FACILITATOR'S GUIDE

TANENBAUM
COMBATING RELIGIOUS PREJUDICE

TANENBAUM | Center for Interreligious Understanding
254 West 31st Street, 7th Floor, New York, NY 10001
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To the Hospital Faculty,

Thank you for your dedication to training medical professionals in religio-cultural competence in medicine and for taking on the role of facilitator in this training. With your help, medical professionals at your hospital will be exposed to the importance of this approach to patient care.

The facilitator's guide, with the accompanying PowerPoint presentation, is created for you by the Tanenbaum Center for Interreligious Understanding, a secular, non-sectarian not-for-profit organization dedicated to providing mutual respect with practical programs that bridge religious difference and combat prejudice in health care settings, workplaces, schools, and areas of armed conflict.

In the larger arena of research on the potential health benefits and connections between spirituality and health and healing, Tanenbaum distinguishes itself by focusing on the fact that religious beliefs and practices are an integral part of many people's lives and an identifier that can become particularly salient in a health care setting, both for patients facing illness, suffering or death, and for health care providers and staff trying to follow their own religious beliefs and practices in the often demanding health care workplace.

These training materials are the result of a collaboration with the Three Faiths Forum Middle East, an organization that uses Scriptural Reasoning to increase cultural engagement and collaboration between Jews, Christians, and Muslims in Israel. The overarching goal for this project was to examine religious diversity in patient care and employee-to-employee interactions at hospitals in Israel and foster effective communication skills in medicine. Three Faiths Forum Middle East addresses these objectives by conducing Scriptural Reasoning workshops with medical and nursing students.

In order to ensure that all training materials Tanenbaum developed on religious and cultural competence were relevant and customized to the Israeli healthcare system, Tanenbaum conducted a needs assessment to establish where religion emerges as an issue in Israeli hospitals in terms of the health care decisions that patients make, the provision of patient-centered care, and as a factor in employee interactions. Tanenbaum compiled our findings into a comprehensive report. These training materials have been created as the result of this cultural assessment. As a supplement to these materials, facilitators and health care providers may wish to review the full assessment report, which can be found here: [INSERT LINK WHEN AVAILABLE].

In brief, our assessment found that addressing the influence of religion in patient reactions and approaches to health care is essential, specifically in Israel, where 96.9% of the population self-identities as religious. In addition, Israel's religious and ethnic diversity means that both

patients and staff are bringing cultures and religious traditions that may be unfamiliar into hospitals.

While there is a growing consensus among Israeli health care practitioners and advocates that religion and culture are important pieces of quality care, many providers neglect or avoid this issue because they feel uncomfortable addressing the topic. Health practitioners who fail to acknowledge and address religion as a potentially important or even pivotal issue in a patient's worldview and health care decision-making process may find themselves ill-equipped to effectively understand, connect with and ultimately treat patients.

This training is designed to provide health care providers with practical information to understand why religion is relevant in a health care setting and tools and guidelines for successfully and appropriately addressing this vital topic with their patients. We hope that this facilitator's guide, together with the accompanying PowerPoint presentation, will serve as an effective resource to help you train health care professionals in the intersecting and multi-faceted fields of religio-cultural competence and health care.

This facilitator's guide was made possible thanks to the generous support of the Polonsky Foundation and the Sternberg Foundation. We extend profound gratitude to the Foundations for their leadership in recognizing the importance of religio-cultural competence in Israeli health care. We also want to thank Miriam Feldmann Kaye of Three Faiths Forum Middle East for her vision and commitment to this project.

Finally, we want to thank the Tanenbaum staff for their dedication to this project's completion. We extend profound thanks to Mark Fowler, whose thought leadership and commitment to excellence helped to shape this project; to Lynn Stoller, who was pivotal in the project's development and implementation; and to Eliza Blanchard for leading the research and development of the training materials and accompanying facilitator's guide.

We are proud to partner with your hospital,

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Section Time Allotment

Section 1 – Introduction: Objectives and Guidelines	
Lecture	10 minutes
Section 2 – Examine why religio-cultural competence is necessary to provide patient care	
Lecture	30 minutes
Section 3 – Recognize the impact of providers' beliefs and practices on patient care	
Respect activity	5 minutes
Lecture	25 minutes
Social identity wheel activity	30 minutes
Section 4 – Examine how providers' personal and professional values influence interactions with patients	
Lecture	25 minutes
Case study activity	35 minutes
Section 5 – Apply communication skills for respectfully interacting with diverse patients around religion	
Lecture	20 minutes
Role play activity	25 minutes
Role play activity	20 minutes
Section 6 – Identify how religious beliefs and practices intersect with employee interactions	
Lecture	15 minutes
Case study activity	30 minutes
Section 7 – Wrapping Up	
Lecture	5 minutes
Question & Answer	5 minutes

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Before you Begin: Materials & Preparation Checklist

1. **Room reservation:** If possible, select a room large enough to accommodate group activities and interaction, but small enough to create an intimate setting where participants can easily engage with one another.

2. **Section Assignments:** Determine how many facilitators will be participating in the day's session and designate who will be responsible for each section.

3. **Materials:** Ensure that the following materials & technology are available for the day:

   - ❑ Projector, screen & computer
   - ❑ PowerPoint slides
   - ❑ White board & markers

4. **Handouts:** Print out sufficient handouts to accommodate the group you are training. Remember to print out an extra copy for yourself and other facilitators as a reference. The handouts required for this training are located in the back of this facilitator's guide and are as follows:

   - ❑ Social Identity Wheel
   - ❑ Provider Values
   - ❑ 15 Trigger Topics
   - ❑ Spiritual Histories: How do I ask?
   - ❑ Jewish Patient: You Are the Patient
   - ❑ Jewish Patient: You Are the Provider
   - ❑ Muslim Patient: You Are the Patient
   - ❑ Muslim Patient: You Are the Provider
   - ❑ 10 Bias Danger Signs
   - ❑ LEARN Model/Respectful Communication

5. **Evaluations:** To measure the impact of the training on participants attitude, knowledge and skills, please have students full out the Evaluation after completing the training.

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SECTION 1 – INTRODUCTION

Objectives & Guidelines

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Section 1 – Introduction: Objectives and Guidelines

Rationale: **Cultural competence is an area of medicine that, overall, receives little time and attention. The result is that participants will come to this training with varying degrees of experience in this area, with most having received limited cultural competence training. In addition, participants may have different expectations about what this training will entail and what their role in the training should be. Identifying the session objectives and guidelines upfront will help participants understand what to expect from the rest of the training and what their roles and conduct should be throughout the day.**

Objectives:

At the end of this session, health care providers should be able to:

- Identify the goals and objectives for the training.
- Articulate expectations around their role and conduct for the training.

Time: 10 minutes (lecture)

Materials: White board & markers

Process:

1) Introduce yourself.

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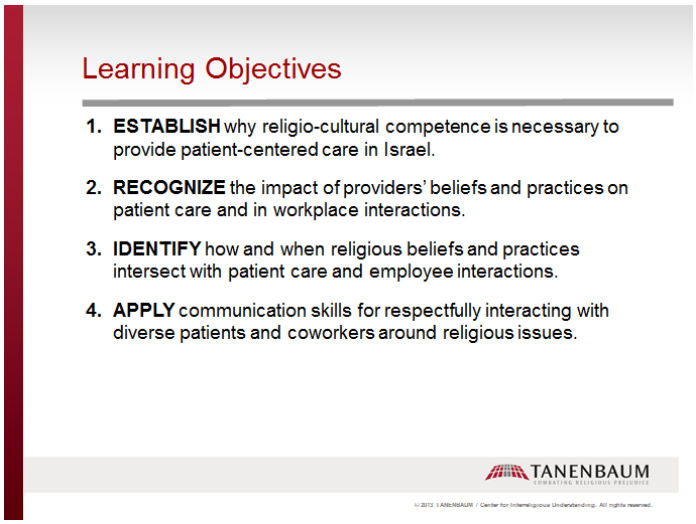
2) Go over the session objectives and ground rules.
3) Ask participants if they have any questions about the session objectives and ground rules, and answer as needed.

Slide 2 – Learning Objectives



1) Discuss the objectives for the session:

   a) **Establish why religio-cultural competence is necessary to provide patient-centered care in Israel.** Explain that this section of the training will include recent statistics that help show Israel's cultural and religious diversity, high levels of immigration, high levels of religiosity, and experiences of religious bias—all of which point to the need for Israeli health care providers to be religio-culturally competent.

   b) **Recognize the impact of providers' beliefs and practices on patient care and in workplace interactions.** Point out that this topic will be covered in two sessions throughout the training. The first section will include a series of activities that will help providers to explore the background that they come from and understand the role that their identities play in their interactions with patients and coworkers. The second section will also discuss the role of a provider's moral, ethical, and/or religious values in health care settings and use a series of examples and an in-depth case study to help providers explore how they would respond in their professional roles to certain patient beliefs and practices.

   c) **Identify how and when religious beliefs and practices intersect with patient care and employee interactions.** Tanenbaum has two tools—the 15 Trigger Topics and 10 Bias Danger Signs—that will be explored in depth to help health

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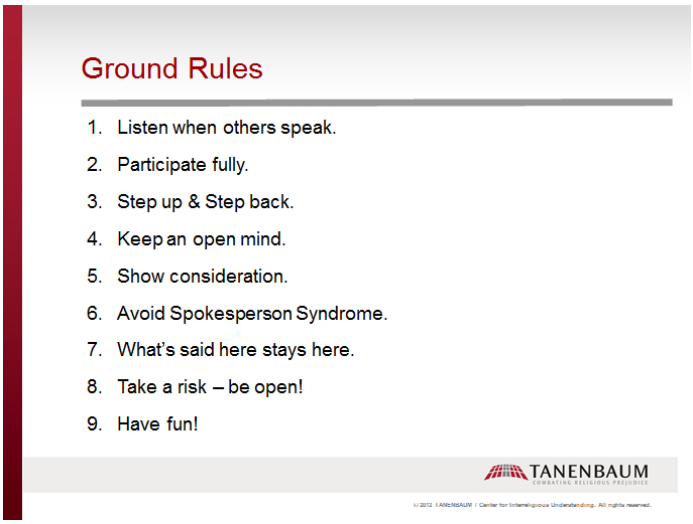
care employees take a thematic approach in identifying where religion is likely to emerge as a relevant identity for both patients and workers.

d) **Apply communication skills for respectfully interacting with diverse patients and coworkers around religious issues.** The training will introduce communication skills and strategies for having productive and respectful conversations about religion with diverse patients and coworkers. The training will also include interactive case studies and role plays to help participants put these skills into practice.

Slide 3 – Ground Rules



1) Go over some ground rules for the day that participants should keep on mind:

   a) **Listen when others speak.** Explain to participants that a helpful indicator for determining if they have stopped listening is if they have started formulating responses in their heads to what someone else is saying, while that person is still speaking. If participants realize this is happening, they should stop and refocus on what is being said.

   b) **Participate fully.** Inform participants that the more they contribute to the discussion throughout the day, the more rewarding and useful the session will be. However, acknowledge that different people are comfortable participating at different levels. Ask participants to challenge themselves by each going one step beyond the level they would normally participate at.

   c) **Step up & Step back.** Ask participants who have a tendency to be reserved to go a step beyond their comfort zone and participate more than they otherwise would. Ask those who already have a high level of engagement and comfort with participating to take a step back at times to give others room to share.

   d) **Keep an open mind.** Ask participants to consider points of view other than their own.

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e) **Show consideration.** Emphasize that while participants do not need to agree with the opinions and perspectives of all their colleagues, they do need to behave respectfully.

f) **Avoid Spokesperson Syndrome.** Ask participants to use "I" language and speak from their own experiences, rather than speaking as the representative of an entire religious, ethnic or cultural group. Also advise that they avoid asking others to be the "spokesperson" and instead ask only about individuals' experiences.

g) **What's said here stays here.** Remind the audience to ask before sharing personal stories that other participants have shared with individuals outside the group.

h) **Take a risk – be open!** Rich discussions can only come from conversations where individuals are not afraid to respectfully state their opinions and challenge others to think more deeply and critically.

i) **Have fun!** Often these topics can seem very serious and difficult. It's important to take religious respect seriously, but you can have fun while doing so.

2) Ask participants if they have any ground rules that they would like to add. Write any additional ground rules on the white board.

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SECTION 2 – EXAMINE

Why religio-cultural competence is necessary to provide patient care

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Section 2 – EXAMINE why religio-cultural competence is necessary to provide patient care

Rationale: **This section is designed to illustrate why religion is an aspect of care that needs to be addressed in Israel, so that attendees understand why this topic is relevant to their professional development and practice. Israel is a highly religiously, culturally, and ethnically diverse nation. It is also a country with a high level of religiosity, and religion is often relevant to people's lives. As such, religion is an identifier that needs to be addressed in a health care setting in order to understand how patients and families make medical decisions and think about treatment options.**

Objectives:

At the end of this section, health care providers should be able to:

- Define culture and cultural competence as it relates to health care.
- Name the Israeli Ministry of Health's requirements around cultural competence and define how these requirements relate to their professional role.
- Identify demographic trends and statistics and recognize how these cultural and religious trends necessitate education and training in religious and cultural competence.

Time: 30 minutes (lecture)

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Materials: White board & markers
Process:

1) Explain that this section will demonstrate the policies and demographic trends that make religion and culture an issue that cannot be ignored.

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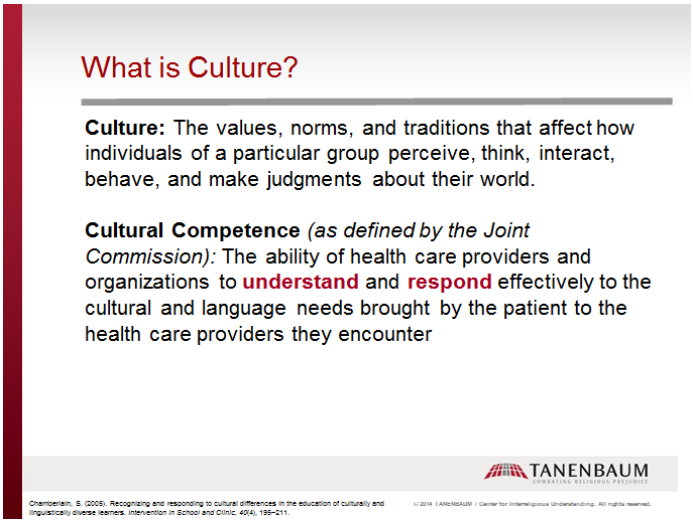
Slide 5 – What is Culture?



1) State that even defining the term **"culture"** is complicated, and that different people define that term in different ways. However, for the purposes of this session, there needs to be a working definition of culture that everyone understands and can reference. Our working definition is **"The values, norms, and traditions that affect how individuals of a particular group perceive, think, interact, and make judgments about their world."**

2) Point out that there also needs to be a working definition of **cultural competence** for this training. That definition is **"The ability of health care providers and organizations to understand and respond effectively to the cultural and language needs brought by the patient to the health care providers they encounter."**[1]

3) Mention that the two words in red, *understand* and *respond*, are particularly important because they speak to the two main components of cultural competence—knowledge (understanding) and skills (responding). This session will address both components of cultural competence and increase participants' knowledge and skill sets.

[1] Chamberlain, S. (2005). Recognizing and responding to cultural differences in the education of culturally and linguistically diverse learners. *Intervention in School and Clinic, 40*(4), 195–211.

