



RELIGIOUS & CULTURAL COMPETENCE in Israeli Health Care

Final Report

The Tanenbaum Center for Interreligious Understanding, as part of a collaboration with the Three Faiths Forum Middle East, has completed an assessment of religio-cultural competence within Israeli health care. Tanenbaum is a secular, non-sectarian non-profit organization based in New York City that promotes mutual respect with practical programs that bridge religious difference and combat prejudice in schools, workplaces, health care settings and areas of armed conflict. Tanenbaum designs trainings and educational resources to change the way people treat one another and to celebrate diversity.

Tanenbaum's *Health Care* program addresses the reality that religion impacts the treatment and decision-making of patients in several key areas of health care such as modesty, informed consent, organ donation, and end of life decision-making and rituals – but health care providers often fail to effectively address religion with patients because they lack the time, training, and/or communication skills to respectfully inquire. Failing to recognize and address a patient's religious needs can erode trust, hamper communication, and ultimately marginalize certain cultural and religious groups, leading to health disparities and substandard care. Tanenbaum trains health care providers in core practices and critical communication skills so that they are prepared to respectfully inquire about patients' religious beliefs, respond accordingly, and anticipate potential areas of conflict. We call this combination of skill sets religio-cultural competence.

Tanenbaum has partnered with the Three Faiths Forum Middle East (3FFME) to examine religious diversity in patient care at hospitals in Israel and to foster effective communication skills in medicine. 3FFME is addressing these objectives by conducting Scriptural Reasoning workshops with medical and nursing students in five hospitals in Israel (these workshops will be discussed in more detail later in the report). Tanenbaum is complementing 3FFME's work through the following needs assessment report. The second year of the project will involve a training to be developed and delivered by Tanenbaum based on the findings of the needs assessment.

Through research and confidential, personal interviews with individuals working in the Israeli health care industry, we examined what infrastructure is already in place to provide culturally competent care to the nation's religiously diverse population; what challenges exist to the provision of religio-culturally competent care; and what recommendations and resources Tanenbaum can offer to enhance the quality of care for the culturally and religiously diverse patient populations of Israel.

The Need

Israeli Religious and Cultural Demographics

The first finding to discuss is the *need* for the provision of religio-culturally competent health care in Israel. Israel is a nation with tremendous religious diversity. Currently, 75.7% of the country is Jewish and 18.6% of

the population is Muslim. The majority of Muslims in Israel are Sunni; a much smaller number are Shi'ite.¹ Smaller percentages of Israel's population are unaffiliated (3.1%), Christian (2%), Buddhist (1%), Hindu (1%), practice a folk religion (1%) or belong to another religion (1%).² Moreover, the country's Jewish majority is far from monolithic. Within that majority, 43.4% of Jews identify as not religious or secular, 38.1% identify as traditional, 9.6% identify as religious, and 8.8% identify as Ultra-Orthodox (also known as Haredi).³ Furthermore, religion is an important force in the lives of many Israelis. A 2012 study commissioned by the AVI CHAI Foundation and released by the Guttman Center at the Israel Democracy Institute reported that 80% of Jews living in Israel say that they believe in God—higher than the percentages of Israeli Jews who said they believed in God when similar studies were conducted in 1991 and 1999. The same study found that 72% of Israeli Jews think that prayer can help a person's situation, and that 76% of Israeli Jews keep kosher.⁴ This shows that a high percentage of Israeli Jews are observant in both their beliefs and practices, and that this level of observance might be relevant in a health care setting in ways ranging from individuals praying when sick to requesting kosher meals when in the hospital.

Religious diversity between and within faith traditions can lead to a variety of challenges.⁵ There have been many well-publicized political and social disputes in recent years between Jews, Muslims, and members of minority religious traditions. Most recently, the summer of 2014 saw rocket launches taking place in Gaza between the Israel Defence Forces and Hamas and other militant groups.⁶ In addition, conflicts and disagreements also emerge within religious traditions. While many secular and Haredi Jews are respectful towards one another, some are not; some secular Jews, for example, may fail to respect Haredi Jews' strict observance of the Sabbath, while some Haredi Jews may believe that secular Jews who do not observe the Sabbath are failing to comply with their religious obligations. In another example, increasing tensions between secular and Haredi Jews were recently highlighted in a debate as to whether Haredi Jewish men should be required to serve in the military.⁷

Israel also has a great deal of cultural and ethnic diversity, influenced in large part by immigration. Thirty-three percent of the nation's residents are immigrants who have come from countries in Europe, Africa, the Middle East, and North America: the countries that have contributed the largest numbers of immigrants to Israel are Russia, Morocco, Romania, the Ukraine, Poland, Iraq, the United States, and Ethiopia.⁸

Religious and ethnic tensions in Israel occur in a broader context. It would follow that these tensions would also seep into a health care setting and influence interactions between health care providers and patients, between health care providers and their colleagues, and among the patient population. For example, one of our interviewees spoke about overhearing Jewish patients comment that Muslim patients "cut in line" to get their ultrasounds before the Jewish patients did. Another interviewee shared that sometimes Jewish patients refuse to be seen by Arab (Muslim or Christian) physicians. A third interviewee shared that sometimes Jewish patients do not want to share a room with Arab patients, or vice versa. That interviewee also shared that

¹ Israeli Ministry of Tourism (2011). *Muslim Community*. Retrieved from

http://www.goisrael.com/Tourism_Eng/Tourist%20Information/Ethnic%20Groups/Pages/Muslim%20Community.aspx.

² Pew Research Center. (2010). Population All Israel. *Pew-Templeton Global Religious Futures Project*. Retrieved from

http://www.globalreligiousfutures.org/explorer/custom/#/?subtopic=15&chartType=pie&data_type=percentage&year=2010&religious_affiliation=all&countries=Israel&destination=to&age_group=all

³ Central Bureau of Statistics (2012). Persons Aged Over 20 by Religiosity and by Selected Characteristics. *Statistical Abstract of Israel-2012*. Retrieved from http://www.cbs.gov.il/reader/shnaton/templ_shnaton_e.html?num_tab=st07_06x&CYear=2012

⁴ Fleisher, M. (2012, January 30). Survey: Big Upswing in Religiosity in Israel. *The Jewish Press*. <http://www.jewishpress.com/news/survey-big-upswing-in-religiosity-in-israel/2012/01/30/>

⁵ Heller, A. & Sharf, I. (2014, May 5). Ultra-Orthodox Jews Gradually Enlist In Israeli Military As Haredim Recruitment Increases. *The Huffington Post*. Retrieved from http://www.huffingtonpost.com/2014/05/05/ultra-orthodox-jews-israel_n_5268526.html

⁶ Reuters. (2014, September 3). Israel shows evidence of rocket fire from Gaza schools. Retrieved from

<http://www.reuters.com/article/2014/09/03/us-mideast-gaza-toll-idUSKBN0GY1DS20140903>.

