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Beyond Religion, Science and Secularism: Health Beliefs and Complex Diversity in the North of Ireland

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Beyond Religion, Science and Secularism: Health Beliefs and Complex Diversity in the North of Ireland

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Abstract

Discussions on diversity call for a consideration of 'intimate beliefs' that extend beyond structural and organisational differences to include highly nuanced ideas and practices. Complex diversity is therefore taken as transcending Western-centric and modernist notions of religiosity and religion, and requires a discussion of wider, less articulated, but more organic, intimate (localised) beliefs and practices, that predate modern and formally established expressions of religion, including Christianity. Using data from two ethnographic sites, this discussion pays attention to the role of folk beliefs in Northern Ireland and the relationship with religion, ethnicity and health care. It considers how folk beliefs and folk practices are commonly integrated with biomedical health care practices. The paper then tries to draw out more general theoretical and practical implications and points out areas of concern for Western governments and influential international bodies such as the World Health Organisation (WHO).

Religion as medicine and medicine as religion

Religion is classically defined as “a unified system of beliefs and practices relative to sacred things... which unite into one single moral community called a Church, all those who adhere to them’ (Durkheim 1976: 47). In this sense it is belief in the spiritual. It involves symbolic acts and has established institutions to facilitate ritual and ceremony. It is, “symbolic practice, group organisation and institution” (Hamilton 2005:18). Religion cannot be underestimated as a key component for social organisation since it prescribes explicit rules (and sanctions) for living. It provides, “those mechanisms which most strongly establish, anchor, contextualize and regulate meaningful order and orderly meaning...” (Lambek 2008: 10).

However, the distinction between ‘religiosity’ (belief in the supernatural, ‘otherworldly’) and ‘religion’ (as organising principle, such as a church, ‘this worldly’), is important and requires discussion of more general ‘belief systems’. These are the systems (or matrix of ideas and beliefs) that attempt to provide a cognitive and social framework to

help us understand and organise our lives. These ‘sacred canopies’ offer a cosmological explanation of events and experiences and account for the unpredictable, the unexplained and the unknown, and offer us coping strategies to deal with the exigencies of life, illness, good fortune, death and afterlife (Berger 1990). As a belief system religion offers us security and peace of mind and provides structure and predictability in uncertain and dangerous circumstances (Malinowski 1974 [1948]). In short, belief systems enable us to make sense of the world in which we live¹.

Classical sociological discussions on religion have taken different positions. Durkheim and Weber underscore ‘the social’ and ‘the individual’ in defining, understanding and reifying the role, place and significance of ‘other worldly’ spiritual ideas and shared cosmological beliefs.

For Durkheim religion represented ‘the social collective’; for Weber this was ‘moral individualism’ and subjectivism. Both principles are central to discussions concerning the traditional and the modern, superstition and science, and, as a consequence, to seemingly competing (health) paradigms in the Western world (Moore and McClean 2010: 27)

Weber famously highlighted what he saw as a defining historical shift associated with ‘modern’² social, economic and cognitive structures, *i.e.* the rejection of supernatural ideas. Weber refers to

The inner loneliness affecting Calvinists as the culmination of a process that had been initiated by Hebrew prophets and fostered by Hellenistic science, a process which eliminated magic from the world: salvation and redemption could no longer be found through the magic of the church (Kassell 2005a)

In the West, religion has been traditionally articulated as being tied to Christianity as the historically dominant church, one with messianic and universalistic principles. However, varied and multiple cosmological beliefs, such as folk beliefs, pre-date Christianity and form part of an ancient system of beliefs that have influenced and continue to influence modern life. These are largely absent in contemporary discourses on religion and belief. Aspects of these more occult belief systems, alternatively referred to as ‘folk systems’, ‘folk beliefs’, ‘folk medicine’ or ‘folk healing’³, continue in the face of modernity and (the now varied representations) of the established church in the West. These become particularly visible when individuals or loved ones are faced with illness, incapacity or death, and it is then when individuals and communities resort to folk medicine and seek out and utilise folk healers. These practices are tied to faith and belief, but go beyond modern religious ideas and modern scientific explanations, and this makes them important.