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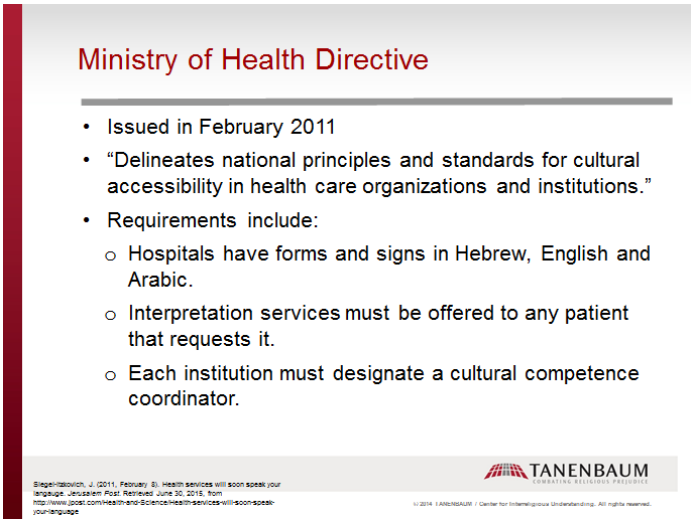
Slide 6 – Israeli Ministry of Health Directive on Cultural Competence



1) Ask participants if they're familiar with the Ministry of Health cultural competence directive. Estimate the percentage of people in the room have heard of the directive.

2) Explain, for those who don't know, that in **February of 2011** the Ministry of Health issued a cultural competence directive that **"delineates national principles and standards for cultural accessibility in health care organizations and institutions."** These requirements were issued in part because of a push by organizations such as the Jerusalem Intercultural Center, the Jerusalem Foundation, the New Israel Fund, and Emun Hatsibur to establish cultural competence requirements for health care institutions in law. Before 2011, institutions only implemented culturally competence care measures if they wished to and saw the value in doing so, since there were no legal requirements around this. The directive aims to increase the culturally competent care measures implemented in Israeli hospitals by providing legal requirements around culturally competent care.

3) Specific requirements outlined by the directive include:

   a) **Having all forms and signs in hospitals be in Hebrew, English and Arabic (and potentially additional languages if relevant to that particular hospital);**

   b) **Offering interpretation services to any patient who requires it; and**

   c) **Designating a cultural competence coordinator at each institution.**[2]

[2] Siegel-Itzkovich, J. (2011, February 8). Health services will soon speak your langauge. *Jerusalem Post*. Retrieved June 30, 2015, from http://www.jpost.com/Health-and-Science/Health-services-will-soon-speak-your-language.

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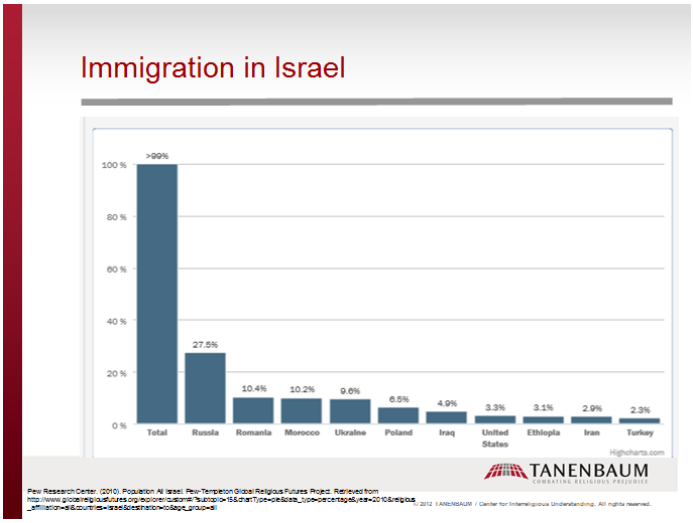
4) Ask participants for positive examples of what their institution has done to address cultural competence. Write down examples on the white board.

5) Ask participants for examples of areas where their institution could do more to address cultural competence. Write down examples on the white board.

6) Point out that the goal for today is to help institutions go beyond the language access initiatives required by the directive and address other, less commonly addressed aspects of cultural competence.

Slide 7 – Immigration in Israel



1) Point out that 33% of people currently living in Israel were born in countries outside of Israel.[3] This high rate of immigration contributes to Israel's overall ethnic and cultural diversity. Increased diversity makes it more likely that providers will work with patients who belong to unfamiliar cultures and religions. This dynamic increases the need for health care providers to be trained in the knowledge and skills to provide culturally competent care to these diverse patient populations.

2) Share that the graph illustrates the countries where Israel's foreign-born population is most likely to come from: Russia, Romania, Morocco, Ukraine, Poland, Iraq, and the United States. These countries are in different regions and have different cultural backgrounds, so Israelis are likely to interact with people from cultures different from their own in general, and in a health care setting.

[3] Pew Research Center. (2010). Population All Israel. Pew-Templeton Global Religious Futures Project. Retrieved from http://www.globalreligiousfutures.org/explorer/.

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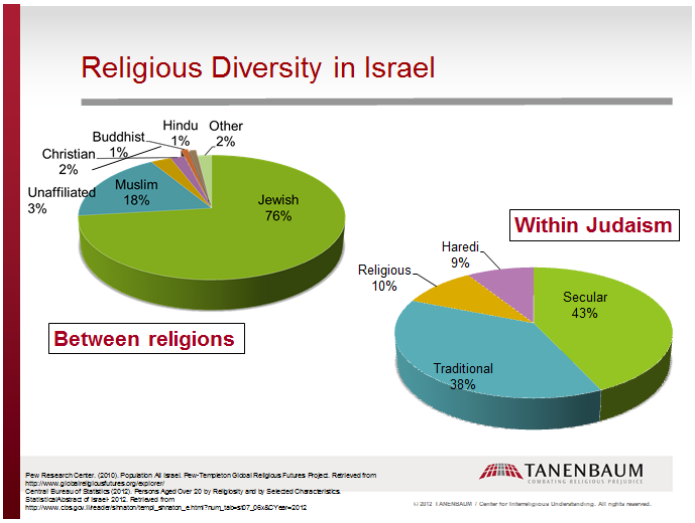
Slide 8 – Religious Diversity in Israel



1) Explain to participants that there is tremendous diversity both between and within religions. The first graph on the left of the screen shows Israel's religious demographic breakdown:

   a) 76% Jewish
   b) 19% Muslim
   c) 3.1% unaffiliated
   d) 2% Christian
   e) 1% Buddhist
   f) 1% Hindu
   g) 1% Folk tradition
   h) 2% Other.

   These statistics were collected by the Pew-Templeton Global Religious Futures Project in 2010, based on the 2008 Israeli census, which surveyed about 2% of Israel's population which, in 2008, was 7,420,000 people.[4,5]

[4] Pew Research Center. (2010). Population All Israel. Pew-Templeton Global Religious Futures Project. Retrieved from http://www.globalreligiousfutures.org/explorer/.
[5] The United Nations International Seminar on Population and Housing Censuses: The 2008 Integrated Census in Israel and Future Censuses. Retrieved from http://unstats.un.org/unsd/demographic/meetings/Conferences/Korea/2012/docs/s04-2-1-Israel.pdf.

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2) These numbers show the religious diversity within Israel's population, but the second graph on the right hand side of the screen shows the diversity that exists even within Israel's Jewish majority:

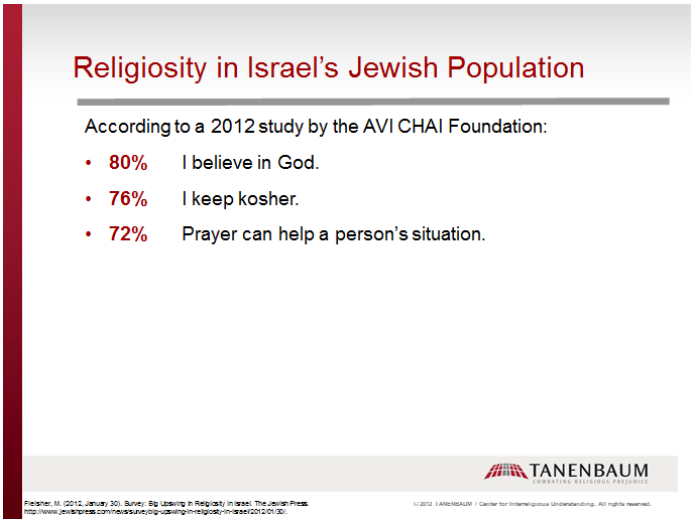
   a) 38% of Israel's Jewish population identifies as traditional;
   b) 10% identifies as religious;
   c) 9% identifies as Haredi; and
   d) 43% identifies as secular.

   These statics were collected by Israel's Central Bureau of Statistics in 2010 based on their survey of Israeli adults over the age of 20, with a sample size of 4,778 Israelis total and 3,308 Jewish Israelis.[6]

3) Note that even within a specific identification of Judaism, people will believe and practice in very different ways. Inform participants that even if the majority of patients they see come from one particular religious affiliation, it does not mean that those patient populations lack diversity. Knowing that a patient is Jewish, Muslim, Christian etc. does not necessarily tell you how that person believes or practices, or how those beliefs or practices will emerge in a health care setting—even if you think you know, it's always important to respectfully ask.

[6] 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.

Slide 9 – Religiosity in Israel's Jewish Population



1) Inform participants that in addition to its high levels of cultural and religious diversity, Israel is a country with a high level of religiosity. A 2012 study conducted by the AVI CHAI Foundation found that **80% of Jewish Israelis believe in God**, which is higher than the number of Jewish Israelis who reported a belief in God when similar studies were conducted in 1991 and 1999.[7] This indicates that religion is increasingly playing a prominent role in the lives of Jewish Israelis.

2) The 2012 study also found that **76% of Jewish Israelis keep kosher**, and **72% believe that prayer can help a person's situation**.[8] These statistics illustrate that religion can come up for Jewish Israelis in ways that directly relate to health care, either in terms of accommodations they may need in a hospital setting (like kosher food) or how they think about the relationship between religion and health (such as a belief that prayer can help a person's situation).

3) Emphasize that diversity within a religious tradition is not unique to Judaism. Within every religious tradition there is a great deal of diversity in how people believe and practice, and this diversity impacts patients' health and health care access as well as the provision of care for these patients.

[7] Fleisher, M. (2012, January 30). Survey: Big Upswing in Religiosity in Israel. The Jewish Press. http://www.jewishpress.com/news/surveybig-upswing-in-religiosity-in-israel/2012/01/30/.
[8] Fleisher, M. (2012, January 30). Survey: Big Upswing in Religiosity in Israel. The Jewish Press. http://www.jewishpress.com/news/surveybig-upswing-in-religiosity-in-israel/2012/01/30/.

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Slide 10 – Religious Bias in Hiring Practices

1) Point out to participants that religious identity can also impact Israeli workplaces in both overt and subtle ways. A survey poll of Jewish Israelis commissioned by Israel's Equal Employment Opportunity Commission (EEOC) in 2014 indicated that there is significant overt workplace bias in Israel based on ethnicity, religion, and gender. The EEOC surveyed 500 people who were a representative sample of Israel's adult Jewish population and Hebrew speakers. The survey found that:

   a) **46% of Jewish Israelis expressed reluctance to work with Arab men.**
   b) **30% expressed reluctance to work with Haredi Jewish men.**
   c) **28% expressed reluctance to work with Arab women.**
   d) **42% of possible employers expressed reluctance to hire Arab men.**
   e) **37% of possible employers expressed reluctance to hire Haredi men.**[9]

2) An EEOC official who works at the Economic Ministry was quoted in an interview stating that she thought these statistics showed that the respondents made hiring decisions based on prejudices rather than experience.[10]

[9]Israeli National News, "Employers Prejudiced Against Hareidi Men, Arabs, Working Mothers," retrieved from http://www.israelnationalnews.com/News/News.aspx/179046#.VQMdrOEgwxL.
[10] Israeli National News, "Employers Prejudiced Against Hareidi Men, Arabs, Working Mothers," retrieved from http://www.israelnationalnews.com/News/News.aspx/179046#.VQMdrOEgwxL.

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3) These statistics demonstrate that people in Israel's workforce from certain religions or ethnicities may face particular barriers to employment, speaking to the need for training on how to minimize bias in the workplace at all stages of employment, including hiring, and how to respectfully communicate around religious issues.

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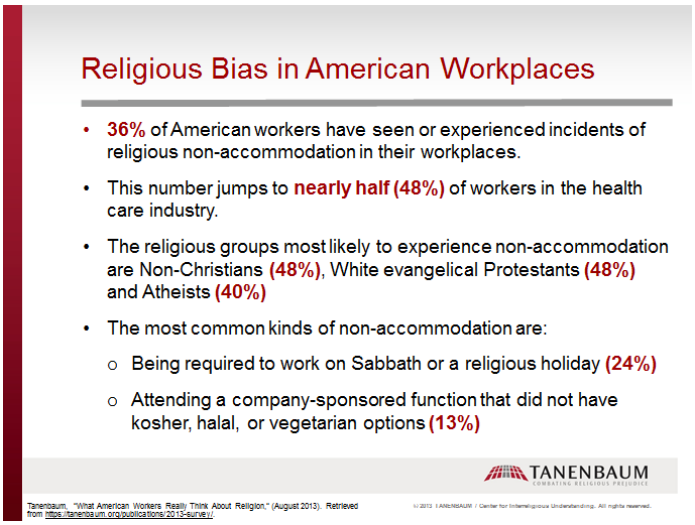
Slide 11 – Religious Bias in U.S. Workplaces



1) Explain that while the previous slide focused on overt hiring bias in Israeli workplace, there are more subtle instances of bias in workplaces as well. In 2013 Tanenbaum conducted a survey of American workers and religion.[11] This was a nationally representative survey of 2,024 American adults who are employed part time or full time. Acknowledge that these statistics are specific to the United States, but still point to some important themes regarding religious bias in the workplace that are applicable in any country, including Israel.

2) To understand Americans' experiences of religious bias in the workplace, the survey asked about nine specific forms on non-accommodation (that is, not having one's religious needs met): Attire, Devotion, Diet, Icons, Prayer, Ridicule, Holidays/Scheduling, Networks, and Socializing. Go over the statistics on the screen:

   a) First, **36% of American workers have seen or experienced incidents of religious non-accommodation in their workplaces.**

   b) **The percentage of American workers who have either witnessed or experienced religious non-accommodation jumps to 48% of workers in the health care industry.** This means that in the United States, the health care industry is the one where workers are most likely to experience religious non-accommodation—especially related to scheduling and holidays. This is likely due to the 24/7 nature of many health care-related jobs, which makes accommodating religious practice that much more challenging. While there is no data on whether this trend holds true outside of the United States, it seems likely that the demanding nature of working in the health

[11] Tanenbaum, "What American Workers Really Think About Religion," (August 2013). Retrieved from https://tanenbaum.org/publications/2013-survey/.

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care industry would pose challenges around religious accommodation in Israel as well as the United States. The qualitative research that Tanenbaum completed during the cultural assessment of Israeli health care indicates that this is in fact the case.

c) In American workplaces in general, **the religious groups most likely to experience non-accommodation are non-Christians, white evangelical Protestants, and atheists**. The important takeaway from this finding is that religion discrimination is not just a minority issue. People of all religious backgrounds can experience religious bias in the workplace. In the United States, it is important to remember that the beliefs and practices of Christians, like people of all other faith backgrounds, need to be respected and accommodated in the workplace. In Israel, it is important to remember that people who are Jewish can still experience or witness religious non-accommodation, even if they work predominantly with other Jews. This is in part because of the diversity of religious belief and practice that exists within religious traditions.

d) **The most common types of non-accommodation measured in Tanenbaum's 2013 survey are being required to work on a Sabbath or religious holiday (24%), or attending a company-sponsored function that did not have kosher, halal or vegetarian meal options (13%).** The data from this survey does not cover what kinds of non-accommodation would be widely prevalent in Israel, but the qualitative research Tanenbaum conducted during the cultural assessment of Israeli health care indicates that scheduling and diet are areas of conflict in Israel as well as the United States.

