss constituted by the discomfort that another's view *and practice* regarding a controversial matter such as abortion or euthanasia entails. Of course, this requires of religious people the in-principle possibility of supporting conscientious objection claims from those with whom they disagree. Considering their own early history, Christians in favour of, for example, Anglican establishment should be 'the first to grasp the importance of minorities [other than themselves] gaining protection and respect from a hitherto indifferent or hostile majority culture'.[56] Chaplin's notion of accommodation, suitably amended by denying the necessity of confessional silence, at least in the practice of healthcare, would protect the in-principle possibility of CO for all people, whether secular or religious. In doing so, it mitigates the risk to a culture in which there is public recognition of the significance of religious beliefs for healthcare and thereby creates a context in which confidence and literacy regarding religious and secular beliefs can grow.

[52]Chaplin, op. cit. note 16, p. 133.
[53]Biggar, op. cit. note 44, p. 210.
[54]Chaplin comments, 'formal adoption of a statutory duty of reasonable accommodation would…send a powerful signal by the state of its commitment to convictional pluralism….-sending a message to individuals wrestling with issues of conscience that the law is solicitous of their concerns and does not regard them as eccentric but as normal, indeed in principle honourable. Elevating public respect for conscience through statutory respect is precisely the sort of instrument that a society committed to democratic pluralism should embrace'. (Chaplin, op. cit. note 16, p. 147)
[55]Ibid: 143.
[56]Ibid: 136.

3.2 | Accommodation and clinical ethics

Second, a similar political doctrine to that of Schuklenk and Smalling has also been applied to clinical ethics by Janet Malek, who claims that a 'clinical ethics consultant's religious worldview has no place in developing ethical recommendations or communicating about them with patients, surrogates, and clinicians'.[57] By this programmatic secularism, Malek intends that clinical ethicists should not give any space to their religious reasoning in formulating their thinking or in communicating that thinking with patients or colleagues (although they may, where appropriate, talk about religion—including their own religious beliefs—in building rapport). Note that the restriction Malek recommends does not apply to patients explaining the reasons for their expectations in religious terms and so a focus on patients' religious reasoning is not to the point here.

Malek makes two particularly important arguments in support of her claim. First, that those offering clinical ethics advice should do so on the basis of 'bioethical consensus'; if there is no consensus, then 'accepted moral principles' should be used to think through issues.[58] On Malek's view, religious thinking cannot contribute either to consensus or to accepted moral principles and so has no place in clinical ethics. Second, she thinks that there should be 'consistency' between those offering ethical expertise.[59] If some draw on religious arguments and others do not, then this would introduce inconsistency and so be illegitimate. Were there no good grounds for either of these claims, then her recommendation that religious thought should be disaccommodated from clinical ethics could be set aside.

Against the first claim, independently attesting Chaplin's distinction between the 'epistemological' and the 'sociological', Colgrove and Evans observe that

> There is no bioethical consensus concerning the right, the good, or the virtuous. There are dominant, politically successful paradigms that convey authority as a result of their popularity amongst select circles of society, but this is not as a result of their ability to establish a canonical account of medical morality.[60]

Even if there were such a consensus, Colgrove and Evans remark that Malek's view would require that religious people involved in providing clinical ethics who agree with a certain consensus would

[57]Malek, J. (2019). The appropriate role of a clinical ethic consultant's religious worldview in consultative work: Nearly none. *HEC Forum*, *31*(2), 91–102, p. 92. Malek is here ruling out even the role of religious reasoning in the internal mental processes of the ethicist on the grounds that such reasoning deploys tools outside a set of allegedly 'accepted bioethical concepts' (p. 95).
[58]Ibid: 95.
[59]Ibid: 97.
[60]Colgrove, N., & Evans, K. K. (2019). The place of religious content in clinical ethics consultations: A reply to Janet Malek. *HEC Forum*, *31*(4), 305–323, p. 307. Note that the widely cited four principles do not themselves constitute a consensus but rather a structure for discussing what *is* the good which is to be done, what *is* the bad which is not to be done, what *is* autonomy and what does respect for it require, and what *is* justice—matters about which there is no consensus.