⁷ BBC News: *Middle East*. (2014, March 12). Israel ends ultra-Orthodox military service exemptions. Retrieved from <http://www.bbc.com/news/world-middle-east-26542316>

⁸ Pew Research Center. (2010). Top countries of origin for immigrants to Israel. *Pew-Templeton Global Religious Futures Project*.

http://www.globalreligiousfutures.org/explorer/custom/#/?subtopic=22&chartType=bar&data_type=percentage&year=2010&religious_affiliation=28&countries=Israel&destination=to

she knows an Israeli Arab nurse who is often reluctant to treat non-Israeli Arab patients. This nurse believed that he was caught between the two sides of the Israeli-Palestinian conflict, and that non-Israeli Arabs were negatively impacting his ability to live as an Israeli Arab. This tension made him feel such hostility towards Arab patients that he preferred not to treat them.

The blog run by the Jerusalem Inter-Cultural Center (JICC)⁹ further chronicles the conflicts that find their way into health care provider and patient relationships. For example, the staff at a hospital in Jerusalem, seeing a rapid growth of the Haredi population in the neighborhood, expressed fear that Haredi patients were “forcing their beliefs and belief systems on everything around them.” On the other hand, health care workers felt pressured to bring patients into their clinic as their performance is measured, in part, on the economic efficacy of the clinic. JICC commented in their blog that staff seemed to feel that the struggle taking place in their community and hospital was a reflection of “the great struggle for control in Jerusalem between Haredi and non-Haredi Jews.”¹⁰

There can be additional cultural or ethnic tensions in the provision of patient care. A 2012 article chronicled several instances of Israeli hospitals refusing to treat African patients, ostensibly because of their lack of insurance.¹¹ Some of the instances mentioned within the article include:

- An Eritrean woman suffering from severe stomach pains was turned away from the hospital because she did not have insurance.
- A Tel Aviv hospital stated they would limit admissions and ban visits by African asylum seekers “out of concern for the spread of infectious diseases to other patients.”
- The same hospital stated that they would separate African and Israeli women in the maternity ward even if the former had been found to be free of infectious diseases. African and Israeli babies were also to be separated. The Israeli Ministry of Health denounced the move.
- In early 2011 a physician in Eilat refused to care for a pregnant African woman, telling her that he did not tend to Sudanese patients.
- In late 2010, an Eritrean man who had been attacked on the street by an Israeli man in Ashkelon was turned away from a local hospital even though he was bleeding.

The Impact of Identity on Interactions with Others

Israeli doctors and nurses seem aware of the ways in which religion may impact health care and the decisions that patients make. From our interviews, health care providers shared that they are used to patients asking for kosher or halal meals, requesting to speak with a health care provider of the same sex because of religious concerns about modesty, or consulting with a religious leader before making a health care decision. Israeli health care providers seemed more familiar with the intersections of religion and health care than our experience with providers in the United States. This may be because there is a high rate of religiosity among Israeli Jews, as discussed above. In addition, Judaism and Islam are both highly practice-based religions with practices that often come up in a health care setting; hospitals and physicians may

⁹ The Jerusalem Intercultural Center Blog. (2014, June 17). New in Healthcare Cultural Competency Services – Consultation on Issues Pertaining to Jewish Law. [Web Log Post]. Retrieved from <http://jicc.org.il/category/blog/>

¹⁰ The Jerusalem Center Intercultural Center Blog (2013, July 13). Cultural Competency in the Health Care System – for the Haredi sector. [Web Log Post]. Retrieved from <http://jer-icc.org/blog/?cat=9%20%20Outlines%20tensions%20between%20increasing%20Haredi%20population%20in%20formally%20non-Haredi%20areas%20of%20Jerusalem>

¹¹ Guarnieri, M. (2012, July 30). Israeli hospitals refusing to treat African patients. *+972 Magazine*. Retrieved from <http://972mag.com/israeli-hospitals-refusing-to-treat-african-patients/52120/>

therefore be used to identifying and accommodating health care needs related to the religious beliefs and practices of their patient population.

Although health care providers frequently see requests for religious accommodations based on religion, we at Tanenbaum speculate that these providers (like providers in other settings, including the United States) may not recognize how their own identities, whether they be racial, ethnic, or religious, impact their interactions with patients. For example, one interviewee shared with us that she feared her “secular” hospital was becoming too accommodating of religious practices, and was losing its secular identity. The same physician stated that many of her female Bedouin patients preferred to have their husbands make reproductive health decisions on their behalf. She explained that, as a younger woman, she was upset by this practice and would try to convince her patients to make their own health care decisions. However, as an older woman she gradually came to the conclusion that, for some families, communicating with the husband was the most effective way of communicating with the patient herself. In both of these instances, the physician’s own lens (cultural/religious/social perspective) influenced both how she thought about her hospital as a health care institution and how she interacted with patients.

A health care provider’s lens can influence clinical encounters related to diagnosis and treatment. A psychiatrist told us that treating patients from other cultures and religions can be complex because one cannot always be sure whether certain behaviors (for example, a woman in her thirties living with her father) are normative within the patient’s cultural and religious framework. Another interviewee shared that because she is an Orthodox Jew she understands some patients’ requests to wash their hands before engaging in religious rituals, and helps accommodate these requests, in a way that some of her colleagues of different religious background do not.

A third interviewee shared an example of how doctors may make assumptions about their patients’ medical choices based on their religious beliefs. Some doctors who primarily treat Haredi women may assume that none of their female Haredi patients will want to know about birth control options. (While many Haredi women may feel comfortable using various forms of contraception, others may want to, or feel obligated to, consult a rabbinical authority to receive permission before using birth control for any reason. In addition, fertility has taken on a political context in Israel, with Haredi women often being encouraged to have more children than secular Israeli or Arab women.¹²) In these encounters, the physicians’ perceptions and understandings of Haredi women influence the health care options they offer their patients.