SECTION 3 – RECOGNIZE

The impact of providers' beliefs and practices on patient care

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Section 3 – RECOGNIZE the impact of providers' beliefs and practices on patient care

Rationale: **This section will help providers recognize the important but often overlooked impact of their own beliefs and practices on patient care and in workplace interactions. Medical professionals sometimes operate with the false impression that their assessments and decision-making exist in a vacuum that is "objective" and separate and apart from their own religious, cultural and other social identities. Asking participants to examine how their own "lens" influences their perceptions of, and interactions with, patients and coworkers will help them to be more aware and cautious of when their "lens" could result in misinterpreting or overlooking the needs, intentions, or actions of their patients or coworkers.**

Objectives:

At the end of this section, health care providers should be able to:

- Recognize that "respect" is interpreted differently across cultures and faith traditions.
- Distinguish between generalizations and generalized knowledge that devolves into stereotypes.
- Identify how and why unconscious bias manifests itself in a health care setting and how to minimize its effect.
- State statistics that demonstrate the implications that unconscious bias has for patients, specifically minority groups.

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- Define social identities and describe how they influence our experiences and shape the lens through which we view others.

Time: 1 hour

- Respect activity (5 minutes)
- Lecture (25 minutes)
- Social identity wheel activity (30 minutes)

Materials:

- White board & markers
- **Social Identity Wheel**

Process:

1) Explain that this section will involve a discussion of how our thought processes influence how we view patients and ultimately how we diagnose and care for them. Who "we" (the practitioners) are influences how we interact with patients and can impact the care we provide.

Slide 13 – Respect Activity

Rationale: **This is an icebreaker exercise that quickly and visually illustrates the largest barrier to respectful interactions – namely, how can we be respectful of others when we don't know what respect looks like to them? Effective communication with patients is the only way to understand what respect looks like for them. This exercise sets up the following section, which provides guidelines and strategies for communicating with patients in order to identify and define respectful care as the individual patient sees it.**

Objectives:

At the end of this activity, health care providers should be able to:

- Recognize that "respect" is interpreted differently across cultures and faith traditions.

Time: 5 minutes

Materials: White board & markers

Process:

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1) Explain that two statements will appear on the screen one at a time. Ask participants to stand (or raise their hand if standing is difficult) if they AGREE or STRONGLY AGREE with each statement.

2) Click to bring up the first statement: ***I always treat people of other religious faiths with respect.*** Count how many people stand up or raise their hands for this statement or provide a rough estimate. Generally, a high percentage of participants stand up for this statement.

3) Click to bring up the second statement: ***People of other religious faiths always treat me with respect.*** Count how many people stand up or raise their hands for this statement or provide a rough estimate. Generally, fewer people stand up for this statement.

4) Note that one would think that the results would be close to equal. Ask participants to share their thoughts on why there is such a discrepancy between the response to the first statement and the second. If everyone feels that they are always being respectful, then why do people feel that they are not always being respected? Write down participant responses on the white board.

5) Ultimately make sure that participants come away understanding the following points:

    a) Our understanding of respectful behavior varies across cultures and religions.

    b) Given cultural and religious differences, the *intent* of our actions may not match up to their ultimate *impact.* But, however good our intentions, we are still responsible for both the intent and impact of our actions.

    c) Respect does not have to mean agreement. You can ultimately disagree with a patient or coworker while still being respectful

    d) Respect is a *behavior,* not a feeling. Respect is measured in actions and the impact they have on the patient or coworker.

    e) More effective communication with patients and coworkers can help overcome the disconnect in understanding what respectful behavior looks like to someone else.

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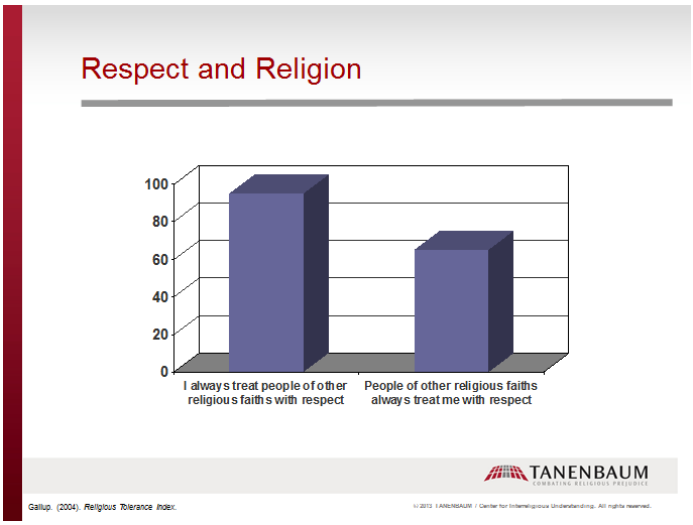
Slide 14 – Respect and Religion



1) Explain that the statements on the previous slide were taken from the *Tolerance Index*, an external study conducted by the Gallup Organization in 2004. The poll found that while 95% of people said they *always* treated people of other religious faiths with respect, only 65% of people actually felt that they were *always* treated with respect.[12]

2) Reiterate the point that while we may think we approach others respectfully around the topic of religion, in fact, we approach the idea of "respect" from our own lens and identity. What is respectful behavior varies across cultures and can therefore be misinterpreted. Since most of us know very little about religious beliefs and practices that are not our own, it's all too easy to think we are being respectful, when we're actually not.

> FOR EXAMPLE: An Orthodox Jewish male patient refuses to shake hands with a female physician. In this case, the *intent* of the physician is to show respect with what she considers to be a standard gesture of introduction. However, shaking hands is not respectful behavior for this particular patient whose religious practices surrounding modesty dictate that he not shake hands with women. So in this case the *impact* of this particular gesture – though respectful in intent – is not received as such, but rather, makes the patient uncomfortable.

[12] Gallup. (2004). *Religious Tolerance Index*.

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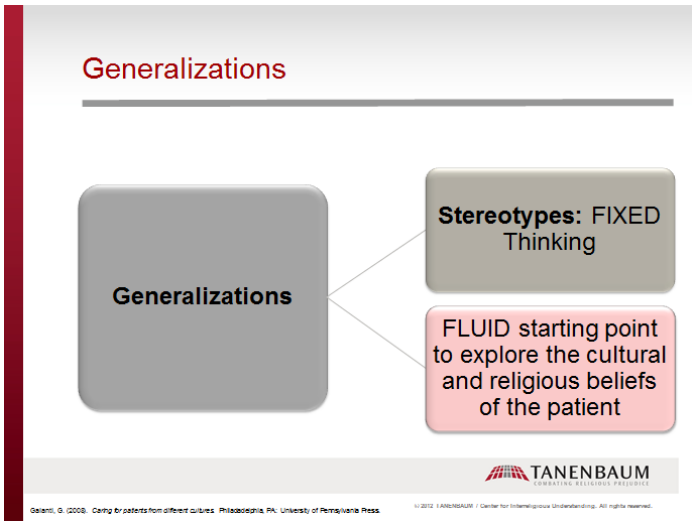
Slide 15 – Generalizations



Rationale: **This section is used to present generalizations as a useful and necessary tool for processing information, while cautioning participants against the dangers of taking actions with patients based solely on these initial assumptions. Generalizations left unchecked devolve into stereotypes, resulting in incomplete or inaccurate portraits of a patient's needs and concerns.**

1) Begin by defining **generalizations** as common trends that provide a starting point to better understand and anticipate behavior.

2) Generalizations are what we use to categorize and process the overwhelming amount of information we are bombarded with on a daily basis. In a fast-paced and confusing world, our brain creates these necessary short cuts to break down and process information. This natural process of breaking down new information into manageable categories is necessary and can be helpful, but it can also be dangerous if misused.

3) Use the slide graphic to illustrate how generalizations can veer off in two different directions. If used appropriately, generalizations can be a useful tool to explore the religious and cultural beliefs of the patient by providing some clues as to relevant questions to ask, which ultimately results in a better understanding of the patient. When used incorrectly,

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generalizations devolve into stereotypes where thinking becomes fixed and no attempt is made to look beyond the initial assumptions made.[13]

4) State the following to illustrate the point above. When you are diagnosing a patient you can make an assumption, given a set of symptoms, as to what might be the most likely cause. However, it is still necessary to ask questions and perform tests to ensure your theory is correct. The same holds true when dealing with culture and religion. You can make certain generalizations about a patient given his or her cultural and religious background, but you cannot *assume* this to be true without asking questions and further exploring the issue.

FOR EXAMPLE:

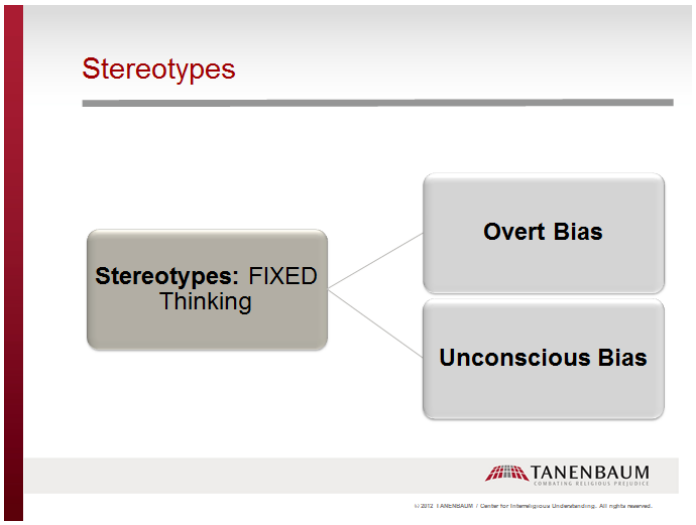
A generalization: This patient is a Jehovah's Witness and therefore his or her parents may have some concerns regarding blood and blood products being used in his or her treatment. This is an area I may need to discuss further with the parents of my patient.

A stereotype: This patient is a Jehovah's Witness and his or her parents will therefore unequivocally reject any use of blood or blood products for their child. I will need to immediately obtain a court order to ensure that I can do a blood transfusion if necessary.

5) Tell participants that today they will be exposed to a number of generalizations about a variety of faith traditions and cultural belief systems. These generalizations are meant to serve as practical guidelines. They are *not* meant to be the only reality or truth for every practitioner of that religion.

[13] Galanti, G. (2008). *Caring for patients from different cultures.* Philadelphia, PA: University of Pennsylvania Press.

Slide 16 – Stereotypes



Rationale: **This slide and the following three slides are intended to make practitioners aware of the fact that bias is often unconscious – influencing our behaviors and decisions without our being aware of it. The only preventive measure for this form of bias is to identify and confront what our biases are (we all have them) and to develop vigilance against allowing those biases to influence our interactions with patients. This section is intended to encourage participants to consider where their own biases lie and mitigate the impact of these biases by monitoring their behavior.**

1) Use the slide graphic to show that stereotyping can lead to two possible outcomes. Define **overt prejudice**, one of the outcomes of stereotyping. Overt prejudice is the form of bias that we are more commonly familiar with, the explicit form of discrimination that openly devalues another human being based on assumptions made about him or her. Overt prejudice is the more visible form of bias.

2) **Unconscious bias** is a more subtle, but equally damaging, form of bias. Unconscious bias is a stereotype that has become so ingrained that it operates automatically – and therefore unconsciously. It forms out of the natural categorization process that our brains use to process information. Unconscious bias emerges when we begin to place value on a certain category that then triggers a specific attitude or reaction. Unfortunately, these attitudes are so ingrained in our thought process by social influences and media exposure that we are often completely unaware of them.

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3) Mention that the next few slides will provide examples of how both overt and unconscious bias can show up in a health care setting.

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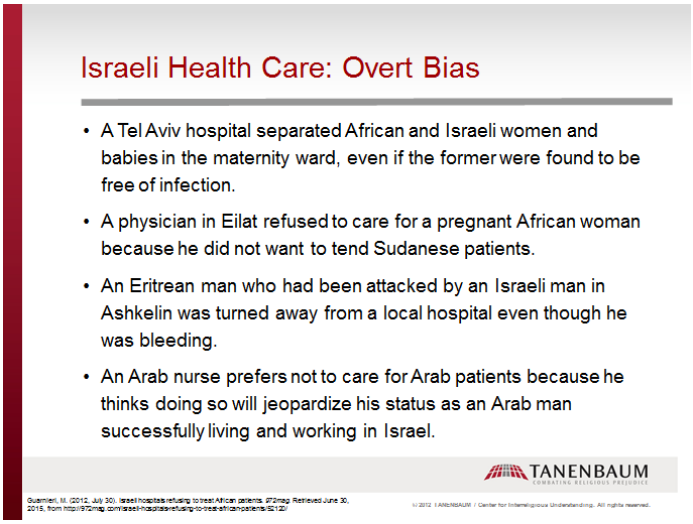
Slide 17 – Israeli Health Care – Overt Bias



1) Explain that overt bias based on race, ethnicity, religion, and other identifiers unfortunately continues to play a role in health care interactions between patients and providers, as illustrated in these examples:

   a) **A Tel Aviv hospital separated African and Israeli women and babies in the maternity ward, even if the former were found to be free of infection.**

   b) **A physician in Eilat refused to care for a pregnant African woman because he did not want to tend Sudanese patients.**

   c) **An Eritrean man who had been attacked by an Israeli man in Ashkelin was turned away from a local hospital even though he was bleeding.**

   d) **An Arab nurse prefers not to care for Arab patients because he thinks doing so will jeopardize his status as an Arab man successfully living and working in Israel**.

2) Mention that the first three examples are all instances of overt bias against African patients. Ostensibly, these hospitals or providers turned away patients based on concerns that they would spread infectious diseases. However, these behaviors persisted even when African patients were found to be free of infectious diseases, and the Israeli Ministry of Health called these practices "racist."[14]

[14] Guarnieri, M. (2012, July 30). Israeli hospitals refusing to treat African patients. *972mag*. Retrieved June 30, 2015, from http://972mag.com/israeli-hospitals-refusing-to-treat-african-patients/52120/.

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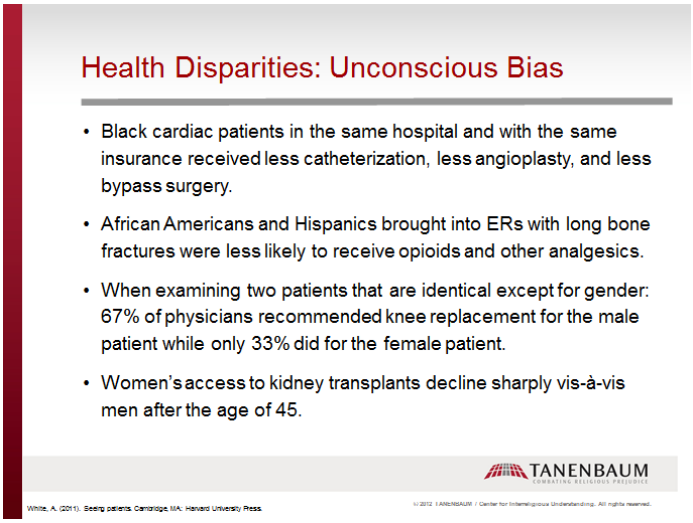
3) The last example refers to overt bias against Arab patients from an Arab nurse. People can have overt bias for people within their own ethnic/racial/cultural/religious group.