have to set aside their religious reasoning (somewhere in their inner mind perhaps) and support the consensus based on solely non-religious reasoning. This seems an onerous, perhaps impossible psychological requirement, amounting to religious people being excluded from clinical ethics provision. On Chaplin's view, it also gives unwarranted privilege to a secular set of philosophical beliefs (or 'faiths') which, while they may be held by an elite group, should not be permitted the appearance of dominance.

Therefore, Malek's approach seems to constitute a form of workplace discrimination, singling out religious people for onerous psychological requirements and extra scrutiny, as distinct from those who hold other similarly lawful, although still contestable, non-religious beliefs. On Chaplin's analysis, what is happening in clinical ethics decision-making is that, while a final decision about what to do might be stated in doctrine-light terms, the reasonings behind the decisions will be very various. This does not make the final decision 'secular' but public, reflecting an uneasy but sufficient agreement which is good enough to determine action but certainly not stable enough to call a consensus. Again, taking up Chaplin's analysis, whether one reads such situations sociologically or not makes a significant difference to what one thinks is happening ethically.

As to Malek's argument about consistency, Ashley Moyse has observed a distinction between Malek's programmatic secularism which seeks to remove the public standing of religious reasoning and flatten out the plurality of beliefs operative in healthcare; and a procedural secularism which, by contrast, 'aims to cultivate a conversation between distinctive worldviews, and religions, where each is encouraged and enabled to share moral speech on their own terms'.[61]

What Moyse criticises in Malek's approach is an idea of ethics reduced to a kind of technique, on the model of technological production. For Moyse, Malek's notion of consistency aims to reliably produce the same kind of product in similar circumstances anywhere a similar kind of moral question arises. Even were this a workable notion—and surely circumstances vary very widely—the standard of consistency here is hard to justify in a democratic society in which difference of opinion and challenge should be welcomed. To freeze out such diversity at this level of political society is a controversial political move. The desire for consistency seems an inherently conservative position, entailing a closed-shop for ideas and debate, from which those of cultural and religious groups are systematically disaccommodated.

By contrast, and in accordance with Chaplin's account, Moyse advocates a culture in which plurality is not rejected but accommodated. Such plurality, he thinks, will improve ethical reasoning as part of a societal process of civic education and robust discourse in which all reasoning receives appropriate kinds of scrutiny. As in CO, reducing exposure to religious reasoning in this setting seems likely to fit healthcare less well with respect to confidence and literacy regarding religion and thus the ability to identify and address disadvantage. Whether or not a robust conversation between rival values and beliefs will be enhanced via Biggar's Anglican establishment vision or the kind of arrangements seen, for example, in Canada where networks of religious hospitals exist, is a further question, the answer to which is ineradicably linked to the specific political and religious histories of individual nation-states.

3.3 | Accommodation and resource allocation

Third, Malek's approach, which aims to govern policy at the level of clinical ethics conversations, especially with patients, mirrors an argument which reckons religion irrelevant, strictly speaking, to healthcare resource decision-making. Norman Daniels, extending Rawls' thought, rejects the relevance of religious reasoning in his application of consensus public reason to healthcare, thereby refusing to accommodate its significance even at the level of individual patient encounters.[62] He targets religion as particularly pernicious because of what he thinks of as its tendency to *cause* various kinds of disadvantage and inequality. The examples he gives are particularly focussed on monotheistic religions which appeal to the miraculous over against, as he sees it, the scientific.[63] I have argued, against Daniels' account, that healthcare poses a challenge to consensus public reason in as much as it shows that, in a variety of important cases, public reason is inescapably subject to 'indeterminacy', rendering it incomplete, and thus demonstrating the necessity of so-called 'nonpublic' reasoning, including religious reasoning. This is not a case of atheistic assumptions determining what counts as a public reason but rather an overestimation of the capacity of consensus public reason to be determinate in specific cases and an underestimation of the role of what Cecile Laborde calls 'social ontologies' at work in the apparently neutral reasoning of those who reject religious reasoning as 'nonpublic'. As a result, Daniels' ban on religious beliefs forming part of the justification for resource-allocation decisions should not be accepted.[64] Chaplin's account of unrecognised secular faith forms a complementary line of critique. A secular faith offers a doctrine of how to order political life well. But such a doctrine is bound to be controversial. What lies behind the last reason someone can offer for their doctrine is a substantive belief in one or more religious or secular 'higher values',[65] about, for example, the nature of the human person, personal fulfilment, freedom or autonomy. The extent to which a political