In addition, health care providers may not be aware of how their identities impact how they perceive and interact with colleagues. While some interviewees described the work environment as very inclusive and accommodating of religious differences, other interviewees have had the opposite experience. One interviewee shared that social and political tensions can seep into interactions between hospital staff members, and that hospitals are rarely willing to acknowledge that tensions between Jewish and Muslim staff members do in fact exist. Another interviewee shared that tensions exist within the hospital based on ethnic (rather than religious) lines, and that these tensions are exacerbated when a broader social or political crisis occurs in Israel. She mentioned, for example, that she has heard Jewish employees have disagreements with Arab employees, and then mutter “Arab!” under their breath as they walk away.

Israeli health care providers seem to recognize that religion is salient to their patients and impacts the decisions their patients make. However, they may not be as conscious of how their own backgrounds and identities involving religion can influence how they view and interact with their patients and colleagues. Furthermore, the religious identity of the hospital itself—whether it is secular, Jewish, or affiliated with another religious tradition—may influence how the patient population is treated and what kind of religious

¹² Meacham, T. (2009, March 1). Contraception. *Jewish Women: A Comprehensive Historical Encyclopedia*. Retrieved from <http://jwa.org/encyclopedia/article/contraception>

accommodations the hospital is willing to make. The hospital's identity may even impact which patients go there—several health care providers told us that patients often self-segregate based on religion, with Arab Muslim patients going to hospitals known for treating Arab Muslim patients, Haredi Jewish patients going to hospitals known for treating Haredi Jewish patients, and secular Jewish patients going to hospitals known for treating secular Jewish patients. One individual we interviewed mentioned that some doctors, particularly those at hospitals that generally treat Haredi patients, have relationships with rabbis wherein the rabbi will advise and encourage his congregants to see that particular physician. The physician, not wanting to lose the rabbi's endorsement, may feel pressured not to contradict the rabbi's teachings on health care and may not, for example, provide women with birth control. In instances like this, the identities of the patients, providers, faith community leaders, and health care institutions all play a role in the health care the patient ultimately receives.

This highlights an important tension regarding the provision of culturally competent health care in Israel. Some hospitals in Israel have primarily secular identities, and some have primarily religious identities – Jewish, Christian or Muslim. While there is not a standard definition for what constitutes a secular versus religious hospital, these identities can be based on the hospital's history (who founded the hospital and for what purpose), their leadership, or the religious demographics of their patient populations. A concern among some health care practitioners is that if Jewish patients attend hospitals that identify as secular and request religious accommodations, like food that meets their particular definition of kosher, to what extent can the hospital accommodate these requests without losing its identity as a secular institution? Several of our interviewees spoke about this issue, and one interviewee spoke directly about her concern that accommodating all patients' religious beliefs would have the effect of transforming hospitals into synagogues. When addressing religio-cultural competence in Israeli health care, one must address the need to train providers on how their religious, cultural and social identities (and those of their institutions) impact patient care in addition to educating them on where religion may become relevant for patients.

A Gap in Training and Education

When asked, the majority of our interviewees shared with us that their hospitals do not provide extensive training in religio-cultural competence, but felt that they and their colleagues would benefit from such trainings. Many interviewees shared that linguistic competence is progressing more quickly than other areas of cultural competence. In fact, one of the health care providers we interviewed stated that at his hospital, people often think that offering language-appropriate signage and other translation services is all that is necessary to be culturally competent. He thought, however, that his hospital needed to do more around cultural competence because linguistic competence is only one aspect of cultural competence overall. One interviewee lamented that while there are cross-cultural training models that exist, none of them are specific to Israel's unique cultural and religious context. While some hospitals have begun to institute cultural competence trainings (which will be described in more detail below), these trainings seem to be at their beginning stages. The lack of existing trainings around religious and cultural competence, and the fact that providers think such trainings would be useful, points to the need to address this topic in greater detail.

Institutional Policies and Strategies

Our interviews also identified a lack of institutionalized strategies and tools that could assist health care providers in more effectively and consistently addressing the topic of religion and culture with their patients. For example, many of the health care providers we spoke with shared that their hospitals do not ask patients about their religious affiliation anywhere on the hospital admission form. Instead, providers believe that their patients will let them know if they have religious concerns, or think they can intuit a patient's religious concerns based on how the patient is dressed or what the patient's name is. We have heard similar sentiments from medical practitioners in the United States as well. At Tanenbaum, we recommend

that providers go beyond the initial question about religion commonly found on an admission form and ask patients in a proactive and ongoing way about their religious concerns as it relates to their care. None of the providers who we spoke with take spiritual histories (that is, ask patients if they have any religious beliefs or practices that will become relevant during their medical care) and, as a result, patients may be reluctant to bring up religious concerns to their doctors. It is therefore important for doctors to actively ask about religious concerns, and for such questions to be a matter of institutional policy, in order to provide patients with religio-culturally competent care.

Furthermore—as will be discussed in more detail below—hospitals seem to be without formal institutional policies (or at least no employee we spoke to was aware of these policies if they do in fact exist) to accommodate employees' religious needs, such as requests for days off around religious holidays, or requests for religiously motivated attire. Many interviewees shared that these requests are accommodated, but in very informal ways. One interviewee, however, shared that she had trouble taking off religious holidays, and believed that this was a problem shared by other employees. While it may be true that many employees' religious needs are generally accommodated without formal policies, it is clear that some employees have experiences of non-accommodation. It is therefore a better practice to have policies in place, and to clearly communicate those policies, in order to help make employees feel more comfortable requesting accommodations and to prevent conflicts from arising in the future.

In conclusion, several factors point to the need for Israeli health care providers to be religio-culturally competent: Israel's religious diversity, religion's influence on interactions between people in Israel, religion's salience as an identity within the health care setting, and the fact that providers do not often implement strategies, such as taking spiritual histories, for addressing the topic of religion with patients.

Current Policies and Practices

Government Policies and Practices

Fortunately, Israel is already addressing cultural competence in a variety of ways. First, the Israeli Ministry of Health issued a Directive on Cultural Competency in February 2011. This directive “delineates national principles and standards for cultural accessibility in health care organizations and institutions.”¹³ Among these principles are requirements that all forms that require a patient's signature, hospital signs, and call centers be written in Hebrew, English, and Arabic; depending on the population of a specific hospital, hospitals may also be required to offer these forms in additional commonly spoken languages, like Russian. The Directive also requires that interpretation services be offered (by an employed interpreter, bilingual staff member, or telephone service) to any patient that requests it.