Slide 18 – Health Disparities – Unconscious Bias



1) Explain that unconscious bias also plays a role in interactions with patients or coworkers by influencing our behaviors and decisions without our being aware of it. Unfortunately, unconscious bias in health care can lead to health disparities, as in the examples on the screen from the U.S. context:

   a) **Black cardiac patients in the same hospital and with the same insurance received less catheterization, less angioplasty, and less bypass surgery than white patients.** One hypothesis for this phenomenon is that physicians unconsciously believe that black patients are less likely to adhere to treatment recommendations than white patients, and therefore offer treatment less often. [15]

   b) **African Americans and Hispanics brought into ERs with long bone fractures were less likely to receive opioids and other analgesics.** In the United States some doctors may have the ingrained bias that African Americans or Hispanics do not experience pain as intensely, or may be coming to the ER specifically to seek drugs. As a result of this unconscious bias providers are less likely to prescribe pain medication such as opioids to African American and Hispanic patients. [16]

[15] Green, A. (2007). Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *Journal of Internal Medicine, 22*(9), 1231-1281.
[16] Todd, K. (2000). Ethnicity and analgesic practice. *Annals of Emergency Medicine, 35*(2), 11-16.

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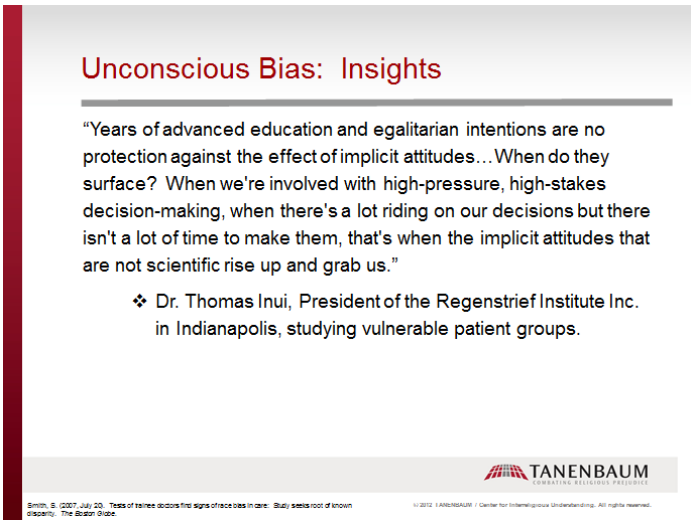
c) **When examining two patients who were identical except for gender, 67% of physicians recommended knee replacement for the male patient while only 33% did for the female patient**. This may be based on unconscious stereotypes that women's complaints of pain are emotional or psychosomatic rather than physical, or because physicians are better able to understand the way men generally present complaints of pain (in a more factual and reserved manner) compared to the way women present complaints of pain (as more of a narrative and personal style).[17]

d) **Women's access to kidney transplants declined sharply vis-à-vis men after the age of 45.** In this instance, unconscious bias might make providers think that women are frailer than men of the same age, even though there is no medical evidence supporting this.[18]

2) Ask participants if they can think of examples of either overt or unconscious bias that they have encountered. Ask participants to identify whether the instance of bias they're referring to is overt or unconscious. If they seem to be misidentifying unconscious bias as overt bias, or vice versa, articulate why the example they gave seems to be an example of one kind of bias rather than the other. Write examples on the white board.

[17] Borkhoff, C. (2008). The effect of patients' sex on physicians' recommendations for total knee arthroplasty. *Canadian Medical Association Journal,* 6, 178.
[18] Segev, D. (2009). Age and comorbidities are effect modifiers of gender disparities in renal transplantation. *Journal of the American Society of Nephrology*.

Slide 19 – Unconscious Bias: Insights



1) Use the quote on the slide to highlight the fact that unconscious bias most often emerges during times of stress and time pressure, which are often conditions that are present in health care settings. Under these conditions we are more likely to fall back on shortcuts – stereotyping being a form of "mental" shortcut.[19]

   "Years of advanced education and egalitarian intentions are no protection against the effect of implicit attitudes…. When do they surface? When we're involved with high-pressure, high-stakes decision-making, when there's a lot riding on our decisions but there isn't a lot of time to make them, that's when the implicit attitudes that are not scientific rise up and grab us."

   – Dr. Thomas Inui, President of the Regenstrief Institute Inc. in Indianapolis, which studies vulnerable patient groups

2) The only preventive measure for unconscious bias is to identify and confront what our biases are and be aware of when these biases influence our interactions with patients. Emphasize that *none* of us are immune to unconscious bias.

[19] Smith, S. (2007, July 20). Tests of trainee doctors find signs of race bias in care: Study seeks root of known disparity. *The Boston Globe.*

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3) Point out that the rest of the session is intended to encourage participants to consider where their own biases lie and mitigate the impact of these biases by giving them tools to monitor their behavior.

Slide 20 – Culture, Belief and Practice

Rationale: **Religion can interact with health care in three different dimensions: the religious *beliefs* that drive or influence patient decision-making, the *practices* that may intersect with health or health care, and the cultural background of the patient that shapes both religious beliefs and religious practices. Providers should have a clear understanding of these three components in order to competently identify religious concerns and be able to communicate with patients and/or their families about these concerns.**

1) In order to understand the impact that religion has on health care decisions and patient-centered care, the concept of religion needs to be properly defined. For the purpose of this training religion will be defined as being composed of three elements: culture, belief, and practice. These three components are all interwoven, each one influencing the other. Review the definition and corresponding example for each element.

   a) **Culture** is defined as the **values, norms, and traditions of a particular group.** In other words, "culture" is the unwritten rules that define our perception of how to do things "right."

FOR EXAMPLE**:** If a Somali woman requests that her daughter be seen by a female doctor, this belief can be dictated by a cultural interpretation of her religious beliefs regarding modesty.

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b) **Belief** is defined as the **conviction of the truth of some statement or the reality of some being or phenomenon.** It is what we know to be fundamentally true and is unique to each individual. Belief is often influenced by religious doctrine, but the interpretation of that doctrine is unique to the individual.

FOR EXAMPLE: A patient, or his or her family, may refuse treatment out of the belief that God will decide when it is time to die. Another person within the same tradition, however, may accept treatment because he or she believes that medicine is a gift from God and that there is a religious obligation to extend life as long as possible.

c) **Practice** is defined as a **repeated or customary action** that is seen as the usual way of doing something.

FOR EXAMPLE: A patient may alter his or her medication regimen in order to observe a fast for a religious holiday. Again, religious practices are often influenced by a combination of cultural and religious beliefs. Some religious traditions require more “doing” than others.

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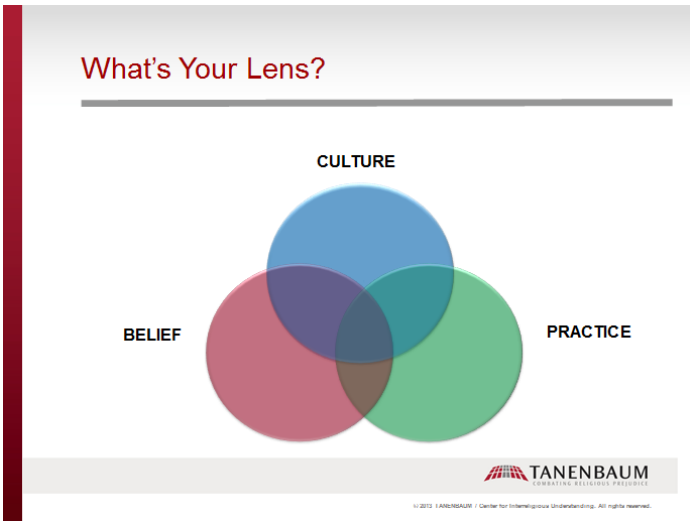
Slide 21 – What's Your Lens?



1) The Venn diagram is a visual representation of this working definition of religion as the intersection of the three elements of culture, belief, and practice. It illustrates that we each balance these three elements differently.

2) Ask participants to consider where they would place themselves on this diagram.

3) Ask participants to consider whether someone else would be able to accurately place them where they place themselves on the diagram. Make the point that our religiosity is often not visible to others, but just because it is not visible does not mean that it is not important or influential in our lives. It is therefore vital to ask patients about their religious beliefs rather than making assumptions based on outward appearances. Ask participants if anyone has ever made an assumption about their religious beliefs.

4) Each patient falls somewhere on this Venn diagram. How we understand people with whom we interact is a combination of:

   a) what we know (or think we know) about a person's background and;

   b) our own cultural and religious lens (perspective).

5) Providers often place patients on this diagram based on their own religious lens. Each person's religiosity shapes how they view and interpret the religiosity of others.

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6) Present the following examples of patients:

   a) A Jewish patient who was raised in a Haredi Jewish community (culture), attends Synagogue every Saturday (practice), keeps kosher, and feels strongly connected to God (belief). This patient's religiosity would likely fall within the intersection of culture, belief and practice, at the center of the Venn diagram

   b) Another Jewish patient who was raised in a Reform Jewish community (culture) and strongly identifies as Jewish. While he does not regularly attend Synagogue, keep kosher or maintain other Jewish practices, he does devoutly believe in God. This patient's religiosity probably falls within the intersection of culture and belief. Note, however, that someone that does not know this particular patient might assume that he does not believe in God, and therefore might inaccurately place him squarely in the circle of "culture" on the Venn diagram.

7) Present the example of a female patient coming to the hospital wearing a burqa.

   a) Ask participants what assumptions they might make about this patient's culture, beliefs and practice.

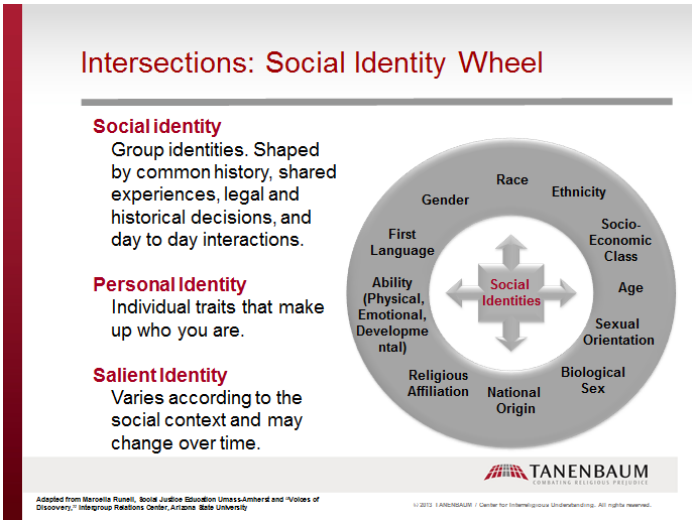
   b) Then ask participants to think through whether they can know if these assumptions are accurate.

   c) Based on responses point out or reemphasize that while one might assume that the burqa symbolizes the patient's devout Muslim belief and practice as well as her culture, in reality the patient may not actually believe in God but is simply adhering to a common cultural practice within her community.

   d) More specific to healthcare, the provider may also assume that wearing a burqa means this patient has beliefs against the use of birth control or wants medical information shared with a male relative, which may not necessarily be the case.

   e) Conclude by reinforcing the point that providers may make assumptions about a patient's religiosity based on a few details that they then analyze through their own lens.

Slide 22 – Intersections: Social Identity Wheel



Rationale: **This activity is designed to push participants to consider how their identities impact their thinking and their interactions with others. By understanding that their own identities impact their perceptions and behavior, participants will be guided to understand that this same dynamic holds true for their patients. When interacting with patients, health care providers should always ask themselves the following questions: "What identity is salient for me at the moment?", "What identity might be salient for my patient?" and "How might these salient identities influence our interactions?"**

Objectives:

At the end of this activity, health care providers should be able to:

- Define social identities, and illustrate how the salience of these identities can change depending on context.
- Understand that our identities influence our experiences.
- Illustrate how our identities shape the lens through which we view others.

Time: 30 minutes

Materials:

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- White board & markers
- **Social Identity Wheel**

Process:

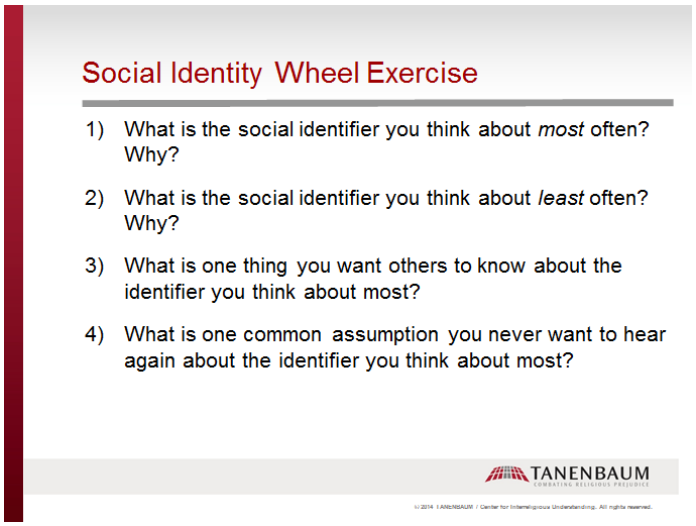
1) **Explain the three different aspects of identity** as they are listed on the slide. Use yourself as an example when illustrating each concept.

   a) **Social Identity: These are group identities that are shaped by common history, shared experiences, legal and historical decisions, and day-to-day interactions.** Refer to the social identity wheel on the right hand side of the slide to illustrate some examples of social identities. For example, the official languages in Israel are Hebrew, Arabic and English. In this context, not having one of these as a first language is a social identity.

   b) **Personal Identity: Personal identity is different from social identity in that it defines the *individual* traits that make up who you are.** One way to distinguish personal identities from social identities is that our personal identities don't generally involve discrimination or prejudice. For example, being a middle child, playing the piano, or enjoying cooking are personal identities.

   c) **Salient Identity: This is the identity that is most *meaningful* at a particular moment and place in time. It varies according to the context you find yourself in and can change from one moment to the next.** Salient identity is an "in the moment" experience, not a generalized experience. For example, gender may become salient for a physician at the moment that a patient of the opposite sex refuses to be examined by him or her due to religious/cultural concerns.

Slide 23 – Social Identity Wheel Exercise



1) Distribute the **Social Identity Wheel handout**.

2) Ask participants to break into groups of 4-5 and discuss the questions on the PowerPoint slide (that are also in the handout). Let participants know that they will have 15 minutes to discuss the questions and then return to the main group. Note that no one is required to share information that they consider private or would prefer not to share in this venue.

3) Provide a 1-minute warning for everyone to wrap up their conversations.

4) Ask participants to stop and then engage the audience in a group discussion. Ask each group to share key points from their discussion and what insights they arrived at for each question.

   a) **What is the social identifier you think about most often? Why?**

FOR EXAMPLE: Someone may most frequently think about being female because she lives alone and, based on her schedule, often walks alone at night. She is very conscious of her gender in those moments on the basis of being vulnerable in ways that men generally are not.

KEY POINT: The identities we think about most are the ones that make us feel different or vulnerable.

   b) **What is the social identifier you think about least often? Why?**

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FOR EXAMPLE: Someone who does not have a physical disability might rarely think about their status as an able-bodied person. Since most facilities and other aspects of society are designed for people without disabilities, many people without disabilities might not be conscious of this aspect of their identity.