Christianity began its ascendancy under Roman law as the official (and mandatory) religion of the Roman Empire⁴. Then, it expanded *via* the Crusades, various migrations and land conquests, inquisitions and witch-hunts (in both ‘the Old’ and ‘New World’). Christianity banished, but also fostered superstition, effectively establishing a

¹ Rappaport, however, more recently refers to a model of religion and the sacred as, ‘a property of discourse’ (in Lambek 2006: 9).

² Modern and modernity should be understood as problematic sociological concepts, but for this paper and ease of readership refers to the era of post-enlightenment, industrial and immediate post-industrial age.

³ The nomenclature is problematic in the existing literature, since the ideas associated with these are diverse and relate to a multiplicity of beliefs and cross cultural practices.

⁴ Under Constantine and later his sons.

monopoly of magic. Religion and religious practice in the West have been synonymous with Christianity, yet many Christian principles and beliefs are actually built upon more pagan practices (Porter 1993,1998). Formal scientific medicine (often referred to today as ‘biomedicine’) and more occult health care, such as folk healing, qualify for discussions on complex diversity since religion and medicine are metaphorically interchangeable. The historical interconnectedness is outlined elsewhere (Turner 1995, Trevor Roper 2006)⁵.

Folk-inspired healing such as folk healing, spiritual healing and crystal healing are part of a broad healing system that can be defined in an anthropological sense as minority religion since it exhibits many of the same features (McClellan and Moore, 2014, forthcoming).

The idea that the world was becoming ‘individualised’ dates back to the mid-seventeenth century. The Enlightenment was thought to bring with it a profound paradigmatic shift. Cosmological and ideological beliefs began to be challenged in an increasingly rationally inclined social order. Religion, and the established church, with all of its institutional and power structures, appeared to be doomed as social commentators underscored the shift from antiquity to modernity, from community to society, and from magic to science (Comte 1865 [2009], Tönnies 1887 [2002]), for Weber see Gerth and Mills 1948). Evolutionary and anthropological theories of the nineteenth century appeared to provide the *coup de grace* as the world appeared to become ‘disenchanted’. Religion, or at least the theistic relevance of religion, would diminish and ultimately become obsolete.

Medicine emerged from piety, religion and the church (Lane 2001). Formal medical practice, with its particular brand of Cartesian philosophy, expanded throughout the early nineteenth century in Europe and came to dominate Western health care ideology. Modern science justified this. Medical practice became licensed in Britain in 1858 and bound to *legal* rather than *social* or moral obligation (Porter 1998: McClellan and Moore 2013). As biomedicine developed it came to dominate in terms of legitimacy, authority and control with increasing occupational protectionism, effectively eliminating competition from informal practitioners (empirics) many of whom were women. Religion proselytised and biomedicine medicalised. New hierarchies and symbolism emerged to displace the old superstitious order. As biomedicine expanded, it also began to extend its orbit of power and influence well beyond health matters to other social and political affairs.

Religion and Health in Northern Ireland

The North of Ireland is synonymous with social, political and religious conflict, and this has stimulated considerable interest and animated debate among academics and journalists, particularly in more recent times⁶. This interest shows little sign of abating. The Province is politically British and part of the United Kingdom (UK), yet geographically Irish. Its nation-state ancestry is therefore contested. The historical background to civil unrest in the region points to religion and specifically to Protestant/Catholic religious affiliation as the basis of physical, social and ethnic divisions. The region is commonly portrayed as a clash of two cultures, two religions, and two national identities, British and Irish. Religion here aligns itself with regional and local identity and is an important maker for nationhood (Geertz 1966). Others provide more fictive ideas of nationalism (Anderson 1983), and it is

⁵ That is common belief, trust, acceptance and observance of behaviour, dietary observance, cleanliness, and judicious moral action toward a collective good.

⁶ Some have suggested that this had added to the complexity of researching Northern Ireland. ‘There are approximately 10,000 works on the conflict in Northern Ireland specifically, and this does not include works on conflict theory’ (Cunningham 1998).

this idea of ‘notional identity’ that crucially represents important political communities and continuities. Religion is thus representative of a cultural system, fostering a sense of belonging to a real or ‘imagined community’. As a consequence, many Protestants and Catholics in Northern Ireland live separate and encapsulated lives. Contacts outside the local community therefore are often limited.