The Directive additionally mandates that health care institutions train at least one member of the management staff as a “cultural competence coordinator,” in addition to their other responsibilities, and recommends that all health service staff members participate in cultural competence courses.¹⁴ Hospitals and other health care institutions are clearly making strides in implementing the requirements of this Directive; every provider we interviewed mentioned that their hospital now had a cultural competence coordinator (sometimes this role was filled by the person we were interviewing), and some of our interviewees also spoke about other cultural competence initiatives their institutions were undertaking—for example, translating signage into other languages or creating videos showing role plays of doctor-patient interactions as an educational tool.

¹³ The Jerusalem Foundation. (2012, March). Cultural Competence in the Health Care System in Jerusalem: Report on 2011 Activity. *Coexistence: The Jerusalem Foundation*. <http://www.jerusalemfoundation.org/media/30967/Cultural-Competency-2011-Detailed-Report.pdf>

¹⁴ The Jerusalem Foundation. (2012, March). Cultural Competence in the Health Care System in Jerusalem: Report on 2011 Activity. *Coexistence: The Jerusalem Foundation*. Retrieved from <http://www.jerusalemfoundation.org/media/30967/Cultural-Competency-2011-Detailed-Report.pdf>

Additional Programs and Resources

Another resource in place for addressing culturally competent health care is the Jerusalem Inter-Cultural Center (JICC). JICC was founded in 1999 “with the aim to assist the city’s residents, from diverse identities, in becoming responsible, active partners in shaping the development of their communities and Jerusalem’s future.”¹⁵ JICC works in a variety of ways to assist professionals, activists and organizations in promoting community dialogue in Jerusalem—and one of these ways is promoting information and strategies to encourage and facilitate culturally competent health care. During our interview process, we spoke with a JICC staff member who shared that the organization’s work in the field of health care generally falls into three categories: offering institutions qualified interpretation services; providing cultural competence training for staff; and working directly and regularly with cultural competence coordinators (through, for example, a monthly meeting) to see what changes need to be made on an institutional level.

In addition to the work done by the JICC, there is a specific program run by Clalit Health Services (one of Israel’s major health insurance companies) and the Joint Distribution Committee (a Jewish humanitarian assistance organization) aimed at promoting health among Ethiopian immigrants in the primary care setting that offers an interesting model for cross-cultural care. This program, called Refuah Shlemah (which can be translated to mean “get well soon” or “full recovery,” and also refers to a Jewish prayer that is said for a loved one who is ill), was started in 1984. The purpose of the program is to improve care for the large Ethiopian immigrant population in Israel (nearly 80,000 Ethiopians have immigrated to Israel since Refuah Shlemah was started). This program was needed because cultural and language barriers made it difficult for Ethiopian immigrants to navigate the primary health care system and other health services, and for doctors to appropriately diagnose and treat this population. As a result, Ethiopian immigrants have experienced health disparities that Refuah Shlemah aimed to close.

The objectives of Refuah Shlemah were to significantly improve the services that are given in the primary care setting by making them culturally appropriate; to have Ethiopian members participate more fully with self-care and follow-up; and to prevent detrimental changes in lifestyle through health education and promotion. The program has aimed to accomplish these goals by employing Ethiopian immigrants to work as health liaisons and inter-cultural mediators between patients and families; training clinical staff in cultural competence specific to the needs of Ethiopian patients; and implementing health education activities for new immigrants. So far, Refuah Shlemah has had successes, including a decline in the rate of hospital admissions among patients with asthma and an improvement in maintaining weight and engaging in physical exercise among patients with diabetes.¹⁶¹⁷ This program, like the other initiatives detailed above, represents the positive steps being taken to make Israeli health care more culturally competent.

Another program that can be accessed by Israeli hospitals working towards culturally competent health care is the Three Faith Forum Middle East’s Scriptural Reasoning program. This program is based on the idea that Jews, Christians and Muslims interact in Israel but rarely have the opportunity to learn more about each other’s cultures. 3FFME uses a method called Scriptural Reasoning that was developed by the University of Cambridge. In workshops, participants of different faiths and cultural backgrounds read from the Quran, New Testament and Tanakh and use these texts to prompt discussions. 3FFME is currently working in five hospitals in Israel, using the Scriptural Reasoning method to help participants improve their interactions with

¹⁵ The Jerusalem Intercultural Center. About the JICC. *JICC.org.il*. Retrieved from <http://jicc.org.il/about-the-jicc/>

¹⁶ Levin-Zamir, D. (2007, December 20). “Refuah Shlema” – Cultural Liasons in Primary Care Lessons Learned from 10 Years of Implementation. *New York/Jerusalem Dialogue Project Series of Webinars Exploring Cultural Competency: Health Care Meeting the Challenges of Diverse Societies*. <http://cc.nyjerusalem dialogue.org/>

¹⁷ N. Nirel, S. Ismail, M. Taragin. (2002). The Effect of the “Refuah Shlema” Intervention Program for Ethiopian Immigrants on the Care and Health Status of Patients with Asthma and Diabetes. *Myers-JDC-Brookdale Applied Research for Social Change*. Retrieved from <http://brookdale.jdc.org.il/?CategoryID=192&ArticleID=170>

their diverse colleagues. In three of the five hospitals, the workshops are compulsory based on the Israeli Ministry of Health's Cultural Competence Directive.¹⁸

Institutional Policies and Practices

In addition to the above legal requirements, resources, and programs, many hospitals and medical schools are engaging in their own cultural competence work in a variety of ways. One individual whose hospital is also affiliated with a medical school shared that the school offers courses on cross-cultural competence, focusing on religion as well as culture more broadly. She also shared that the Ben-Gurion School of Medicine offers courses on communication and decision-making that touch on culture. Another doctor from the Nazareth Hospital shared that he is working with the Ministry of Health on creating videos that show doctor-patient interactions. These videos will primarily show doctors communicating with patients around the provision of clinical medical information, but will also include some interactions that provide examples of how to communicate with patients when the primary concern during the encounter is related to culture. This doctor also shared that he teaches cross-cultural medicine at the university associated with his hospital. Other hospitals' specific work around cultural competence includes:

- Bikur Holim Hospital has a medical translation course for 33 staff including translation into Yiddish, held three basic training workshops for 80 staff members, and receives 30 formal requests for translation per month.
- In 2011 and 2012 the Jerusalem Center for Mental Health created multi-level activities related to mental health and cultural competence.
- Hadassah – Mount Scopus offered six basic cultural competence workshops for 115 medical staff members. In addition, the patients' information booklet and other forms were translated into Arabic (half of the 28,000 people admitted to Hadassah Mount Scopus each year are Arab (or speak Arabic); 60-70 people requested the translation service each month).
- Alyn Hospital had 25 new staff members undergo basic cultural competence training, and is continuing to work on adapting the physical facility, including signage and forms.
- Clalit Health Services offered basic cultural competence training courses to staff at the Neve Ya'akov clinic, and also offered a follow-up session for 25 senior staff members at primary care clinics in the Jerusalem region.¹⁹