KEY POINT: The identities we think about least are the ones that are the "norm" and provide us with power, access, safety and comfort.

c) **What is one thing you want others to know about the identifier you think about most?**

FOR EXAMPLE: Over the last several months and years, public debates have taken place about whether Islam as a religion fosters terrorism and violence and leads to the oppression of women and religious minorities. Someone who is Muslim and lives in a country where being Muslim is the minority might want others to know about how he believes and practices and about his views on various cultural and political topics so that people do not assume that the media coverage about his religion reflects how he defines his faith.

KEY POINT: Providers should engage in self-reflection and learn to identify stereotypes about their own identities and the identities of others.

d) **What is one common assumption you never want to hear again about the identifier you think about most?**

FOR EXAMPLE: In the United States, people sometimes try to show that they are not prejudiced against people of other races and ethnicities by saying that they "don't see color." However people who are from races and ethnicities that have historically been discriminated against may interpret this statement as a failure to acknowledge the continuing legacy of racism and the real challenges that they still face based on conscious and unconscious stereotypes about their race/ethnicity.

KEY POINT: It's important for health care providers to identify stereotypes in order to address potential barriers to understanding and communicating with patients as well as to minimize the potential for health disparities.

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SECTION 4 – EXAMINE

How providers' personal and professional values influence interactions with patients

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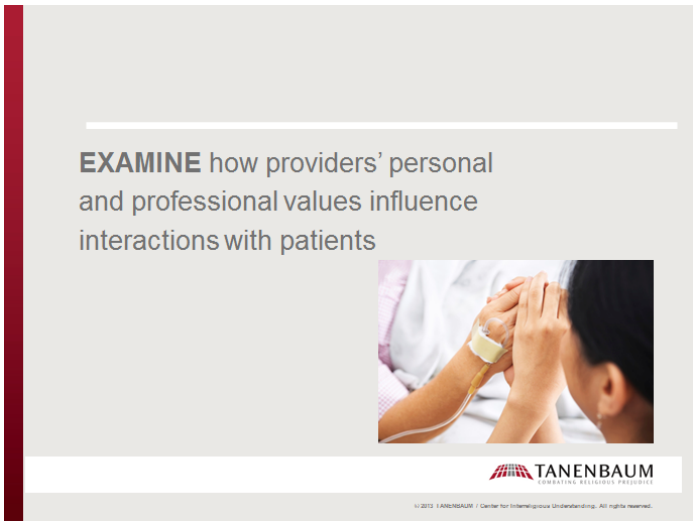
Section 4 – EXAMINE how providers' personal and professional values influence interactions with patients



Rationale: **Providers' personal and professional values can influence interactions with patients in a myriad of ways. This section will assist health care providers in learning to understand different types of personal and professional objections in the context of a health care setting, identify when provider values influence interactions with patients and develop skill sets to appropriately manage situations where these values comes into play in the care of patients.**

Objectives:

At the end of this section, providers should be able to:

- Describe how personal and professional objections to a patient's decision can emerge in a health care setting.
- Distinguish between personal preference, professional integrity and personal conscience.
- Identify recommendations and strategies for caring for patients when personal or professional values come into play.

Time: 1 hour

- 25 minutes (lecture)

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- 35 minutes (case study discussion)

Materials:

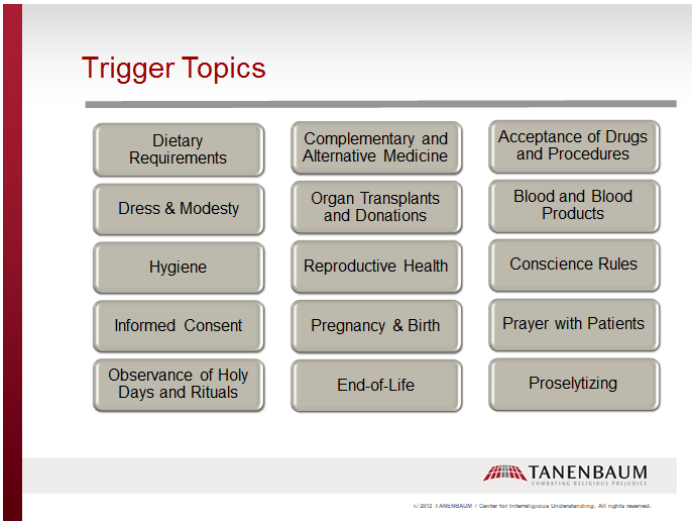
- White board & markers
- **15 Trigger Topics**
- **Provider Values**

Process:

1) Explain to participants that this section will build on the previous section's discussion of identity by focusing on specific ways in which a health care provider's personal or professional identity can impact a provider's care of patients.

2) Inform participants that this section will include a case study to help providers explore their personal and professional values and discuss how those values may impact patient care.

Slide 25 – Trigger Topics



Rationale: **The "trigger topics" are presented to participants as a simple and practical tool for identifying where and when they should be mindful of religion emerging as an issue for patients, so that they can be proactive in addressing these issues. It is impossible to learn everything there is to know about every religion, but it *is* possible to learn to recognize frequent themes within a health care setting that often trigger issues in regard to religious beliefs and/or practices.**

1) Tell participants that this list represents 15 trigger topics where religion often comes up.

2) Note that there is tremendous diversity within and between belief systems and faith traditions. Furthermore, since providers and patients all have complex social identities, just knowing what religion a patient comes from, or even knowing a great deal about that religion, is not enough to know how that patient's religiosity will become salient in a health care setting and in interactions with a health care provider.

3) Point out that given the diversity between and within faith traditions, it is neither realistic nor practical to learn everything about every religious belief or practice that one may encounter in a health care setting. However, what is possible is recognizing areas where religion often comes up, in order to know what questions to ask and be better prepared to deal with potential conflicts and challenges as they arise.

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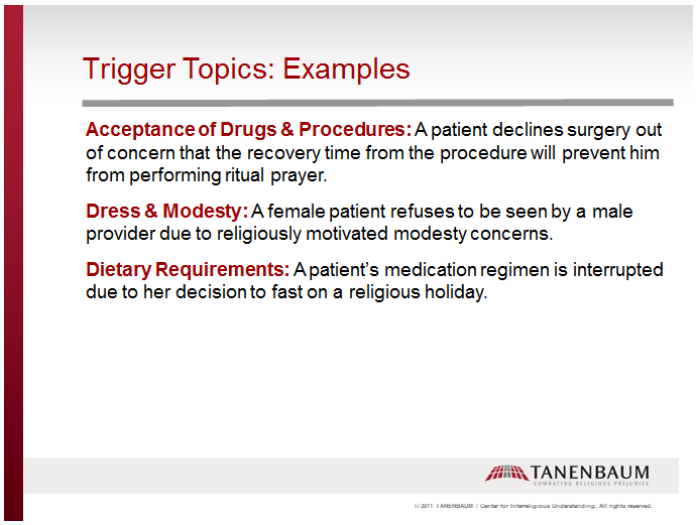
Slide 26 – Trigger Topics: Examples



1) Review the Trigger Topics examples on the screen:

   a) **Acceptance of Drugs & Procedures: A patient declines surgery out of concern that the recovery time from the procedure will prevent him from performing ritual prayer.**

   b) **Dress & Modesty: A female patient refuses to be seen by a male provider due to religiously motivated modesty concerns.**

   c) **Dietary Requirements: A patient's medication regimen is interrupted by her decision to fast on a religious holiday.**

2) Note that none of these three examples specify a particular religion. These situations could come up with patients who are Jewish, Muslim, Christian, or belong to another religious tradition. Some of the Trigger Topics may be more common for some religions than others (i.e. "Blood & Blood Products" usually comes up in reference to Jehovah's Witness patients), but in general these topics show where religion may emerge in a health care setting across religious traditions.

3) Distribute the **Trigger Topics handout.** Let participants know that this handout can be used as a reference providing the definition of each Trigger Topic. If participants ask about a specific Trigger Topic, definitions and examples are below (trainers should also feel free to use examples from their own experiences):

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a) **Dietary Requirements** – Patients may have certain religiously motivated food restrictions, such as only eating kosher or halal foods. There may also be circumstances where a patient observes a religious fast and is refusing solids, liquids or both. For example, a Jewish patients' family may be concerned as to whether the food being served in the hospital has the same type of kosher certification as the food they serve at home.

b) **Dress & Modesty –** This area may include a patient's preference regarding being examined by a same sex practitioner, the amount of physical contact they are comfortable with, certain topics they might be reluctant to discuss, and their level of comfort exposing certain parts of their body. For example, a Mormon patient is reluctant to remove her undergarments for an exam. Some Mormons wear a sacred undergarment, which is only removed for reasons of hygiene and laundering. It may be removed for medical reasons, but some patients may be hesitant to do so.

c) **Hygiene –** Patients may have certain religious requirements surrounding hygiene, such as washing before prayer or mealtimes. Certain religious denominations may also have certain requirements around grooming. For example, a Sikh patient objects to being shaved in preparation for a surgery. In the Sikh religion, uncut hair is an article of faith.

d) **Informed Consent –** Patients and/or their parents may need to consult with a third party such as a religious leader or elder before making medical decisions. For example, a Jewish mother insists on speaking to her Rabbi before consenting to a surgical procedure for her daughter.

e) **Observance of Holy Days and Rituals –** Holy days, holidays, and fast days may fall during the course of a patient's stay at the hospital or may interfere with a patient's treatment plan. For example, a Muslim patient wishes to fast for Ramadan.

f) **Traditional and Alternative Remedies –** Patients may choose to use traditional or alternative remedies instead of, or in conjunction with, their standard treatment. Patients may neglect to tell their health care provider about any alternative treatments they are seeking because they fear ridicule or judgment. For example, the parents of a young child who is diagnosed with psychosis want to have their child exorcised by a Catholic priest.

g) **Organ Transplants and Donations –** Patients and their families may have religious beliefs that influence their willingness to accept a donor organ or agree to donate an organ. For example, the family of a Japanese child who is brain dead is asked if they will agree to organ donation. They are furious at the suggestion because, according to their Shinto beliefs, interfering with a corpse brings bad luck and injures the relationship between the dead and the bereaved.

h) **Reproductive Health –** Patients and their families may have certain views on contraception, abortion, in vitro fertilization and sterilization that are grounded in religious beliefs. For example, a Catholic family is reluctant to consider birth control pills as a treatment option for their teenage daughter, who suffers from endometriosis.

i) **Pregnancy & Birth –** Patients may have religio-cultural practices or beliefs associated with pregnancy, birth, or post-partum care, such as particular foods that should be eaten or rituals to perform. For example, in some traditional Asian cultures, women spend the month after a baby's birth in seclusion. Typically, a woman's relatives would care for her but, more recently, the practice has been outsourced to postpartum doulas and confinement centers.

j) **End-of-Life –** There may be certain religious or cultural rituals that are performed right before or after death, as well as specific practices regarding handling of the body after death and preparation for burial. In addition, certain religions and denominations within those faith traditions may have differing perspectives on the definition of death. For example, a Jewish woman is pronounced brain-dead but her family refuses to withdraw care, stating that Jewish law defines death as the cessation of breath and heartbeat.

k) **Acceptance of Drugs and Procedures –** Patients may have religious objections to a particular drug or medical procedure if the treatment contains a religiously forbidden substance such as alcohol, narcotics, or other substances that conflict with dietary restrictions. There may also be objections to treatments due to conflicts with religious practices or holy days or due to conflicting perspectives as to the cause of an illness. For example, a Hmong man with brain stem herniation refuses surgery, insisting that if his lost soul is recovered he will heal.

l) **Blood and Blood Products –** Patients and their families may have religious beliefs that restrict the use of blood transfusions or other blood products. For example, the parents of a four-month-old baby girl in need of surgery due to a congenital heart defect insist that no blood transfusions be performed during surgery because they are Jehovah's Witnesses.

m) **Conscience Rules –** In certain circumstances, a health care provider may have a religious or moral objection to a medical procedure or treatment plan that a patient has requested or that is medically necessary. In other circumstances, a health care provider may have a religious or moral objection to a patient's and/or their family's refusal of a surgical procedure or treatment plan based on that patient's and/or their family's religious beliefs. For example, an Orthodox Jewish doctor objects to turning off the respirator of a patient who was brought to the emergency room comatose after she ran her car into a

tree.[20] Inform participants that this Trigger Topic will be covered in more detail in a few minutes.

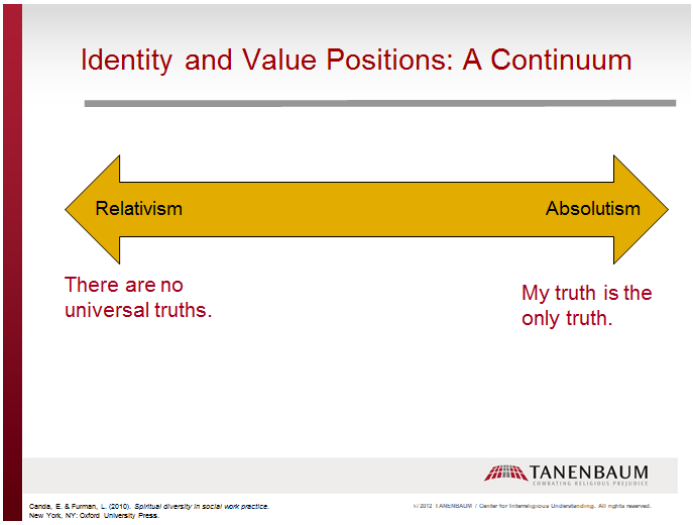
n) **Prayer with Patients –** Patients may ask their providers to pray with them as a form of support. In these circumstances, the provider must determine how they can react in a manner that is respectful to the patient and appropriate to the health care setting, and does not conflict with his/her own beliefs. For example, a Catholic patient asks a Jewish health care provider to pray with him. The provider feels uncomfortable doing so but isn't sure how to say no and still provide comfort to the patient.

o) **Proselytizing –** Inappropriate religious expression can be problematic in a health care setting. While the strict definition of proselytizing is "what occurs when one person attempts to convince another of the correctness of his/her religious beliefs," for a health care setting it is defined more broadly to encompass more subtle communications that are inappropriate in the context of a health care setting and the patient-provider relationship. For example, in the middle of drawing blood, a phlebotomist asks the patient if she has accepted Jesus Christ as her personal savior.

4) Ask participants what examples of Trigger Topics have come up in their own experience. Write examples on the white board.

[20] Rosner, F. (2005). An Observant Jewish physician working in a secular ethical society: ethical dilemmas. Israeli Medical Association Journal, 7, 53-57.

Slide 27 – Identity and Value Positions: A Continuum



1) One of the challenges to respecting cultural and religious differences in belief, practice and perspective is that, to a large extent, these are the dynamics that shape our understanding of what is right and wrong, normal and abnormal, acceptable and unacceptable, appropriate or inappropriate, professional or unprofessional, helpful or unhelpful. If health care providers fundamentally believe that something their patient chooses (for example, having an abortion), is wrong, then providers must balance their personal values with simultaneously respecting their professional and ethical obligations to the patient.