In spite of the more problematised, individualised and cognitive accounts of identity offered elsewhere (Jenkins 2008), collective allegiances in Northern Ireland are still largely determined by ethnic, politico-religious factors. The two dominant ethnic religious communities have different political cultures and different interpretations of history. While the current political rhetoric is one of multiculturalism and the celebration of diversity, religion (as culture) remains a key source of serious social and political division in spite of the ‘Good Friday Agreement’ in 1998, and the relative peace that the Province is said to be experiencing⁷. Without wishing to add to hackneyed debates on what has euphemistically been referred to as, ‘the Troubles in Northern Ireland’, we may summarise that the conflict is regarded as one of competing groups who align themselves historically, socially and politically in terms of ethnic-religious affiliation. Religion (not necessarily religiosity or spiritual belief) remains an important marker of identity for many.

Today, multicultural and multi-ethnic Britain and Ireland espouse the principles of social equity and political parity. This also translates into equality in health care. This was the driver for government initiatives in Britain and Northern Ireland to target health and social need (in response to The White Paper, *The Health of The Nation* 1992). The locally applied interpretation of this, ‘The Regional Strategy for Health and Social Well-being 1997-2002’, underpinned government commitment to conduct research into social and health disparities.

In 1995 the Department of Health (Northern Ireland) funded ethnographic research to add to investigations of social and health inequality. Two large statistical health studies had already been completed in Northern Ireland. These provided important data but were deemed limited in terms of their scope and depth (Stringer 1990; Robson, Bradford & Deas 1994)⁸. The key aim of the ethnographic investigation was to provide an (emic) interpretation of perceptions of health and health experiences that rested on personal accounts of people living in two small rural towns, one predominantly Roman Catholic (Ballymacross), and one Protestant (Hunterstown)⁹. The investigations primarily sought to assess health and related need in each community. An ethnographic approach therefore was thought to provide a more nuanced account of health beliefs and behaviour. The research was concerned with self-reported health; factors influencing health status and ‘health chances’ (morbidity and mortality); health service provision and take up; perceptions of health care delivery; and how local people interpreted and prioritised health needs. It also considered whether health chances were connected to ethnic religious affiliation. For example, recent debates within sociology, anthropology and public health surrounding the role ‘social capital’ plays in affecting health, have received considerable attention (Kawachi *et al.* 1997, Putnam 2000, Klinenberg 2002).

The findings were produced as two government reports (Moore *et al.* 1997a/b and Mason *et al.* 1999, as well as several journal publications). They emphasised multiple and interrelated factors as determinants of health. Health behaviour and health capital were outlined as significant factors in the reports. However, unanticipated findings from the

⁷ Witness the current dispute over flying flags by Ulster Protestants, who fear a sell out to Republican demands, and recent attempts by extremist Republican paramilitaries to carry out attacks on security forces.

⁸ A full discussion of methods is presented by Moore *et al.* (2010). See the use of an ethnographic approach to assessment of health need in Northern Ireland in NT Research Vol.1 No.4, 1996.

⁹ Meaning that more than 80% Roman Catholic or Protestant. Ballymacross and Hunterstown are pseudonyms.

fieldwork highlighted the important role that folk beliefs and folk healing played in the lives of local people in both communities.

Ethnographies

Ballymacross and Hunterstown could be described as being fairly representative of many rural market towns in Northern Ireland. The local economy was largely dependent on farming and small family businesses. Local people preferred to live close to kin and among co-religionists. These practices acted against promoting crosscutting ties¹⁰.

Ballymacross

In Ballymacross the Catholic Church was centrally involved in a variety of social, cultural and sporting activities. The Gaelic Athletic Association (GAA) supported mainly Catholic links within the parish and with other parishes. This helped produce a distinct sense of culture and common social and political attitude. The church not only provided moral leadership but also had a much wider role, for example in mediating local level disputes. The church emphasised community obligation and spiritual religious solidarity. There were no physicians (General Practitioners - GP) in the town. The nearest was based some miles away in another town. The local pharmacist/chemist, however, was indigenous to the town and was regarded as an important substitute for many.