Challenges and Better Practices in Patient Care

Tanenbaum developed a tool called the *15 Trigger Topics*—15 areas we have identified where religion and health care often intersect (see appendix). We take this approach because we find that conducting trainings on what specific religious traditions believe and how they practice can lead to stereotyping as it ignores the diversity of individual belief and practice within faith traditions. Focusing on these overarching triggers is a more effective framework for health care providers to think about religion and health care as it assists health care providers in identifying and addressing challenges they encounter thematically across a variety of faith traditions. During our interviews we asked about these *Trigger Topics*, and also used them as a framework for our research. The anecdotal data shows both the conflicts that can emerge between religion and health care in Israel, and offer some better practices that exist for resolving these conflicts.

¹⁸ Three Faiths Forum. 3FF Middle East. Retrieved from <http://www.3ff.org.uk/programmes/middle-east.php>.

¹⁹ The Jerusalem Foundation. (2012, March). Cultural Competence in the Health Care System in Jerusalem: Report on 2011 Activity. *Coexistence: The Jerusalem Foundation*. <http://www.jerusalemfoundation.org/media/30967/Cultural-Competency-2011-Detailed-Report.pdf>

Dietary Requirements: Some patients have religiously motivated food restrictions which can impact meals during their hospital stays. In Israel, the idea of accommodating religious dietary requirements (kosher and halal meals for example) seems a matter of course. All of the health care providers we spoke with shared that their hospitals provide kosher meals—although they noted that patients practice kosher in a wide range of ways. Therefore, some patients will still bring in kosher food from outside the hospital because they observe the laws of kosher more strictly than the hospital. In addition, some Muslim patients inadvertently cause offense by bringing food that is not kosher into the hospital, especially during Passover, where additional dietary restrictions are in place. In this example, hospitals would need to balance the needs of both Jewish and Muslim (or other non-Jewish) patients. The hospital should educate all patients on what food can and cannot be allowed in the hospital throughout the year. The hospital should also work with all patients to ensure that they feel welcome within the hospital and can meet their own dietary requirements.

Informed Consent: The principle of autonomy—that is, patients making independent decisions based on their values and priorities — is increasingly prioritized within the global medical community. However, this principle does not carry the same weight in every culture and some religions and cultures, broadly defined, place a greater emphasis on making decisions as a family unit or with input from a religious leader. For example, some patients may want a family member or religious leader to make decisions on their behalf without even knowing their own diagnoses. An interviewee we spoke with stressed that her hospital works hard to empower patients to make their own decisions, which can conflict with patients' desires to have their rabbi or imam make their medical decisions. There are also instances where a husband, for personal or cultural reasons, makes medical decisions on his wife's behalf. Examples shared during our interviews include a husband requesting that hospital staff not disclose to his wife their baby has a serious illness, or a husband preventing his wife from obtaining a life-saving mastectomy. In these instances, one interviewee shared that the hospital tries to negotiate these issues and find a compromise based on the hospital, patient, and spouse/family member's concerns and motivations. Another interviewee shared that they generally respect family members' desires to not disclose a particular diagnosis to the patient, especially if this decision will not change the treatment plan and if the patient is not asking detailed questions. In situations such as these, Tanenbaum asserts that training staff in proactively incorporating family members or faith leaders into the conversation and decision-making process is key.

Conscience: Conscientious objections can impact health care providers' interactions with patients—for example, if a patient wishes to have life support withdrawn and a doctor has a religious and/or ethical belief in doing everything possible to sustain that patient's life. As described earlier in this report, one interviewee shared that when she was younger she believed strongly in always fully disclosing to her female patients all the details involved with their condition and care—and that as she grew older she became more flexible and understanding about the cultural norms that entail communicating with the husband as a way to work with the wife. She added that it would be helpful to implement trainings or other initiatives to help younger doctors cultivate this flexibility and understanding. Both of these examples demonstrate the value of providing trainings that build health care providers' awareness of how their own social and personal identities influence their interactions with patients. These trainings are one possible strategy for managing situations where the religious or moral conscience of the provider or institution (in terms of policy and practices) clash with that of the patient and/or family. In cases such as these, the challenge is finding a balance between respecting and accommodating the health care provider's religious beliefs without impacting the patient's access to care, quality of care, or compromising the patient's autonomy. Hospitals should strive to accommodate providers' religious beliefs and practices while recognizing that there are other concerns in a hospital setting besides such accommodations.

Pregnancy & Birth: One interviewee shared that some of her patients are reluctant to accept C-Sections because they fear this will compromise their ability to have additional children, prompting their husbands to take other wives. In these instances there is an opportunity for providers to recognize that the patient's priorities and primary concerns may be very different from the concerns of the health care provider. Health care providers may recommend a C-Section because it is medically preferred, and not understand that a patient could prefer a riskier option in order to avoid a detrimental effect on her family relationships after the birth of the child. In these instances, it becomes critical for providers to have the skills necessary to speak with patients such that at the end of a conversation (or series of conversations) the patient understands the medical risks and the provider understands the nature of the patient's concerns in order to provide the appropriate and preferred care.

End of Life: In Jewish law, there is a prohibition on ending a life which can be interpreted as a prohibition against removing or turning off artificial means of keeping a patient alive. This can lead to a number of issues. For example, a patient may have end of life preferences that conflict with a health care provider's religious values. There may also be instances in which a patient and/or family wants to continue care and the hospital feels that this is an inappropriate use of medical resources. In instances where a conflict emerges between patient/family and provider, a conversation with all relevant parties can be helpful to fully understand underlying fears/concerns on all sides and then work through possible solutions. Chaplains can often be valuable resources during end-of-life conversations, or in facilitating conversations between a patient's rabbi or other religious leader and the patient's health care provider. (However, as this report will discuss later, there is a need for Israel to develop a more robust chaplaincy presence than is currently in place). These conflicts also speak to the importance of asking patients about their religious beliefs and practices at the start of the patient's care: if a conflict between the patient/family and doctor/hospital exists, it is better to identify that conflict as soon as possible so that a solution can be established before a crisis emerges.

