At a time when many government and public bodies are recognising the importance of engaging with faith communities, **Aziz Sheikh** advocates that the UK should provide specific health services for Muslims. But **Aneez Esmail** argues that such services could enhance stigmatism

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NO How we judge human identity is central to the question of whether we monitor religious identity in healthcare settings. The reality is that identity is not singular but complex and encompasses ethnicity, religion, social class, and even the value systems of our parents and other influential figures.

History is replete with examples where the fostering of a singular identity is subsequently used to encourage violence and persecution against people who are not conceived as being part of that identity—the holocaust, communal violence between Muslims and Hindus in India, the genocide committed by Hutus against Tutsis in Rwanda, and the ethnic violence between Serbs, Croats, and Bosnian Muslims in the former Yugoslavia are a few examples. The terrorist attacks in New York in 2001 and London in 2005, the continuing conflict in the Middle East, and the war in Iraq have led many people to question the relationship that Muslims in the West have with their governments. Crude categorisations of Muslims and their beliefs, Samuel Huntington's popularisation of the theory on the clash of civilisations, and the emergence of Islamophobia have encouraged many to assert their singular identity. This is what often lies behind pleas for special treatment and special services for certain people.

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The assertion of singular identities is not just restricted to Muslims. As an antiracism campaigner, I have despaired at the way many South Asian doctors have begun to organise themselves along religious lines (including along caste lines). They then proceed to find fault with each other forgetting that the real problem is racism. Racism within the medical profession does not distinguish between differing religious groupings and results in all ethnic minority doctors being disadvantaged.[1]

Faith matters

There is a strong case to argue that in healthcare settings, religion does matter to some people.[2] In the NHS it seems reasonable that we try to plan and configure our services to take account of needs that may have their roots in particular beliefs—so in some areas having access to chaplains for different faiths may be important, as is the provision of halal, kosher, and vegetarian food.

It is also right that we should not force Muslim and Jewish people to use poorly regulated male circumcision services. But that does not mean that the NHS should provide them—having an accredited list of doctors who have been trained to carry out the procedure may be the service that the NHS should provide. However, we cannot meet everyone's demands for special services based on their religious identity: it would not be practical. In some cases there are practices which may be morally and ethically unacceptable—for example, female circumcision and the refusal to accept blood transfusions in life saving situations.

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We cannot assume that religious identity is homogeneous. Members of the same religion are not all the same and their needs may be different. There are many sects within Islam that place differing emphasis on many of the core tenets of the religion, and they do not all translate into the same requirements for faith based services.[3]

Understanding individuals' needs

Underlying our approach to demands for faith and culturally based services should be a set of principles. A good place to start is understanding the sociopolitical consensus that exists in this country—essentially the UK is a secularising country albeit one that draws heavily on Christian values in its laws and structures. It is not a secular country in so far as secularism is defined as an ideology that seeks to eradicate religion from public life—look at the examples of church schools and the role of the Queen as head of the Anglican Church. What defines this country is the result of a secularisation process that has taken place over hundreds of years and that is built on pluralism. Pluralism defines our democracy and encourages mutual respect and tolerance.

In planning our services we should encourage respect and tolerance without having special services for defined groups of people. Going down the path of providing special services for defined groups risks stigmatisation and stereotyping. This means that when we see someone with a Muslim name on a maternity ward we assume that she will need to pray five times a day, have special dietary requirements, and want to have her male child circumcised. We make no allowance for the fact that different Muslims conduct their lives in different ways.

The way forward is not a crude categorisation of people into even more tightly defined groups. We already monitor peoples' ethnicity, not because we believe that this is how people want to categorise themselves but because we recognise that racism is prevalent in our society and that it affects certain groups disproportionately. Monitoring ethnicity allows us to assess the effectiveness of our services and challenge inequality. It is not about assuming that the Asian patient has a core set of beliefs about illness because of fixed ethnic traits.

In an ideal world doctors would ask patients about ethnic identity not because it is an abstract concept used for monitoring but because patients may see it as an important part of their self. They would ask about a patient's beliefs not so that they can be categorised but because it might be important for the patient in their illness.

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References are in the full version on bmj.com