2) Challenges often arise when health care providers embrace one of two extreme perspectives:

   a) The first perspective is **relativism**, the perspective that there are no universal truths of what is right and wrong (for example, and extreme example would be that there is no universal truth that killing someone or exploiting children is wrong). This is not a practical or realistic approach because it endorses a belief that there is no universal right or wrong and health care providers, by the nature of their job, are often put in a position of determining what is moral, ethical or advisable in a medical situation. In that context, a "relativist" approach is impractical, to say the least.

   b) The second position is **absolutism** – the perspective that one's own cultural or religious views are the only correct ones (for example, someone might state that their faith and beliefs are the only beliefs that are "right.") This, again, is not a practical perspective and one that clashes with a health care professional's obligations to their patient in terms of patient autonomy. Absolutism denies patients the right to self-

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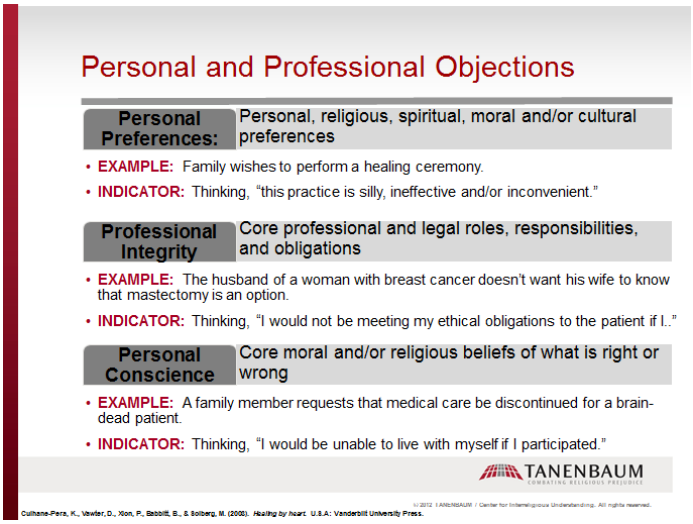
determination and promotes discrimination on the basis of what the provider believes to be right and wrong.[21]

3) Generally speaking, the most effective and ethical approach will lie somewhere between these extremes. Of course, determining what that middle ground looks like in practice is easier said than done. Inform participants that they will soon be given a case study that will help them better identify that middle ground as it relates specifically to their roles and responsibilities as health care professionals.

4) Point out to providers that where they fall on this spectrum will likely change, or has changed, throughout their careers based on age, experience, and other factors. For example, some young providers think that their perspective is the only one, and as they grow older they see the value in meeting patients where they are and delivering care that makes sense to the patient in the context of his or her culture and religion.

[21] Canda, E. & Furman, L. (2010). *Spiritual diversity in social work practice.* New York, NY: Oxford University Press.

Slide 28 – Personal and Professional Obligations



1) Explain that when providers object to patients' health care decisions, these objections can be based on a number of different personal or profession objections. In order for a provider to know what to do when they object to something a patient or family member wants them to do or not do they first need to be able to accurately identify what kind of objection they may be experiencing. Define and discuss the three terms listed on the slide:

2) **Personal preferences are defined here as personal, spiritual, religious, moral and/or cultural preferences.**

   a) FOR EXAMPLE, **a health care provider may object to a family wishing to perform a healing ceremony like an exorcism**, not because he or she has any concerns of safety or personal conscience but because he or she finds the practice ineffective, inconvenient and/or uncomfortable.

   b) INDICATOR: An indicator that a provider's objection is based on a personal preference would be an internal reaction or thought process that states, "**This practice is silly, ineffective and/or inconvenient."**

3) **Professional Integrity is defined as core professional and legal roles, responsibilities and obligations.** An objection to a patient's and/or their family's wishes based on professional integrity can be distinguished from personal preference in that it would violate the provider's ethical and professional obligations, as opposed to simply causing discomfort or inconvenience. Professional integrity is guided by a number of different factors, including hospital policy, government regulations, and ethical responsibilities (i.e., respect for patient autonomy).

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a) FOR EXAMPLE**, a physician may object to a patient's husband's request that his wife not be informed that mastectomy is an option for treating her breast cancer.** A health care provider's objection to this request could be defined as an objection based on professional integrity if he/she felt that it violated his/her ethical and professional obligations to the patient.

b) INDICATOR: An indicator that a provider's objection is based on professional integrity would be an internal reaction or thought process that states, **"I would not be meeting my ethical obligations to the patient if I…"**

4) **Personal conscience can be defined as core moral and/or religious beliefs of what is right or wrong.** Objections based on personal conscience stem from moral and/or religious beliefs rather than ethical and/or professional responsibilities.[22]

a) FOR EXAMPLE, **a physician may object to a patient's decision to terminate a pregnancy.** In this case the objection would not be based on concerns regarding safety or professionalism, but rather moral and/or religious convictions.

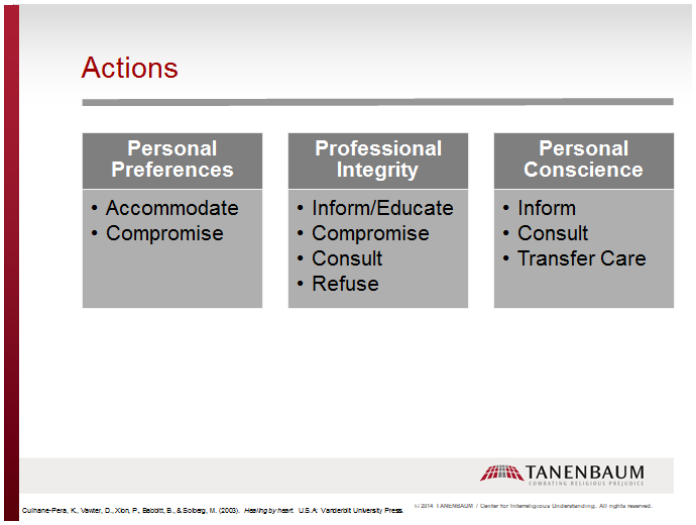
b) INDICATOR: An indicator that a provider's objection is based on a personal preference would be an internal reaction or thought process that states, **"I would be unable to live with myself if I participated."**

5) Note that in some instances a health care provider may have an objection where professional integrity and personal conscience overlap. For example, a health care provider may object to a terminally ill patient's request that measures be taken to hasten his/her death. This could conflict both with providers' professional/legal obligations and their religious/moral convictions regarding the preservation of life.

6) Once these three definitions have been reviewed, ask the audience to provide some of their own examples to test their comprehension of these three terms.

[22] Culhane-Pera, K., Vawter, D., Xion, P., Babbitt, B., & Solberg, M. (2003). *Healing by heart.* U.S.A: Vanderbilt University Press.

Slide 29 – Personal and Professional Obligations



1) Explain that this slide illustrates some of the appropriate actions that can be taken for each form of objection. Emphasize that the recommendations listed are guidelines and not absolutes.

2) If a provider's objection is based on **personal preference,** the following actions and responses are suggested:

   a) **Accommodation:** Note that if a health care provider's objection to a patient's and/or his or her family's wishes is based solely on personal preference, a good faith effort should be made to accommodate the patient's request.

   b) **Compromise:** In other instances, it may not be possible to fully accommodate the patient's request, in which case an appropriate compromise should be arranged.

FOR EXAMPLE: A patient and/or his family may ask the doctor to alter his medication regimen so that the patient can observe a fast. While it might be the provider's preference that the patient not disrupt his medication schedule, this kind of request should be accommodated if it is safe to do so.

3) If a provider's objection is based on **professional integrity,** the following actions/responses are suggested:

   a) **Inform/Educate:** Providers should *inform* the patient and/or his or her family of their objection and then provide clear information to help patients/families *understand* their objection. In addition, the patient and/or family should be given the opportunity to

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educate the provider in the religious/cultural beliefs and/or practices that are shaping their decision. This ensures that the patient's request or refusal is not due to a misunderstanding and that both patient and provider have the information necessary to make an informed decision.

b) **Compromise:** In some instances a compromise can be reached that accommodates the patient's/family's request *without* violating the health care provider's obligations to the patient.

> FOR EXAMPLE: A four-month-old infant had tricuspid atresia with severe cyanosis in need of emergent surgery. The parents, Jehovah's Witnesses, had refused to have blood administered. The surgeons said they would try to do the operation without bypass but warned the parents of the increased risks. The procedure was ultimately performed off of the bypass, though it was more difficult for the doctor. The surgery was performed without administering blood with a good outcome.[23]

a) **Consult:** Health care providers faced with a situation where their professional integrity conflicts with the request of a patient and/or family should always consult with their supervisors for guidance. In addition, bringing pastoral care and, if appropriate, the hospital ethics committee into the conversation to provide support and guidance can be helpful for both patient and provider.

b) **Refuse:** When all other avenues have been exhausted, the patient and/or family must be informed in as respectful and tactful a manner as possible that their request cannot be accommodated. While legal action should always be a last resort, it may, in rare instances, be necessary. Providers should have been in constant communication about this situation with their supervisor and should look to him or her to determine appropriate next steps.

4) If a provider's objection is based on **personal conscience,** the following actions/responses are suggested:

a) **Inform:** The first step in situations involving personal conscience should be to clearly understand the patient's/family's request. If the health care provider determines that the patient's request violates his or her personal conscience, he or she should inform their supervisor. The health care provider should make sure that the patient is aware of all of the treatment options available to him or her but should, under no circumstances, try to persuade the patient/family to select one course of treatment over another if the provider's recommendations are guided by his or her religious/moral beliefs rather than professional recommendations.

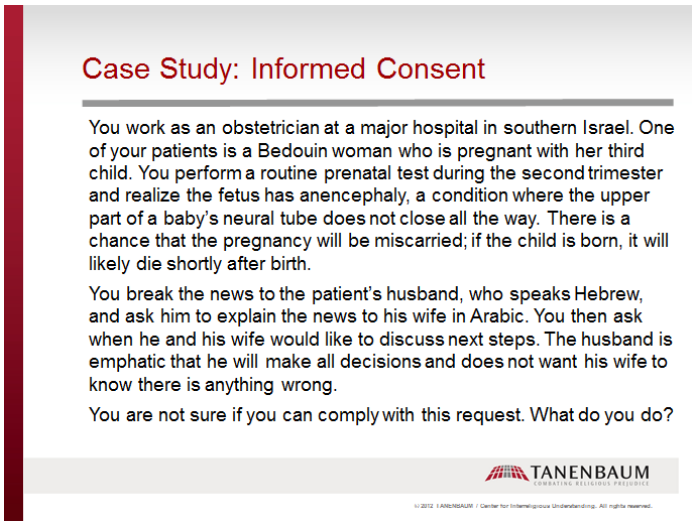
[23] Hardart, G. (2011). Cardiac Surgery for Children of Jehovah's Witnesses: Subtleties Beyond Prince v. Massachusetts – *Ethics for Lunch series* made possible by the Arnold P. Gold Foundation.

b) **Consult:** As with cases involving professional integrity, providers faced with a situation where their personal conscience conflicts with the request of a patient and/or family should immediately inform their supervisor. In addition, bringing pastoral care – and if appropriate, the hospital ethics committee – into the conversation as a source of support and/or guidance can be helpful for both patient and provider.

c) **Transfer Care:** If it is established that a genuine conflict exists between the needs/requests of the patient and the personal conscience of the provider, it is appropriate to transfer care.[24]

[24] Culhane-Pera, K., Vawter, D., Xion, P., Babbitt, B., & Solberg, M. (2003). *Healing by heart.* U.S.A: Vanderbilt University Press.

Slide 30 – Case Study: Informed Consent



Rationale: **This case will help providers put themselves in a situation where they may object to a request made by a patient or, in this instance, a family member. Targeted questions will help providers to explore the nature of their objection to this request and what appropriate next steps they could take to manage this situation. The case study will conclude with key takeaways and a helpful framework for providers to use when managing real-life situations where they object to a patient's request, decision or preference for personal or professional reasons.**

Objectives:

At the end of this activity, providers should be able to:

- Recognize encounters where a provider objects to a patient's request, decision or preference.
- Apply frameworks for managing situations where a provider objects to a patient's request, decision or preference.

Time: 35 minutes

Materials: **Provider Values**

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Process:

1) Ask participants to read the following case study:

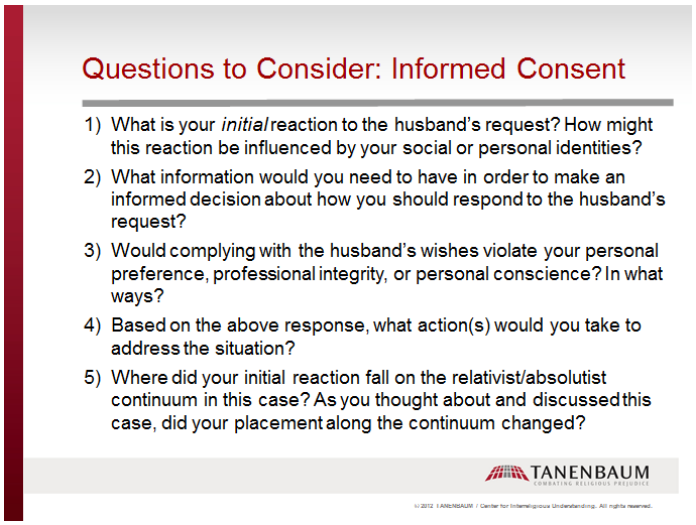
   You work as an obstetrician at a major hospital in southern Israel. One of your patients is a Bedouin woman who is pregnant with her third child. You perform a routine prenatal test during the second trimester and realize the fetus has anencephaly, a condition where the upper part of a baby's neural tube does not close all the way. There is a chance that the pregnancy will be miscarried; if the child is born, it will likely die shortly after birth.

   You break the news to the father, who speaks Hebrew, and ask him to explain the news to his wife in Arabic. You then ask when he and his wife would like to discuss next steps. The father is emphatic that he will make all decisions and does not want his wife to know there is anything wrong.

   You are not sure if you can comply with this request. What do you do?

2) Note to participants that while there is clearly an issue in the case regarding appropriate use of interpreter services, this dimension of cultural competence will not be the focus of the discussion that will follow. Ideally all patients would receive communications in their primary language, but in reality this does not always happen, especially in cases like this where one spouse already speaks the same language as the provider and the other spouse has not requested interpretation services. Rather than discussing language access, the discussion today will be on whether they would have an objection to complying with the husband's request and if so, why.

Slide 31 – Questions to Consider: Informed Consent



1) Distribute the **Provider Values handout** for participants to reference throughout the activity.

2) Ask participants to break into groups of 4-5 and respond to the following questions below. After 15 minutes, ask participants to return to the large group and ask them to share some of their answers to each question. Final points to make for each discussion question should include the points listed below.

   a) **What is your *initial* reaction to the husband's request? How might this reaction be influenced by your social and personal identities?**

   - When we first encounter cases where we have a personal or professional objection, our initial reaction is usually not as nuanced as later reactions – for example, thinking "It would be completely wrong not to tell a woman what is wrong with her baby" or "I can't believe a man would ever keep this information from his wife."

   - These types of reactions may be influenced by personal beliefs about a woman's right to know information about her own body, or professional beliefs about the importance of disclosing relevant medical information to patients.

   - Initial reactions may also be influenced by social and cultural values about the importance of individual autonomy. Some cultures stress the importance of individual decision-making and others place a greater emphasis on making

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decisions as a family or community. People who come from a culture based more on individualism may interpret family-based decision-making as failing to fully inform all individuals involved in the process.

b) **What information would you need to have in order to make an informed decision about how you should respond to the husband's request?**

- Laws or formal hospital policies that would guide next steps on these types of cases.

- Similar cases that the hospital has dealt with before that can be used as a resource or guide to determine appropriate actions.

- The wife's preferences regarding informed consent. Again, one should *ask* rather than assume. It may be that the wife has asked that medical information and/or decisions be shared only with her husband.