Although appropriate and respectful communication is always important between doctor and patient, Israeli law does recognize one innovative way to manage end of life conflicts. Some Jewish patients and family members interpret Jewish law as prohibiting withholding life-saving measures, but believe that it may be acceptable to deny the administration of life support measures that merely prolong imminent death²⁰. With this dynamic in mind, in 2005, the Knesset passed a bill allowing for "passive euthanasia"—that is, artificial means of keeping a patient alive will be put on a 24-hour clock. At the end of each 24-hour period, patients and families can either request and receive an extension—or not. If they don't, the life support will be halted without requiring a physician to violate Jewish law by actively turning off life support.²¹

Health care institutions may face additional obstacles around end of life rituals. One interviewee shared that she once worked with an Arab patient who was dying, and her entire extended family and community came to the hospital to mourn her. There were over 100 people in the halls of the hospital, and some hospital employees expressed concerns over their ability to work effectively given that environment. The hospital was concerned, however, that asking Arab families to decrease their number of visitors will be perceived as discrimination since Jewish patients usually bring smaller number of guests into the hospital, and would therefore not require the same request. In instances like these, it is important to make sure that the patients' needs and preferences are accommodated when possible, without impeding the hospital staff's ability to do their jobs. If a patient's religious practice is clearly infringing on staff's ability to do their job, then it might be appropriate to ask the patient to refrain from that practice. This request should be carefully communicated to make it clear that it is based on the hospital's operating needs and not on any prejudice towards a religious population or towards the practice itself. Hospital staff should also be willing to work with the patient and

²⁰ Isserles, Rabbi Moses. Shulchan Aruch YD 339:1

²¹ Siegel-Itzkovich, J. (2005, June 12). Knesset Passes Euthanasia Bill. *The Jerusalem Post*. <http://www.jpost.com/Health-and-Sci-Tech/Health/Knesset-passes-euthanasia-bill>

family to find a compromise that meets some of the patients' religious needs while allowing hospital staff to do their work effectively.

Organ Donation: Until very recently, Israel has ranked at the bottom of Western countries in terms of rates of organ donation. This has largely been due to Jewish law prohibiting the desecration of the dead, which some people interpret as a prohibition on organ donation. In addition, many Orthodox and Haredi Jews will not accept brain death as death, which presents additional problems in organ donation. As a result, there has been a disconnect between many members of the health care community and members of the Orthodox Jewish community around organ donation. This disconnect has created a great deal of public distrust on the issue of organ donation; one family even tried to steal their loved one's body from a hospital morgue because they feared that the hospital would perform a post-mortem against the family's wishes.²² The low rates of organ donation in Israel speak to a challenge between individuals' beliefs and practices and protecting the public good.

One effective way of addressing this conflict, and other public health issues, is to work with faith leaders and communities. The Halachic Organ Donor Society has had great success in increasing organ donation in Israel by engaging with rabbis to make the point that Jewish law is often interpreted to mean that saving a life is of the utmost importance and would supersede other religious requirements about the body staying intact after death. In addition, the Chief Rabbinate of Israel has accepted brain death as the moment of death.

That being said, however, individuals and communities may reject this opinion and consider the cessation of heartbeat and breathing, rather than the cessation of brain activity, to constitute death. In addition, diversity within religious traditions means that some Jews do not accept even cadaveric organ donation based on their belief against desecrating the body after death. While the Halachic Organ Donor Society and other efforts to increase organ donation have had successes, it is also important to keep in mind that this does not represent a uniform opinion among Israel's Jewish population as to the validity of brain death as the moment of death or the acceptability of organ donation involving either brain dead patients or cadavers.

There is currently an option that allows Israeli citizens to obtain an organ donor card saying that, in the case of brain death, they would like a rabbi to weigh in on whether organ donation would be acceptable. In 2012 the Knesset passed a law stating that if two patients have an identical medical need for an organ transplant, and one patient has a signed organ donor card, priority will be given to that patient. That law, in conjunction with the increased publicity and education campaign around organ donation conducted with faith community leaders, led to a 60% increase in organ transplants in 2012.²³

While much of the public debate around organ donation in Israel revolves around Jewish attitudes towards organ donation, it is important to keep in mind that people of other faiths may have religiously motivated objections to organ donation or feel a religiously motivated imperative to donate organs. In Islam, for example, the body after death is meant to have a special place of honor and should not be violated. As a result, there are two primary schools of thought around organ donation – one that says that saving a life takes priority over the personal costs imposed by organ donation, and one that says that saving a life is not an absolute obligation if it imposes significant costs. In general, the decision about whether to be an organ donor is considered a personal one based on the individual's interpretation of the costs associated with the donation. Muslims may be encouraged to consult a religious scholar when making this decision.²⁴

²² Berman, R. (2007, September). HODS on IBA News: Organ Donation and Jewish Law. *The Halachic Organ Donor Society*. Retrieved from http://www.hods.org/english/h-issues/YouTube_video%20pages/IBANews_4.asp

²³ Ofri, D. (2012, February 16). In Israel, a New Approach to Organ Donation. *The New York Times Well Blog*. Retrieved from <http://well.blogs.nytimes.com/2012/02/16/in-israel-a-new-approach-to-organ-donation/>

²⁴ National Health Institute. Islam and organ donation: A guide to organ donation and Muslim beliefs. Retrieved from http://www.organdonation.nhs.uk/how_to_become_a_donor/religious_perspectives/leaflets/islam_and_organ_donation.asp.

While the issue of organ donation, from a broader perspective, is largely a matter of public health, it also has implications for clinical encounters. Health care providers should be aware of the religious reasons why some patients may not want to donate an organ and approach this subject with respect and sensitivity in order to build trust. Health care providers should also be aware of the resources provided by the Halachic Organ Donor Society so they can provide informed recommendations or direct patients or families to these resources.²⁵

Challenges in the Healthcare Workplace

In addition to the intersections between religion and patient care outlined above, religious beliefs and practices can also impact interactions between colleagues and the relationship between employees and the health care institutions for which they work. Tanenbaum has another tool, the 10 Bias Danger Signs (see appendix), which outlines the areas where both overt and subtle experiences of bias based on religion or religious beliefs can come up for employees in the workplace. Several of the 10 Bias Danger Signs have shown up in Israeli health care institutions:

Attire: One interviewee shared that employees at the hospital where she works tend to dress fairly modestly although there was no specific policy (that she was aware of) to enforce this practice. She noted that hospital employees would be allowed to dress more modestly than the informal standard that had been set but not less. Many interviewees, when asked, shared that their hospitals did not have formal policies around attire, or were unaware of these policies if they existed. Dressing more or less modestly seemed to be based on what was common to wear in the hospital and what was generally perceived as professional. Some interviewees shared that religiously motivated attire, such as headscarves, is permissible as long as the attire is in colors that correspond to the colors that hospital staff must wear as part of their uniform. One interviewee also shared that in the operating room, there are occasionally conflicts around providers' religiously motivated clothing (long sleeves, for example) interfering with the hygiene standards that need to be upheld during surgery. Usually, there is a way to uphold the hygiene standard while making sure that the staff member feels respected—but there is no written policy around it. We recommend the adoption of policies making it clear that employees are allowed to wear religiously motivated attire in the workplace unless this attire poses a safety or hygiene risk. If it does, hospital management should work with the employee in question to see if a compromise is possible that allows the employee to adhere to his or her modesty standards while still satisfying the hospital's safety and hygiene requirements.