[61]Moyse, A (2022). Malek's programmatic secularism? A dissent. *Christian Bioethics*, *28*(2), 99–108.

[62]Daniels, N. (2008). *Just health: Meeting health needs fairly* (pp. 234–238). CUP.

[63]See, for example, Ibid: 22, 52, 157; Daniels, N., & Sabin J. (2002). *Setting limits fairly: Can we learn to share medical resources?* (p. 53). OUP. What Daniels rightly perceives is that permitting the relevance of religious reasoning in individual cases impacts resource allocation for the rest of society. A family asking for continued, expensive treatment of a patient while they await a miracle to prevent death would be the kind of case Daniels and Sabin have in mind. Of course, his own analysis ignores the way that religious thought has permeated ideas of justice which have been inherited by apparently nonreligious theories of justice, such as a concern for the health status of the poorest.

[64]Hordern, J. (2021). The challenge of healthcare to consensus public reason. *Social Theory and Practice*, *47*(3), 485–517.

[65]Calhoun, C., Juergensmeyer, M., & Van-Antwerpen, J. (2011). Introduction. In C. Calhoun, M. Juergensmeyer, & J. Van-Antwerpen (Eds.), *Rethinking secularism* (p. 19). OUP.

doctrine is controversial is a matter of sociology rather than epistemology or anything so apparently pure as 'reason'.

Friedman's criticism of Daniels on this point consolidates the critique. Regarding 'Accountability for Reasonableness', Daniels' and Sabin's decision-making procedure, Friedman argues that 'its claims to legitimacy, especially in a pluralistic democratic society, ring hollow' because of the highly rarified intellectual position it requires of those involved in justifying decisions. In a version of Chaplin's sociological analysis, Friedman observes that 'everyone except the political philosophers who are proponents of such processes' would be excluded from meaningful participation.[66] And yet just these philosophers, Friedman says, advocates of 'Utilitarianism, Kantianism [or] Libertarianism'—as opposed to any religious doctrine—and believing 'their basic assumptions to be sound, persuasive, and possibly even self-evident' will often be considered by others 'misguided, confused, or incoherent'.[67] Furthermore I note that Daniels' approach reflects Beaman's acute observation that a 'current overemphasis on problems [about religion] has resulted in a corresponding underemphasis on resolution, understanding, and success in negotiating difference'.[68] What is particularly relevant here, however, is the potential impact of Daniels' account, namely to render the accommodation of religious values and beliefs irrelevant to decision-making at an individual or population level. Such an approach presents a risk—and a needlessly exclusionary one at that—to the just treatment of people with religious views, including often vulnerable religious minorities in societies dominated by secular commitments.