- The husband's motivation for not wanting to inform his wife about the fetus's birth defect. It may be that he is motivated by a desire to make all decisions for his family. However, it is also possible that he is trying to prevent his wife from experiencing suffering and anxiety. Finally, it may be that he knows that her preference is to have him make these decisions, even if this preference has not been documented by other hospital staff. Determining the husband's motivations is important before establishing next steps to manage this situation.

- The long term repercussions of disregarding the husband's wishes. The family's future relationship to the hospital may be affected by disregarding the husband's wishes entirely, potentially making it less likely that the wife returns to the hospital to receive the care she needs.

c) **Would complying with the husband's wishes violate your personal preference, professional integrity, or personal conscience? In what ways?**

- Personal preference: a provider thinks that continuing to treat the wife without her knowledge of the fetus's condition will be inconvenient as it is outside of standard practice.

- Professional integrity: a provider believes that not informing the wife of the condition of her child would violate their ethical obligations to the patient.

- Personal conscience: the provider thinks that a woman's wright to make choices about her health and the health of her child is fundamental. To that end, the provider would feel morally compelled to inform the wife as to the condition of her child.

d) **Based on the above response, what action(s) would you take to address the situation?**

- If a provider objects to this request based on personal preference, he or she could simply accommodate the request or come up with a compromise (i.e. letting the husband know that you agree to accommodate the request unless it begins to pose substantive logistical challenges in how you treat the wife).

- If the provider objects to this request based on professional integrity, he or she could inform the husband that this request will not be honored and why, while giving the husband the chance to educate the provider as to why he made this request in the first place. The provider could also come up with a compromise (i.e. agreeing to honor the husband's request this time but letting him know that in the future the wife will be asked in advance whether she wants to be informed of all health updates). The provider could also consult with a supervisor, ethics committee or consult, or religious leader. Finally, the provider could refuse to accommodate this request and inform the husband of this refusal in a tactful and respectful way, perhaps by engaging a religious or community leader to learn more about how to communicate this refusal respectfully.

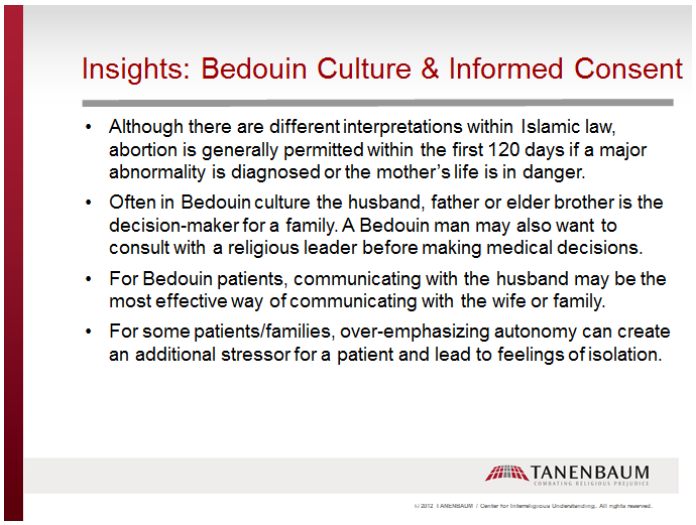
- If the provider objects to this request based on personal conscience, he or she could inform a supervisor about this objection and consult with a religious leader, pastoral care (if the hospital has someone) and the hospital ethics committee to help support the family and provide guidance to the clinician. Based on these conversations, a provider could either transfer care to another provider who is comfortable carrying out the husband's wishes or, if the provider's supervisor and other consultants think it is advisable to do so on professional grounds, inform the wife of the fetus's prognosis even though it goes against the husband's wishes.

e) **Where did your initial reaction fall on the relativist/absolutist continuum in this case? As you thought about and discussed this case, did your placement along the continuum change?**

- When we first encounter cases where we have a personal or professional objection, our initial reactions often fall more on the absolutist end of the spectrum because these reactions are guided by our own personal and social values. Healthcare providers, however, have an obligation to prioritize the values of the patient and

family when making decisions and offering recommendations. This is why it is so important for the provider to reflect on and fully understand their own values as well as those of their patient and/or the patient's family. With this knowledge base, it is possible to adopt a position more towards the middle of the spectrum between absolutism and relativism, where providers are still guided by their sense of right and wrong but can also acknowledge the validity of the patient's point of view and incorporate both into developing a treatment plan.

Slide 32 – Insights: Bedouin Culture & Informed Consent



1) Go over the following insights into Bedouin culture and informed consent and how they relate to this case:

   a) **Although there are different interpretations within Islamic law, abortion is generally permitted within the first 40 days if the pregnancy was caused by rape, and within the first 120 days if a major abnormality is diagnosed.**[25] Although this case is about whether to honor the husband's request that his wife not be informed of their baby's condition, rather than the ethics of terminating a pregnancy, it may be helpful to have some background on what further concerns the husband is weighing upon hearing the news about his baby's condition. Since the majority of Bedouins are Sunni Muslims, understanding what Islamic law has to say about terminating a pregnancy may be helpful background information to have.

   b) **Often in Bedouin culture the husband, father or elder brother is the decision-maker. A Bedouin man may also want to consult with a religious leader before making medical decisions.** Knowing who a family wants as the decision-maker, and whether there are any people outside of the family who may need to be consulted, is an important part of communicating with patients.

[25] Sanctity of Life. (2009, September 7). Retrieved April 2, 2015, from http://www.bbc.co.uk/religion/religions/islam/islamethics/abortion_1.shtml

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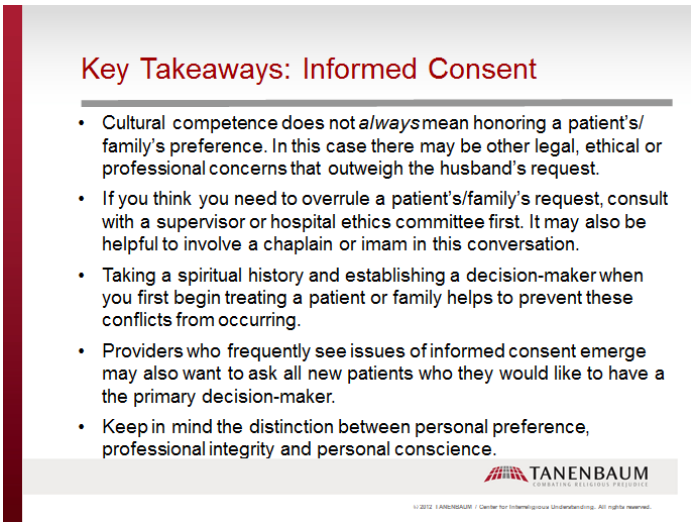
c) **For Bedouin patients, communicating with the husband may be the most effective way of communicating with the wife or family.** In some cases the wife really may want decisions to be made through the husband, or the husband may be more willing to seek medical treatment for his wife if he knows his preferences are honored. Since there may be instances where communicating through the husband leads to higher quality patient care, a provider's wish to override the husband's preference should only be considered if the provider truly believes that this is in the wife's best interest.

d) **For some patients/families, over-emphasizing autonomy can create an additional stressor for a patient and lead to feelings of isolation.**[26] Clinicians may think they are providing respectful and ethical care by consistently asking a patient to make treatment decisions, but for some patients this may lead to feelings of stress or isolation, especially if patients are from cultures or religions that emphasize shared decision-making or do not identify the patient as a decision-maker.

[26] Fu-Chang Tsai, D. (2008). Personhood and Autonomy in Multicultural Health Care Settings. *Virtual Mentor, 10*(3), 171-176.

Slide 33 – Key Takeaways: Informed Consent



1) Review the following recommendations with participants and highlight where the recommendations intersect with the appropriate "actions" outlined on their **Provider Values handout**:

   a) **Cultural competence does not always mean honoring a patient's/family's preference. In this case there may be other legal, ethical or professional concerns that outweigh the husband's request.** Note that one of the appropriate action steps for violations of professional integrity is to *refuse* a request. For example, in the United States an adult Jehovah's Witness can decide against a life-saving blood transfusion, but a hospital has the right to intervene if Jehovah's Witness parents *refuse* a life-saving blood transfusion on behalf of their child.[27]

   In this case, there is an ethical concern regarding not informing the wife about her child's birth defect because she is not being allowed to make a decision (or voice her preference as to who the appropriate decision-maker should be). Therefore, a translator should be brought in to establish what information the wife wants to know and who she wants the decision-maker to be. If she wants her husband to make all further medical decisions, then that preference should be honored—but the provider should not accept

[27] Talati, E. (2012, September 11). Pushing the boundaries: revisiting transfusion of blood products in the children of Jehovah's Witnesses [Web log post]. Retrieved from http://blogs.law.harvard.edu/billofhealth/2012/09/11/pushing-the-boundaries-revisiting-transfusion-of-blood-products-in-the-children-of-jehovahs-witnesses/.

the husband's statement about what is best for his wife without *educating* themselves as to their patient's wishes. This action highlights two additional possible actions for violations related to professional integrity – being *educated/informed* as to the patient's wishes and *compromising* where possible.

b) **If you think you need to overrule a patient's/family's request, *consult*** (another action step linked to addressing potential violations of professional integrity) **with a supervisor or hospital ethics committee first. It may also be helpful to involve a chaplain or imam in this conversation**. Deciding to overrule a patient's or family's preference should not be done in isolation, especially since these issues are usually ones where a provider's values and beliefs play a strong role. Consulting with colleagues, ethics professionals and faith leaders also ensures that decisions are not being made solely because of the provider's beliefs or values as separate from their clinical judgment.

   It may also be helpful to *consult* with a chaplain or religious leader like an imam, both to offer insight on the issues the patient/family may be weighing in this situation, and to strategize about the most respectful and sensitive way to inform the patient/family that their request cannot be honored.

c) **Taking a spiritual history and establishing a decision-maker when you first begin treating a patient or family helps to prevent these conflicts from occurring.** The more a provider *educates* themselves as to their patients' preferences before a medical emergency occurs, the more prepared the provider will be if an emergency happens.

d) **Providers who frequently see issues of informed consent emerge may also want to ask all new patients who they would like to have as the primary decision-maker** and who they would like to be informed/participate in medical decisions.

e) **Keep in mind the distinction between personal preference, professional integrity and personal conscience.** As was previously discussed, each of these objections has different appropriate action steps. Identifying which objection you're experiencing helps to determine what steps to take.

SECTION 5 – APPLY

Communication skills for respectfully interacting with diverse patients about religion

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Section 5 – APPLY communication skills for respectfully interacting with diverse patients around religion.

Rationale: **This section will provide communication skills around respectfully interacting with diverse patients around religion. Religion is a very sensitive topic that many of us are taught to avoid discussing. Health care providers may falsely believe that they can make assumptions about how a patient's religion will influence their care based on the patient's appearance or previous experiences with patients of the same tradition. Other care providers may falsely assume that a patient will bring up any concerns they have based on religion and that it is therefore unnecessary to ask questions. The reality is that asking respectful questions is the only way to reliably determine if a patient and/or their family has concerns about their religious beliefs as it relates to their health care and, if so, how best to address this. To that end, it is important for providers to have the skill sets to respectfully obtain relevant information from patients about their religious beliefs as it affects their health care. This section will provide participants with communication skill sets and guidelines and give them the opportunity to practice those skill sets.**

Objectives:

At the end of this section, health care providers should be able to:

- Describe why spiritual histories are an essential piece of patient-provider interactions.
- Differentiate between spiritual screens, spiritual histories, and spiritual assessments.

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- Understand where and when spiritual histories are appropriate and useful.
- Ask questions in a manner that is respectful and will facilitate trust and openness on the part of the patient.
- Identify what to do with spiritual and cultural information once it has been obtained.

Time: 1 hour and 5 minutes

- 20 minutes (lecture)
- 25 minutes (role play activity)
- 20 minutes (role play activity)

Materials:

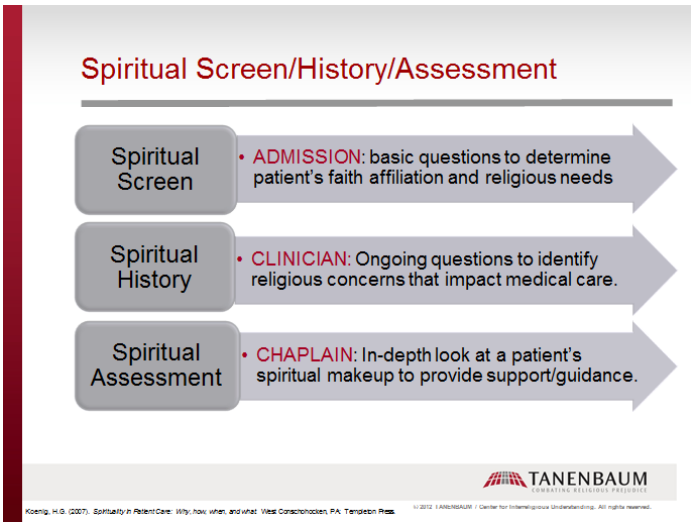
- **Spiritual Histories: How do I ask?**
- **Jewish Patient: You Are the Patient**
- **Jewish Patient: You Are the Provider**
- **Muslim Patient: You Are the Patient**
- **Muslim Patient: You are the Provider**

Process:

1) Tell participants that the next section will provide some practical tools and guidelines for respectfully communicating with patients about their beliefs and practices and more effectively incorporating them into their care.

2) Note that at the end of this section they will have the opportunity to practice the skills being presented through a role play exercise.

Slide 35 – Spiritual Screen/History/Assessment



1) Begin by explaining that each of these three different terms represents a different format for questioning patients and families around their religious beliefs/practices. These three pieces are meant to build upon one another. Additionally, each format has very different objectives and is often carried out by different members of the health care team. Point out that the spiritual history will primarily be what doctors and nurses are responsible for.[28]

2) The first step to uncovering how a patient's religious beliefs/practices might impact their care is what is sometimes called a "spiritual screen**." A spiritual screen generally includes a very basic initial series of questions that can be covered during admissions on an intake form:**

   a) Ascertain a patient's religious affiliation or belief system;

   b) Determine whether the patient is a member of a faith community; and

   c) Determine what, if any, immediate religious concerns the patient and/or his or her family has about his or her care.

3) A spiritual screen will provide an introductory snapshot of the importance of the patient's religious beliefs in his or her health care. This very basic information should be obtained

[28] Koenig, H.G. (2007). *Spirituality in Patient Care: Why, how, when, and what.* West Conschohocken, PA: Templeton Press.

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from every patient during admission. However, if it is not, this gap in knowledge can be quickly filled while a physician obtains a social history.

4) The information obtained during a spiritual screen should be confirmed by the physician and then used to continue the conversation as needed throughout the care of the patient. This conversation is referred to as a spiritual history**. A spiritual history should be taken from every patient.** Emphasize that a spiritual history need not be (and often *will* not be) one singular conversation with a patient, but can and should be an ongoing dialogue between patient/family and provider.

5) Emphasize that the experience of a spiritual history may vary drastically from patient to patient and family to family. Some patients and families may have a number of concerns that will need to be continuously revisited during the course of their care. For others, the topic of religion may not be salient or relevant at all and will rarely, if ever, come up again.

6) The last term listed on the slide – a spiritual assessment – should be clearly distinguished from the objectives and format of a spiritual history. While a spiritual history is a tool used by *clinicians* to determine if a patient has religious or cultural concerns related to their medical care, **a spiritual assessment is a tool used mostly by *chaplains* to assist patients and families with spiritual crises and explore how to effectively provide spiritual support and guidance.** While practitioners should learn to identify when a patient and/or his or her family is in need of pastoral support, it is *not* appropriate to their role to conduct a spiritual assessment.