A separate but related issue involves employees' accommodation of the modesty requirements held by other employees or by patients. For example, one interviewee shared that a hospital had a swimming pool that was used by patients for physical therapy. Orthodox Jewish patients worked with the hospital to come up with a dress code for the physicians who worked there to dress in a way that respected the modesty requirements of the Orthodox community. Some of these attire changes were considered extreme by certain staff members, who complained that they were being forced to dress to accommodate a religious patient population even though they worked at a secular hospital. The dress code developed by the hospital was an important way to help Orthodox Jewish patients feel comfortable using the pool for physical therapy. Health care providers' adoption of attire that complies with patients' modesty requirements may help providers to demonstrate religio-culturally competent care. That being said, if hospital employees are uncomfortable with this change, then hospital management should be aware that this might impact productivity and morale, and should be willing to come up with a compromise. One such compromise might be setting aside certain hours where the pool would only be used by Orthodox Jewish patients and by providers willing to comply with the attendant dress code.

²⁵ The Halachic Organ Donor Society. Frequently Asked Questions About Halachic Aspects of Organ Donation. *The Halachic Organ Donor Society*. Retrieved from <http://www.hods.org/English/h-issues/faq-halachic.asp>

Devotion: Most interviewees, when asked, shared that their hospital had a synagogue or prayer space for Jewish patients and staff; a smaller number shared that their hospital also had a prayer space for Muslims. However, we also heard during interviews that some hospitals don't have any form of prayer spaces at all, for patients or staff, and that doctors are therefore left to their own devices to find spaces to pray or must leave the hospital for a nearby synagogue or mosque. One interviewee shared her belief that if hospitals create a prayer room for Muslims, Orthodox Jewish patients won't attend those hospitals anymore. Hagai Agmon-Snir, the director of the JICC, has said that while it is acceptable in other countries to have prayer spaces within hospitals for a variety of faiths, "in Israel, to build a Muslim prayer room is seen as a political statement." The JICC also identifies problems around accommodating some religions more than others: for example, their blog states that many hospitals do not "provide religious services to Muslims or Christians. Nurses complain about Muslim men washing their feet in sinks designated for hand washing. The simple solution – low sinks for feet-washing before prayers – cannot be found at any of these places. On the other hand, Jews may receive visits from a rabbi, have meals provided by various religious organizations according to their specific kashrut needs, or pray in an in-hospital synagogue."²⁶ When hospitals fail to accommodate employees' religious needs—especially when the religious needs of other employees are in fact accommodated—it sends a message that the employees are less valued, respected, or welcome to bring their core identities into the workplace. As Agmon-Snir said, providing prayer spaces for Muslim employees "is really a professional statement, not a political one."²⁷

Holidays/Scheduling: In general, Israeli workplaces are closed (for either full- or part-days) for the major Jewish holidays, and weekends are on Friday and Saturday in order to observe Shabbat. However, since hospitals have 24/7 operational needs, there can be scheduling conflicts that emerge around Jewish employees taking time off for Shabbat and Muslim employees taking time off for holidays like Ramadan or the Eid. Some interviewees indicated that no tensions existed around scheduling time off. Other interviewees, however, indicated the exact opposite. One interviewee in particular mentioned that many hospital supervisors are reluctant to grant Jewish employees days off for religious observance, out of concern over the number of holidays they will be required to accommodate. She shared that her supervisor does not allow any of her staff to take off for Hanukah or Passover, since these are week-long holidays that many staff members would want off. This same interviewee shared, however, that the hospital accommodates Muslim staff by allowing them to take off Eid al-Fitr and Eid al-Adha. The hospital also allows Muslim staff to adjust their hours during Ramadan so they work shorter days, and provide meals so the Muslim health care providers can break their fast.

Whether hospital staff are accommodated or not, health care providers seem to rely on informal strategies rather than formal policies to address scheduling conflicts. The interviewee who was not allowed to take time off on Hanukah and Passover was following a policy set by a specific head nurse; she shared that other nurses with other supervisors were allowed very different scheduling accommodations. Accommodations also occurred informally, with several interviewees sharing that Jewish providers cover for Muslim providers during Muslim holidays like the Eid, and that Muslim providers cover for Jewish providers during Jewish holidays like Passover. In this way, employees could avoid working on the religious holidays that they observe. In addition, one interviewee shared that at her hospital, some doctors do not want to use electronic devices or open doors on Shabbat. This has caused some tension with other doctors who are less observant and feel put upon to accommodate the doctors who do observe these Shabbat requirements.

In addition to these specific strains, we heard (as has already been stated) that the tensions around religion in Israel more broadly can impact interactions between staff members or cause tensions that go unaddressed. There may also be discriminatory hiring practices in Israel based on religion; a recent poll

²⁶ Agmon-Snir, H. (2009, May 20). A Call for Cultural Competency in Jerusalem's Medical Services. *The Jerusalem Post*. Retrieved from <http://jer-icc.org/blog/wp-content/uploads/2009/10/jicc-cultural-competence-in-jerusalem-english.pdf>

²⁷ Rebacz, M. (2011, April 28). Diagnosis: a Cultural Competency Deficiency. *The Jerusalem Post*. Retrieved from <http://jicc.org.il/jerusalem-is-leading-the-way-in-cultural-competence/>

found that 46% of Jewish Israelis (both men and women) expressed reluctance to work with Arab men, and 30% expressed reluctance to work with Haredi men. Forty-two percent of Jewish Israeli employers expressed reluctance around employing Arab men, and 37% of Jewish Israeli employers expressed reluctance around employing Haredi men.²⁸

Recommendations

Based on our interviews and research of the state of religio-cultural competence training in Israel, Tanenbaum makes the following recommendations to address the need for religio-cultural competence training related to patient care and around interactions between colleagues in Israeli hospitals:

Education & Training - Patients

Although some institutions are implementing trainings around cultural competence in Israel, these trainings often seem to be in their beginning stages and do not often (based on our findings) address religion specifically. We recommend that health care institutions implement trainings around religio-cultural competence. We also recommend that these trainings focus specifically on the diversity within religious traditions and the importance of taking a spiritual history.