Hunterstown

Hunterstown emerged out of a plantation settlement in the seventeenth century¹¹. Industrialisation stimulated significant growth in a range of occupations in and around the town and local area. It was also a major centre for livestock trade. The social and religious composition of the town revealed a complex mix of co-religionists (as well as some Catholics¹²) often with very divergent and conflicting views and attitudes. Religious denomination and social class cleavages were perceived as significant points of differentiation. There were also a number of smaller churches such as Free Presbyterians. Some also defined themselves as culturally Protestant rather than practicing Christians ('good living'). Protestant unity and identity was more evident at historical and religious high times or at times of social and political unrest (when Catholics and Protestants of all persuasions tended to polarise)¹³. While Ballymacross appeared to show a more homogenous and stable social and political ethos and national identity, Hunterstown appeared to be less egalitarian and less socially integrated.

The Catholic Church in Ballymacross was said to provide an overarching entity and moral authority. Hunterstown, however, appeared to reinforce Weber's position¹⁴ regarding social atomisation and individualism. The community in Ballymacross was seen as supporting the strict involvement of religion and the Church in a variety of social institutions and organisations such as education, major social events and in sport. The community in Hunterstown was separated not only by traditional denominational differences, but also by the emergence of more recent factions in the form of new (inspirational) Protestantism. There was little sense of a cohesive collective identity among Protestants.

¹⁰ The *Ne Temere* decree, which historically insisted that children of mixed marriages (where a spouse is Catholic) be baptised and brought up Catholic, was regarded by Protestants as a major obstacle to community integration.

¹¹ The Northern province of Ulster was colonized by Scottish and English settlers during the early part of the 17th century as part of the Plantation of Ulster.

¹² Accounting for less than 20% of the overall population (Moore *et al* 1997a).

¹³ The annual Protestant 12th of July demonstrations / celebrations is an example of this.

¹⁴ Weber noted that Protestantism subjectified and emphasised asceticism and personal success for salvation.

Given the ethnographic profile of these towns it might reasonably be suggested that since the historical and ethnic religious basis for social division has been (and remains) so profound, then health beliefs, health behaviours and health outlooks might also differ. Catholics are generally believed to emphasise more superstition (and magic). Also, if Weber's observations are accurate, Protestants are more likely to reject superstitious ideas and beliefs (instead relying more on formal scientific biomedicine). Some cross-cultural evidence supports this claim (Graham 1985).

Folk healing in Northern Ireland

In Northern and Southern Ireland, many people believe that there are individuals outside 'orthodox' medicine who have the ability to heal sickness. In both towns local people reported (in private, and only when asked) individuals who, they said, had "the gift of the cure or charm". Further, this knowledge was embedded into tradition and local health belief systems in profound ways¹⁵. People understood how to gain access to folk healers should the need arise. The ethnographic data indicated that very many people had attended a healer at some point, or have had a relative go for a cure.

The cure could be obtained in a number of ways. The person needed to be identified and recognised in the community as a curer and the rules defining this were well understood. For example, the cure was assigned to the healer on the bases of inheritance, birth right or *via* some other special circumstances (Moore and McClean 2010)¹⁶. The type of cure depended on the nature of the ailment. These were usually for less serious conditions, such as skin problems, e.g., warts, ringworm or shingles. But cures could be obtained for more serious conditions, including cancers. The methods of curing also varied. The cure would involve for example, a laying on of hands, or reciting prayers or magical words. Sometimes wands, smoking sticks, herbs or potions might be used. "For the ringworm, he just used a burning stick and held it over the area. I'm sure he said something, but I can't remember what it was." (Wendy – Hunterstown, cited in Moore and McClean 2010).

Curers were often reluctant and reticent practitioners. There was usually no financial transaction, but rather healers felt compelled to heal by a sense of expectancy and social commitment. "I just went to her three times and then the last time I brought her out fruit and teabags" (Angie –Hunterstown cited in Moore and McClean 2010). Each community also had their sceptics. But the narrative of people from varied social and political backgrounds pointed to the cure/charm as being important in these small towns, and very many believed in the efficacy in the cure.