The bioethical arguments in favour of excluding religion in certain ways, detailed in Section 3.1–3.3, are noteworthy because of the consistent political philosophy inherent in them. If they were implemented separately and especially if implemented together, they would significantly shape the civic culture regarding accommodation at the level of individual physician behaviour, clinician-patient encounter and resource allocation. They present a more or less coherent—if highly controversial—view of political culture and reasoning vis-à-vis health. With impressive honesty, they explicitly reject any place for religious values or beliefs in the plurality of beliefs which should be permitted to shape decision-making. Read through Chaplin's, Beaman's and Biggar's analyses, they bring to the surface what might otherwise be submerged namely that the contest about religion in healthcare is not primarily technical or scientific but rather political and cultural.[69] My claim is that, if adopted, these controversial political beliefs would tend to entrench disadvantages and disparities towards religious people. Religious values and beliefs—and religious people to the extent they identify with such values and beliefs—would appear as awkward rather than honoured guests in healthcare; or even as an alien, unwelcome and dangerous intruders into what should be religion-free places.[70]

3.4 | Objections

What objections might there be to this critique? First, perhaps these modes of disaccommodating religion merely represent discrimination against religious people *tout court* rather than discrimination against any particular religious group. The case would be that every and any religious view or person would be treated similarly and so there would be no unevenness in the disadvantage which would accrue to any group or individual. However, even were this discrimination against religious thought and people reckoned just—and we have given reasons via Beaman and, especially, Chaplin why this should not be thought to be so—an evenness of discrimination in practice seems unlikely. Really levelling down on this matter to avoid any disparity seems a more difficult task than its proponents suppose. For, as noted earlier in respect of institutional bias, without positive action to address discrimination, it is much more likely that disadvantage will fall unevenly, whether against religious traditions which are unpopular in certain (probably elite) cultural groupings or against religious traditions which are relatively unknown, marginal or vulnerable.[71]

Second, it might be said that the arguments of Schuklenk, Smalling, Malek and Daniels only require healthcare *staff* and *public decision-makers* to eschew the influence of *their own* religious values and belief on their practice in order to avoid the risk of disadvantaging *patients* from another or no religion. However, there is significant evidence not only that patients want staff to take an interest in their religious beliefs and values because of a desire for holistic care but also that staff who are well-versed in one religious tradition and consider religion important are better placed to provide the care which patients from a plurality of religious traditions want, while remaining conscious of the risk of imposing their beliefs on others.[72] Policy provisions following from the recommendations of Schuklenk, Smalling, Malek and Daniels would have a chilling effect on healthcare staff, diminishing sensitive engagement with religious beliefs.[73] Moreover, there are competences in accommodating religion and negotiating rival forms of secular and religious reasoning

[66]Friedman, A. (2008). Beyond Accountability For Reasonableness. *Bioethics*, *22*, 101–112, p. 108.
[67]Ibid: 109.
[68]Beaman, op. cit. note 1, p. 4.
[69]This general insight has been confirmed in other discourses too, for example with respect to the inescapably political nature of the contested definition of death in healthcare practice (Williams, J. (2017). Death and consensus liberalism. *Philosophers' Imprint*, *17*(20), 1–30).
[70]For criticism of the way that public reason and programmatic secularism depend on certain social ontologies, see Laborde, C. (2018). Abortion, marriage and cognate problems. *The American Journal of Jurisprudence*, *63*(1), 33–48.
[71]It remains an important focus for research as to whether the opposition to religious involvement in healthcare at these various levels is equally distributed or more targeted against those traditions which have historically had more influence in Western healthcare: for example, more against Christianity than against Buddhism.
[72]Best, M., et al., op. cit. note 39.
[73]I note that medical professional guidance seems more pragmatic and less ideological than the bioethical arguments considered. For example, the GMC rightly recognises the interrelation of doctors' and patients' deepest commitments in practice by permitting the interface of doctors' and patients' religious beliefs where deemed appropriate (General Medical Council, *Good Medical Practice*, §54). Far from chilling such relationships into silence about religion, the evidence would suggest that the GMC guidance should be interpreted in a highly positive way to encourage, where appropriate and not harmful, the sharing of religious beliefs. The implication is that if some patients want their views to be taken into account

which healthcare staff might more reliably develop through multiple opportunities for reflective practice in dimensions of healthcare such as CO, clinical ethics and resource allocation. Eliminating these opportunities seems unlikely to fit healthcare institutions to meet the challenge of religious literacy which would enable them to notice and tackle religion-based disadvantage and disparity. For what is not counted as permissibly or respectably public for one group (healthcare staff) seems likely to lead to that group of professionals becoming relatively unskilled in dealing with that matter with respect to another group, namely patients.