- *Taking a Spiritual History:* All individuals interviewed stated that they do not ask about religion and assume that they will either be able to discern a patient's religious needs based on how the patient is dressed or that the patient will mention it if their religion impacts their patient care. We therefore recommend that doctors be trained in what Tanenbaum defines as a "Spiritual History" – a skill set in respectfully and effectively asking patients about their religious beliefs as it relates to their care.
- *Social Identity:* Personal identities shape and color our perceptions of, and behavior toward, others. We therefore recommend training on how the individual identities of health care providers can impact interactions with their patients and colleagues in a health care setting including treatment, management of care, and religious/spiritual support. Participants will learn that recognizing their own cultural lens is the first step to delivering culturally sensitive care.
- *Conscientious Objections:* We recommend training health care providers in what conscience and conscientious objection are in the context of a health care setting, when conscience influences interactions with patients, and in developing skill sets to appropriately manage situations where conscience comes into play.

Education & Training – The Workplace

We also recommend that institutions implement trainings about where religion intersects with the health care workplace, especially since some interviewees as well as supplementary research we conducted indicated that there can be tensions between co-workers related to culture and religion that are not being addressed. These trainings could take many forms, but one idea might be a facilitated "employee panel" of diverse health care providers who could talk about their experiences and help start a dialogue about tensions that may not otherwise be brought up and discussed. A training could potentially cover topics such as:

- *Religious Bias Danger Signs:* Tanenbaum's ten danger signs of obvious and subtle forms of religious bias that frequently show up at work, including religious expression and proselytizing, employee networks, attire, scheduling, backlash to sexual orientation, and accommodations.

²⁸ Pitrikovsky, S. (2014, March 30). Employers Prejudiced Against Hareidi Men, Arabs, Working Mothers. *Israel National News*. Retrieved from http://www.israelnationalnews.com/News/News.aspx/179046#.U2_Ja1dUaSp

- *Communication Strategies:* Case scenarios of actual situations provide opportunities to understand how issues of religion emerge in the workplace, and practice Tanenbaum's strategies for respectful communication. This section will include mixed media video clips and opportunities for hand-on learning including role plays and group activities.
- *Finding creative solutions:* Case and interactive group activities will help participants come up with proactive strategies for how issues pertaining to religion in the workplace (including the need for space and time to pray, or the need to avoid working on a specific religious holiday) can be accommodated.
- *Policies:* The importance of implementing workplace policies such as anti-harassment policies, anti-proselytizing policies, equal employment opportunity policies (in order to be in compliance with Israeli law such as the 1988 Employment (Equal Opportunities) law and policies outlining how employees should request religious accommodations and how managers should respond.

Spiritual Care & Chaplaincy Programs

We further recommend that hospitals develop a more robust chaplaincy. A few of the health care providers we interviewed shared that their hospital had a rabbi on staff who would, for example, make sure the cafeteria is kosher. However, our interviewees said that their hospitals do not have a chaplaincy team—that is, individuals who are trained specifically in tending to the spiritual needs and providing spiritual comfort to all of the patients who are ill. In 2004, Shaare Zedek Hospital received a grant from the UJA-Federation of New York that enabled Jonathan Rudnik to become the first full-time chaplain working at a hospital in Israel.²⁹ Based on our interviews and research, it does not seem that the chaplaincy presence in Israel has become much more robust since that time. Tanenbaum often recommends that doctors draw upon trained and certified chaplains as an educational resource and cultural broker and encourages that they be included as members of the care team. Chaplains can help provide doctors and nurses with information about specific religious beliefs or practices (although it is important to keep in mind the diversity within religious traditions – a chaplain from one religious tradition does not speak for that tradition as a whole). In addition, it is important to recognize the tensions between more and less observant Jews in Israel when engaging a chaplain, since Jews of one denomination of Judaism may be resistant to speaking with a chaplain from another denomination, even if that chaplain is trained to speak with people from a broad array of religious backgrounds. They can also help communicate with a patient and find out whether the patient has any religious concerns about his or her care, and talk through those concerns. Chaplains also provide patients with spiritual and emotional support. However, our interviews with Israeli health care providers show that Israeli hospitals rarely have a robust chaplaincy or spiritual care team, if they have one at all. As a result, physicians don't have the resources and support that they need to tend to the spiritual and religious needs of their patients.

Hospital Policies and Practices

Finally, we recommend that hospitals implement policies around scheduling and time off, appropriate attire, and the use of space for prayer (for both patients and health care providers). These policies help employees feel comfortable bringing their whole selves to work. Tanenbaum's 2013 Survey of American Workers and Religion found that the existence of such policies in the United States increases employee satisfaction and

²⁹ Shaare Zedek Medical Center in Jerusalem (2004, November 18). Israel's first full-time hospital chaplain offers patients support at critical junctures. Retrieved from <http://www.szmc.org.il/?TabId=1241>.

retention.³⁰ Furthermore, the existence of such policies prevents workplace conflicts from emerging by giving managers a protocol to follow if, for example, two employees wish to take off the same day and only one can do so given the needs of the hospital. Finally, the existence of policies often makes employees feel more comfortable asking for a needed accommodation. None of the institutions we researched seemed to have policies around these areas where religion can show up in the workplace, even though some interviewees acknowledged that these areas could be a source of workplace tension. We therefore recommend the adoption of clear policies.

Resources

- Tanenbaum Center for Interreligious Understanding: <https://tanenbaum.org/>
- Three Faiths Forum Middle East <http://www.3ff.org.uk/programmes/middle-east.php>
- Jerusalem Inter-Cultural Center: <http://jicc.org.il/>
- Halachic Organ Donor Society: <http://www.hods.org/>
- Kashouvot (an organization working to establish pastoral care in Israel): <http://www.kashouvot.org/>

³⁰ The Tanenbaum Center for Interreligious Understanding. (2013). What American Workers Really Think About Religion:). Retrieved from <https://tanenbaum.org/publications/2013-survey/>