I have been down that road myself. I'm prepared to do anything at any stage. I would decry them normally, but my youngster had whooping cough a couple of years ago and I beat my way down to K-----. It was just

¹⁵ Curers do not use the term 'magic' themselves. However, as Buckley suggests, "the use of the term 'charm' has magical connotations for local people" (1980: 22).

¹⁶ The narrative reported that the cure was normally passed from mother to son or from father to daughter. However, this depended on the type of cure, and in some instances cures were transferred in very specific ways (Moore and McClean 2010).

horrendous. This was January, and the child was just absolutely horrendous, and I had got to the stage where I had gone to the doctor and then somebody said you need a charm, and I said, point me in the direction of it, and we went down. It was quite funny but I didn't care because she was so fed up and so upset... You don't think you need them until the time comes, then all the ideas of religion, and your teaching goes by the wayside, because if you see a child sick you would do anything (Mrs Wilson, School Principal, Hunterstown; cited in Moore and McClean 2010)

Some healers had a spiritual faith, others did not. The Catholic Church did not officially sanction folk healing. However, some priests were said to have had the cure. The cure/charm was tied to ancient cosmological ideas that involved supernatural (magical) beliefs not necessarily tied to Christianity. The practice found a niche where biomedicine was deemed by local people to be unsympathetic or unsuccessful. In this sense it was perceived as acting pragmatically and as a corrective to the limitations of biomedicine:

We went to B, the two girls had ringworm.... It went away very quickly on one, but it took a wee bit longer on the other. We had gone to the doctor but it didn't make any difference. He gave me some sort of anti-fungal cream to put on it. He said it would take care of it, but it didn't. It just got worse. (Wendy, Hunterstown; cited in Moore and McClean 2010)

The cure emphasises the holistic nature of health. Here, the social, psychological and magical are inseparable.

Health professional responses to folk healing

Cures were never openly spoken about, but there was recognition by local health care professionals that folk healing was an important aspect of life in both communities. GPs in Hunterstown took a pragmatic approach to folk healing. Even a sceptical young locum GP recognised the practical value of cures/charms at the very least, taking some pressure away from over-burdened medical services.

I used to think they were wee men with a crooked finger who would cure your warts. It is surprising to me the people who are into this. Some of these people are the most sensible cosmopolitan persons you could get. (Locum GP, Hunterstown; cited in Moore and McClean 2010)

One young (*locum*) GP interviewed was hostile to folk healing; yet another said he had referred patients to a local healer: "They can use them if they want to – they sometimes work" (GP –Hunterstown; cited in Moore and McClean 2010). GPs recognised that biomedical efficacy and their own practice also rested on acceptance of local cultural ideas on health. In other words, even sceptical GPs were aware that to be effective they should take account of local health beliefs and practices. Health professionals were not only cognisant of folk healing but the practice was even incorporated into their professional working arrangements. Health visitors and midwives would routinely check what substances were added to foodstuffs for small children. Local health professionals interviewed reported that they believed in the power of the cure. Several admitted to using tradition healers themselves, for relatives and also importantly for animals: "We have had animals that have been dehorned and started to bleed, and my husband has gone and got the charm and when they came home they stopped bleeding" (Helen – retired nurse manager; cited in Moore and McClean 2010).

Pharmacists in Ballymacross and Hunterstown firmly expressed their belief in the power of the cure. A chemist in a nearby predominantly Protestant town was also known to have had the cure. While some health care professionals may have believed ‘the cure’, they were not inclined to state this publicly for fear of ridicule by their peers. Those who had ‘the cure’ did not try to undermine the authority of GPs. Rather, curers acted as servitors responding to the social, psychological, spiritual and health needs of these communities. Also, local people were not uncritical. People knew of the limitations of folk medicine and expectations were modest. They were however also quick to point up the limitations and risks in biomedicine.