The claim, therefore, is that instead of creating a culture in which patients, with their religious and nonreligious beliefs, values and practices, are accommodated on equal terms with all other patients, certain arguments, political in kind, which systematically exclude religion's relevance would, if consistently enacted in practice, militate against increasing workforce confidence and literacy to address problems of disadvantage and discrimination in respect of religious values and beliefs in healthcare. The extent to which this *is* happening in practice is a question which cannot be tackled here, although the evidence of NHS managers' views cited earlier shows that such a concern has at least some grounds in reality. The question is whether, if the ideas were acted upon, it would present a serious risk of embedding or deepening religion-based disadvantage and disparity in the provision of care to patients and in the working conditions of healthcare staff. When contrasted with the positive notion of accommodation developed via Chaplin and Biggar, the most plausible answer seems to be that it would present such a risk.

4 | CONCLUSION: COMMUNICATION, AGONISM AND ACCOMMODATION

In conclusion, it might be said that, even if Chaplin's recommendations regarding our deep diversity are accepted, complemented by Biggar's establishment vision and Beaman's emphasis on informal resolution while rejecting her notion of agonistic respect—if, for example, prayer in public institutions is not only permitted but facilitated even at a cost to operating theatre time, if conscientious objection for secular and religious people is legally protected, if clinical ethicists are trained to incorporate religious thinking, and if publicly recognised resource allocation justifications may justly draw upon religious belief—then there remains the question of how people—including religious people—should actually communicate with one another in healthcare. This is a crucial question of civility and prudence.

Chaplin strongly commends the practice of giving a 'public explanation' of one's views that 'sincerely aims to be intelligible and persuasive to as large a proportion of one's fellow citizens as possible'.[74] If this advice is followed then, while it may be the case that, when clinical ethical counsel is discussed, a CO is supported by colleagues, or a resource allocation decision is made, it is apparently justified by a reason everyone could say is their reason; it is really justified by multiple converging reasons of both patients and clinicians. However, both Chaplin and Moyse think of this in broadly liberal political terms while avoiding the strictures of consensus public reason or programmatic secularism. Instead, a *full* range of reasons might be given in communication, including those which, although perhaps intelligible, might be unpersuasive in the sense of others coming to see the world differently. Nonetheless, the exercise of giving one's deepest reasons for the course of action one recommends is not ruled out on this view. Moreover, Chaplin's reasons for this balance of communicative restraint and freedom in communication policy—integrity, diversity and scrutiny—are both fully formed by Christian theology and fully conversant with the liberal democratic theory, taking a specific position within it, and communicated in clearly intelligible and accessible terms.

The job of a healthcare worker might be more overtly agonistic, in Chaplin's sense: for example, to enable a religious person to see the unreasonableness of the reasons they are offering—or at least that the reasons are relatively unreasonable compared with other reasons for action which would suggest a different course. The judgement might be that this is only doubtfully appropriate to any given situation because of the vulnerability of the person and that allowing the religious reasoning of a patient to appear to be decisive is the better approach. However, a judgement that robust discussion and argument is pastorally insensitive should be weighed up with both the role of healthcare in civic education and the consideration of the needs of those who will lose out if a resource is consumed on what are unreasonable grounds. Here, Beaman's and Chaplin's rival *ideas* of agonism meet, ironically, in agonistic debate. Much has to be left to the prudence of the relevant healthcare staff and patients themselves. The discussion of personalised care above here takes the form of agonistic democracy, tailored to the individual patient. The form which such agonism might take is a healthcare-sensitive application of what Jeffrey Stout has called 'immanent criticism'. For Stout, 'immanent critics…either try to show that their opponents' religious views are incoherent, or they try to argue from their opponents' religious premises to the conclusion that [a] proposal is acceptable'.[75] This kind of language, fitted primarily for legislative debate but applied to accommodation in healthcare, might sound pastorally inappropriate. Moreover, in tune with the argument here, it would need to be employed not only in relation to religious beliefs but also to secular beliefs. However, a version of this approach could be employed which is sensitive to the relative vulnerabilities of patient and healthcare worker—or, indeed, between healthcare management and a member of staff exercising a conscientious objection—as well as to that mix of state involvement and personal intimacy Beaman noted and to the complexly religious and secular environment of healthcare. In this environment, what can be understood and agreed

(e.g., in clinical ethics or resource allocation decisions), then it is important that there is sufficient confidence and literacy to provide that expertise.

[74]Chaplin, op. cit. note 16, p. 85.

[75]Stout, J. (2004). *Democracy and tradition* (p. 69). Princeton University Press.

regarding how to accommodate justly the values and beliefs of religious people will vary depending on the sociological make-up of the healthcare institution in question.

Consider the example of how to justify continued cancer care for a patient in the face of a diminishing return in terms of quality of life or extension of life. If someone were to say 'she's a fighter' to explain why someone wishes to continue therapy beyond the stage when many would opt for palliative care, this may be true of the patient's demeanour, but it is hardly a wholly clear or uncontroversial piece of communication.[76] The question of why someone is fighting is not answered by it—whether it is because life is a basic good given by God which is to be fought for, or because this life is all there is and the individual does not want it to end. Neither of these reasons seems in principle more or less reasonable than the other. So as a rhetorical device to be persuasive about gaining access to further care it may be effective, but it certainly does not provide—as it stands—the information necessary for a deep encounter and perhaps agonistic discussion between, for example, patient, family and healthcare staff.

The communication may provide for a kind of uneasy peace in which no nonreligious or religious gatekeeper is publicly endorsing a reason they find unreasonable. However, a deeper aspect of civility in a plural democracy is the integrity between people's identity and their speech. For many there will be an existential significance in explaining their deepest reasons for seeking a particular kind of car—or for being 'a fighter'. To be able to explain such reasons in detail—and for them to be recognised as the reasons why a specific treatment plan is agreed—might be key to the quality of relationships a patient has with those around her. In such cases—and, by implication, in all other cases—while making themselves as plain as possible to those around them, it should not be required of citizens to speak in the controversial terms that certain Rawlsian liberals require. Such a strenuous demand lays a burden which should not be laid upon patients when they are already feeling vulnerable, poorly and powerless. Similarly, for healthcare staff—who commonly also feel vulnerable, poorly and powerless—sustaining integrity at work is of vital importance. It would take a certain level of clear-eyed determination to press ahead with requiring people to speak a 'secular esperanto'[77] to have a hope of gaining the treatment they want or to live with integrity in the workplace. Just as patients' life and health may be disintegrating—or just as clinicians' vocation may be under maximum pressure—they would be required to give reasons which also disintegrate their sense of self.[78] Not only would such an outcome be a grim realisation of the risk to accommodation which Section 3.1–3 discussed but also it would mean a more radical form of disaccommodation, of someone not being able to be at home with themselves. The argument of this paper, however, is that the practice of accommodation, conceived in the form I have argued for here, should prevent such a circumstance from arising.

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CONFLICT OF INTEREST

The author declares no conflict of interest.

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[76]One can *understand* the rhetoric of the battle against cancer (whether individual or institutional) without believing it to be a wholesome form of public speech (see Collins, G. (2018). The atheist problem of disease: Who's to blame? *Theology*, *121*(2), 92–95).

[77]Chaplin, op. cit. note 16, chapter 4.

[78]Ibid: 88.