The wider significance of folk healing

In Northern Ireland religion is still regarded as an important marker in terms of identity, politics and cultural belonging, but folk beliefs evidently carry significant importance for local people. These two encapsulated, religiously segregated, rural communities display common knowledge in terms of the extent of folk ideas, and folk practices. This is highly significant since there was limited scope for cross-cutting ties, interactions or information exchange between these communities. Both emphasised the continued existence of folk health knowledge and pluralist health strategies. The narratives emphasised how folk healing was integral to service provision as a whole¹⁷. In this sense the relationship between folk medicine and biomedicine was symbiotic. In a wider context this research exposes important belief systems thought extinguished, dormant or irrelevant, as being *vital* in the modern context. Folk medicine was not defined or constrained by Cartesian methods. Rather, it offered a more holistic approach emphasizing wider social, psychological and environmental health needs that biomedicine often neglected or misunderstood¹⁸. Folk medicine represents continued and trusted practices that go back to antiquity.

The history of Western biomedicine illustrates how alternative intimate belief systems were marginalised, thereby creating a medical monopoly that emphasised a rigid scientific orthodoxy (Porter 1993, 1998, Lane 2001, McClean and Moore 2013). Alternative healers, so-called *quacks*, were chastised (Wahlberg 2007). However, this study suggests that biomedical dominance, powerful as it was, was never complete. The findings also add significantly to more recent discussions that undermine the whole notion of ‘disenchantment’¹⁹.

Folk beliefs systems and health practices represent an important source of tension and conflict in many so-called ‘advanced Western societies’. There is increasing state and international concern regarding the use and reliance of alternative health practices (see for example, House of Lords 2000, WHO 2002)²⁰. To date, serious discussion on such practices have more often been restricted to debates about services that provide an adjunct to biomedicine, *i.e.* certain aspects of complementary and alternative medicine. However, current public trends suggest not only a continued, but also a widening reliance on, and reference to, folk and alternative medicine. These appear (amid considerable biomedical unease) to be ‘big business’ (Thomas *et al.* 2001, McQuaide 2005, Winnick 2007, Moore

¹⁷ Folk medicine is distinct from CAM (Complementary and Alternative Medicine). (Moore and McClean 2010).

¹⁸ Examples of the shortcomings of biomedicine and modern risk are well documented in both the academic and popular literature (Illich 1976, Douglas 1969 and 1992, Beck 1992, Giddens 1990), while more contemporary research illustrates the increased public perceptions of risk amid various health scandals (see for example, Barrett, Moore and Staines, 2007).

¹⁹ See for example Kassell (2005a). Also, Jenkins (2008) provides an interesting discussion, including a critical outline of Weber’s ideas surrounding ‘disenchantment’.

²⁰ The situations and contexts that the WHO refers to are not comparable to the type of traditional medicine discussed, particularly when it comes to folk healing.

and McClean 2010)²¹. Folk healing is extant and remains an important (yet largely dismissed) part of health care, it seems, in the West. The state is increasingly forced to recognise this and feel they need to legislate, in an effort to manage and control such practices. However, a key problem remains. While some aspects of the Complementary and Alternative Medicine may eventually be subject to regulation and control (although that is by no means assured), folk medicine may not so easily be codified, regulated or commodified, since it does not seek recognition, payment or licensure. Folk beliefs also add to wider debates on religion, secularisation and more nuanced forms of diversity that are likely to need serious philosophical, social, and political debate. Official recognition of folk healing, for example, would undermine the sanctity of science and the legitimation for biomedicine as the one true medicine.

Post-Enlightenment and even modern writers continued in the belief that the world had become 'disenchanted' (Thomas 1973). The findings here suggest that folk health beliefs and practices, although thought to run counter to scientific principles, in fact appear to be integrated with and run alongside scientific (biomedical) models of health. Also, the noted decline in the established church and the prominence of science and biomedicine do not mean that people are less spiritual. Kuhling has suggested that (in a post-Celtic Tiger Ireland) we are experiencing a 'New Age re-enchantment' (Cosgrove *et al.*, 2011: 201-220). However, the evidence presented here would question whether disenchantment actually occurred at all! Important historical work also supports this position. Kassel for example argues that modernity has never really been without magical sentiment (Kassel 2005a, 2005b, 2006)²². This discussion therefore does not support the view that supernatural (magical) or spiritual belief *per se* has waned. Rather Weber, Thomas and others have signally failed to foresee and/or appreciate the enduring presence of superstition that directly or subliminally affects our lives (even those who claim not to be superstitious). In both Ballymacross and Hunterstown people straddled folk healing and biomedicine with relative ease. This does not represent a paradigm shift or an axial moment (Lambert 1999). Rather, it suggests that, in times of personal or family crisis, people pragmatically move *between* magical and scientific worlds.

The role and significance of folk healing also invites discussion on the formations in new religious and/or spiritual movements (Wilson and Cresswell 1999, Cosgrove *et al.* 2011). Folk healing is likely the source of, and basis for a revitalised move towards broader more pluralist beliefs and practices in the West. Witness the rise of new religious or quasi-religious expressions such as the New Age Movement. Cures and charms are common knowledge. These belief systems and practices have survived the rise of formal religion, science and secularism. Belief and trust in scientific regimes, including biomedicine, are today challenged. The process may be likened to a process of secularisation.

Conclusion

In Northern Ireland old religious affiliations have stubbornly been aligned with identity and nationhood and these remain important sources of local level conflict. However, the role of established religion, in particular the Catholic Church, appears to be undergoing major

²¹ See also, "The Role of Complementary and Alternative Medicine in the National Health Service: An investigation into the Potential Contribution of Mainstream Complimentary Therapies to Health care in the UK" (The Smallwood Report 2010). Informal, alternative and complementary medicine (CAM) are now becoming commercially exploited in the USA (McQuaide 2005) Britain and Ireland (Cant and Sharma 2000). See also Collyer (2007).

²² Elizabethan England was marked not only by the development of rationality and science, but also by continued reference to superstition and magic (Kassel 2005b) even in the developing urban centres, where you might least expect to find superstitious beliefs.

change in Ireland, North and South. The Church has lost ground in the wake of a series of scandals, beginning literally with the Bishop Casey²³ affair, including numerous sexual abuse cases and more recently with the case of the Magdalene laundries (Smith 2007)²⁴. The crisis in the established church may be mirrored by a looming crisis, as biomedicine appears to move away from the basic principles of *Primum non nocere* ('first, do no harm'). The iatrogenic consequences of biomedicine are well known. We may include more recent cases of blood contamination, unnecessary surgery and murder, as well as the unashamed rise of the commercially exploited aspects of medicine, such as body enhancement²⁵. If biomedicine continues on this course and with its position of public disavowal, but private acceptance of alternative health practices, including folk healing, we may expect further loss of public confidence in, and alienation from biomedicine. Finally, globalisation and the availability and affordability of travel are significant modern events. Many Western nations have witnessed recent high levels of inward migration. This brings with it multiple and complex (cross-cultural) beliefs systems to the door of the Western physician. The challenge for biomedicine and government is to understand and accommodate these.

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²³ In 1992 Bishop Casey was exposed as having a mistress and child with an American divorcee.

²⁴ The Good Shepherd Sisters ran a laundry and home in Belfast from the late 19th century right up until 1977 and 1990 respectively. Thousands of girls and women passed through its doors. The same order of nuns ran two other laundries, one in Newry that operated into the 1980s, and another in (London)Derry. Smith (2007) highlight's the complicity of the state in what he describes as, "the Nation's architecture of containment (for fallen women), a place where women and children were effectively imprisoned". Another Magdalene Asylum, including steam laundry, was operated by the Church of Ireland in Belfast up to the 1960s.

²⁵ The cases of Dr Neary (Ireland) and Shipman (UK) are also illustrative of this. The winner in 2013 of TV show, *The Apprentice*, Dr Leah Totton from Northern Ireland, plans to market her skills as a physician opening clinics that offer body enhancement procedures (<http://www.independent.co.uk/arts-entertainment/tv/news/surgeons-put-knife-into-the-apprentice-winner-leah-tottons-plan-for-chain-of-botox-clinics-8718124.html>) Retrieved 1/15/14.

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