7) While a spiritual screen and spiritual history should be conducted with *every* patient, a spiritual assessment should only be taken if the patient requests it or if a physician or health care provider determines, based on the spiritual history, that it is necessary due to concerns about spiritual distress, etc.

[Note to Facilitator: The following slide will review areas where doctors are encouraged to ask more detailed and specific questions, as needed.]

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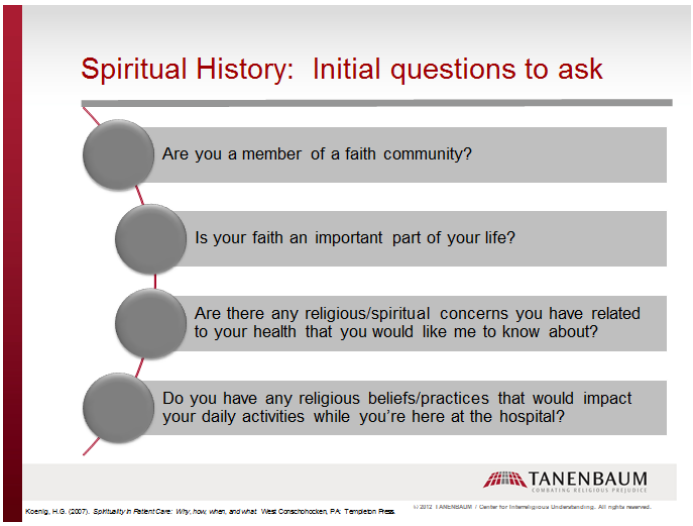
Slide 36 – Spiritual History: Initial questions to ask



1) Before asking questions about spirituality, physicians should always explain *why* they are asking these particular questions. Inquiries about religious beliefs and practices may make some patients and families extremely anxious because they are only familiar with this subject being broached at the end-of-life. Also, many patients are not used to being asked about their religious and/or spiritual beliefs in a medical context. Other patients may become concerned that these questions are being asked as a form of discrimination. Questions should always be put in the appropriate context before proceeding with a spiritual screen or history. Patients should be reassured that these questions are asked of *every* patient.

> FOR EXAMPLE: You might say: "I wanted to ask you a few questions about your religious beliefs. We ask these questions of all our patients to see if there are any beliefs or practices that might become important when we discuss your treatment plan or to find out if you might need any accommodations during your stay at the hospital."

2) Tell participants that these questions can be used as a broad initial assessment to establish whether a patient identifies with a particular faith tradition and if they have any immediate concerns regarding those beliefs in relation to their health care.

3) Present the four questions on the screen, emphasizing that these are just examples of how these questions could be formulated. What is most important is that any questions should

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be open-ended and allow patients and families to honestly express their concerns or wishes regarding the intersection of their faith and their health care.[29]

a) **Are you a member of a faith community?** This question provides a general picture of whether the patient and/or their family is religious and if so, what faith community, if any, they belong to.

b) **Is your faith an important part of your life?** Gives an *initial* measure (which will need to be reevaluated periodically) of how much their religious/spiritual beliefs might impact their care.

c) **Are there any religious/spiritual concerns you have related to your health that you would like me to know about?** This question provides a broad opening for patients to discuss any concerns they have regarding their religious beliefs, as they pertain to their health. It lets patients and/or their families know that religious and/or spiritual concerns can be openly shared with their physician.

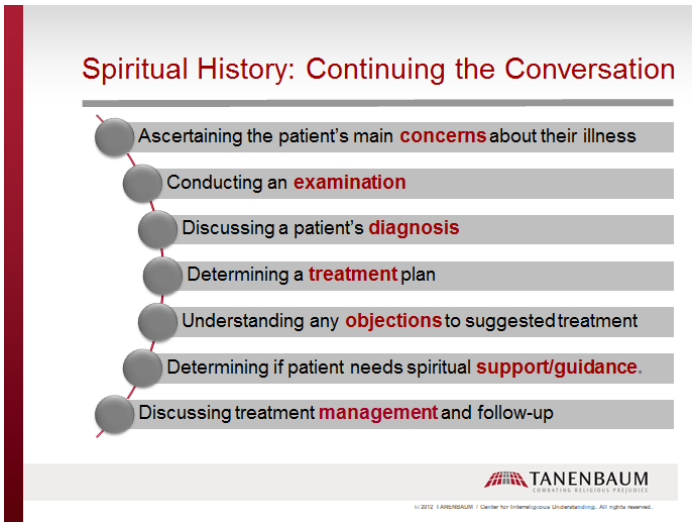
d) **Are there any religious beliefs/practices that would impact your daily activities while you're here at the hospital?** This question pinpoints any immediate religious concerns patients and/or their families may have regarding a hospital stay. It allows patients and/or their families to share whether they have any religious concerns related to Activities of Daily Living (ADL) such as prayer, dietary needs, or observance of Holy Days.

4) Point out that the responses to these questions will offer some initial insights into what "trigger topics" practitioners might need to explore further. Caution participants against jumping to conclusions based on the responses to these initial questions. Remind participants of the distinction between generalizations (used to guide further exploration) and stereotypes (fixed thinking that doesn't move beyond initial assumptions).

5) Mention that physicians should be mindful that the family members of a patient may not identify with the same religious tradition. Sometimes follow-up questions may need to be asked of the patient's family, especially if the family ends up needing to make medical decisions on behalf of the patient (for example, if the patient becomes comatose). Providers should not just assume that the answers given by the patient will apply to the family as well.

[29] Koenig, H.G. (2007). *Spirituality in Patient Care: Why, how, when, and what.* West Conschohocken, PA: Templeton Press

Slide 37 – Spiritual History: Continuing the Conversation



1) Emphasize that the questions laid out in the previous slide are only the beginning. As a patient's care progresses, physicians need to revisit that initial information. The slide lists some areas where additional questions regarding religion and spirituality may be necessary.

   a) **Ascertaining the patient's main concerns:** You may find that your patient's fears and concerns about his or her illness or condition are very different from your own.

FOR EXAMPLE: When treating a Jehovah's Witness whose parents refuse to allow blood transfusions, your main concern may be that blood loss will result in death. The greatest concern for the family might be that by allowing, or being compelled to allow, a blood transfusion, they are forfeiting the eternal life of their child. While this will not (and should not) necessarily change the medical decisions that are made about the child's care, it may help in better understanding the motivations of the parents.

   b) **Conducting an examination:** Patients may have specific religious and/or cultural concerns related to dress and/or modesty. In many cases, very simple steps can be taken to make patients and/or their families more comfortable. A spiritual history will also help to determine how a patient/family defines respectful and appropriate interactions. This is another area of patient-doctor interaction that can vary widely depending on cultural and religious beliefs. Establishing what the patient views as

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respectful interactions can make for a less stressful and more successful patient-provider encounter.

> FOR EXAMPLE: If a patient is uncomfortable with the gowns provided because they violate religious beliefs regarding modesty and dress, then a more modest gown can be provided, and more careful and conservative draping can be practiced during the exam.

c) **Discussing a patient's diagnosis:** As previously discussed, asking about a patient's religious beliefs and practices when determining a diagnosis can potentially provide information that is vital to accurately determining the cause of an illness, or better understanding its manifestations.

> FOR EXAMPLE: David, a 13-year-old Orthodox Jewish boy, washes his hands upwards of twenty times a day because he fears that his hands are not clean enough to learn Torah or say a blessing and that he's not washing his hands "right." Many Orthodox Jews have very specific practices regarding the washing of hands before prayer and before eating. An awareness of religious beliefs and practices will better allow the doctor to distinguish between religious practice and compulsive behavior, and navigate situations where those two elements intersect.[30]

d) **Determining a treatment plan:** An understanding of the patient's religious beliefs and practices can be invaluable to successfully establishing a treatment plan with which the patient and/or their family will comply.

> FOR EXAMPLE: Some Muslim patients may not want to use a pump for chemotherapy because having a continuous infusion pump prevents them from performing the ablutions necessary for prayer. Understanding this concern can help providers develop a treatment plan that does not include a continuous infusion pump.

e) **Understanding any objections to suggested treatment:** A spiritual history explores a patient's and family's understanding of his or her illness, how the illness is impacting his or her life, and what types of treatment the patient wants/is expecting. This insight into the patient's worldview is very important to understanding any objections a patient and/or his or her family may have regarding suggested treatment plans.

> FOR EXAMPLE: A Jehovah's Witness may refuse a blood transfusion for his or her child.

f) **Determining if the patient needs spiritual support/guidance:** Faith can be a source of comfort and guidance for many (but not all) patients and/or their families

[30] Boncheck, A. (2004). Is OCD a Jewish disease? Jewish Action, Winter, 5765.

when they are suffering from an illness or caring for a loved one who is ill. Providing appropriate resources for those patients who seek spiritual support is one key aspect of patient-centered care.

FOR EXAMPLE: A family may wish to have a quiet space to pray and/or consult with their spiritual leader when making difficult decisions about the care of a loved one.

g) **Discussing treatment management and follow-up:** The religious beliefs and practices of patients can also be important when discussing a plan for managing an illness or organizing follow-up treatments. Highlight that this is the area where a practitioner would determine if a spiritual assessment would be appropriate for the patient and/or his or her family.

FOR EXAMPLE: A patient being treated for diabetes may wish to discuss if and how he or she could fast in observance of religious holidays such as Yom Kippur or Ramadan.

FOR EXAMPLE: An eight-year-old Muslim girl with an imperforate anus was admitted to the hospital for a closure of her colostomy and an ileoanal pull through to create an anus. Part of the post-operative care for this surgery involves dilating the rectum with a metal dilator twice each day for two months to ensure patency and to prevent obstruction. The father (who had flown in from abroad with his daughter) resisted and refused to learn how to perform the procedure. His religious beliefs made him especially uncomfortable with the procedure and, due to his cultural background, he was unfamiliar with taking on the role of caregiver, usually left to women. He was also uncomfortable with the all-female staff that was trying to teach him the procedure. A male surgeon, with a male Muslim physician as translator, was able to explain the rationale for the procedure and the consequences for not doing it. The father ultimately agreed to learn the procedure so that he could instruct his wife to do it when he returned home.[31]

[31] Rundle, A., Carvalho, M., & Robinson, M. (2002). *Cultural competence in health care: A practical guide.* San Francisco, CA: John Wiley & Sons, Inc.

Slide 38-39 – How should I ask?

1) Review the list of sample questions provided in the following two slides. These samples illustrate what questions might be useful to include in a spiritual history and how they could be formulated. Emphasize that these are merely examples and that practitioners should customize these questions in a way that works for them and is relevant to the individual patients and families that they are seeing.

2) Distribute the **Spiritual Histories handout** as a reference for care providers.

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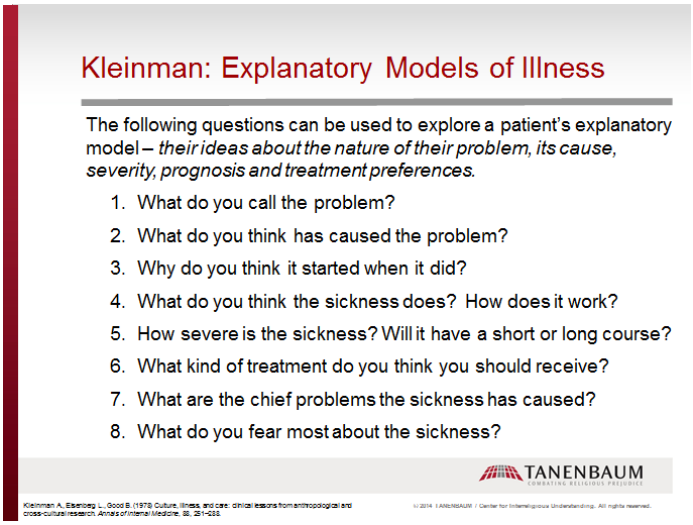
Slide 40 – Kleinman: Explanatory Models of Illness



1) The first step to take in discussing religion, spirituality or culture with a patient and/or their family is to ask the question, do we understand each other? The provider should consider whether their understanding of the issues, the illness, the treatment, the fears, and the problems are the same as the understanding the patient has. When it comes to different religions and cultures, that answer is often "no."

2) The Kleinman model is designed to identify and unpack differences in perspective between patient and provider regarding an illness/injury. It was developed by Arthur Kleinman, a prominent American psychiatrist and medical anthropologist. The questionnaire includes 8 questions (listed on the slide) to aid health care professionals in better understanding how a patient views his or her health issue, how to effectively diagnose a patient, and how to establish trust and develop a treatment plan that the patient and/or family is comfortable with and may be more inclined to adhere to.[32] The questions are:

    a) **What do you call the problem?** A health care provider and patient may have a similar understanding of a health issue, but call it a different name. It is important to be able to identify the culture-specific language your patient and/or their family use in describing their concerns. This is similar to describing medical conditions in layman's terms so that those without a medical background understand – for example, referring to gastroenteritis as the stomach flu.

[32] Kleinman A., Eisenberg L., Good B. (1978) Culture, illness, and care: clinical lessons from anthropological and cross-cultural research. *Annals of Internal Medicine,* 88, 251–288.

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FOR EXAMPLE: A 4 year old child was in an automobile accident. She recovered physically but her family believed that she was suffering from "espanto" or "fear" due to the trauma from the accident. A mental health professional may refer to this as "post-traumatic stress disorder (PTSD)."

b) **What do you think has caused the problem?** Understanding what the patient thinks has caused a medical issue is an important step in identifying what their main concerns are and how they think the issue may be resolved. This in turn helps providers to develop a treatment plan and identify if spiritual support should be a part of the patient's treatment.

FOR EXAMPLE: A patient may believe that they have cancer because God is punishing them. A provider may see this as a biological phenomenon that is simply random "bad luck."

c) **Why do you think it started when it did?** Asking patients or families about why they think a medical condition started helps identify different understandings patient and provider may have as to a primary "event" or circumstance that may have led to the problem.

FOR EXAMPLE: The Hmong family of a 18 month old girl with epilepsy believe that her condition started because her soul was frightened out of her body when her sister slammed a door very loudly. The souls of young children are seen as very fragile at that age.[33]

d) **What do you think the sickness does? How does it work?** This question uncovers any misunderstandings or differences of opinion between provider and patient/family as to how an illness or condition operates.

FOR EXAMPLE: A patient may believe that schizophrenia is caused by spirit possession while a physician will focus on the neurological/genetic causes in terms of their understanding of this illness.

e) **How severe is the sickness? Will it have a short or long course?** This questions helps the physician establish whether the patient thinks of a condition as a curable or chronic condition. Knowing this can help a physician to correct any misperceptions and work with a patient to establish realistic goals for care.

FOR EXAMPLE: A patient may believe that diabetes can be cured while a physician's

[33] Fadiman, A. (1997). *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures*. New York: Farrar, Straus, and Giroux.

understanding is that diabetes is a chronic condition that requires ongoing treatment and management.

f) **What kind of treatment do you think you should receive?** Knowing the care a patient thinks would be beneficial or appropriate can help a provider to establish a treatment plan that includes the patient's preferred care and provide a starting place for a provider to demonstrate what care they think the patient should receive and why.

FOR EXAMPLE: Pentecostal patients may believe that prayer is the best course of action to cure cancer while their physician will advocate for chemotherapy and surgery.

g) **What are the chief problems the sickness has caused?** Medical conditions may create specific problems for people from certain religious/cultural backgrounds that their providers are unaware of. The chief "problems" or concerns for a patient may be distinct from what a health care provider might imagine them to be.

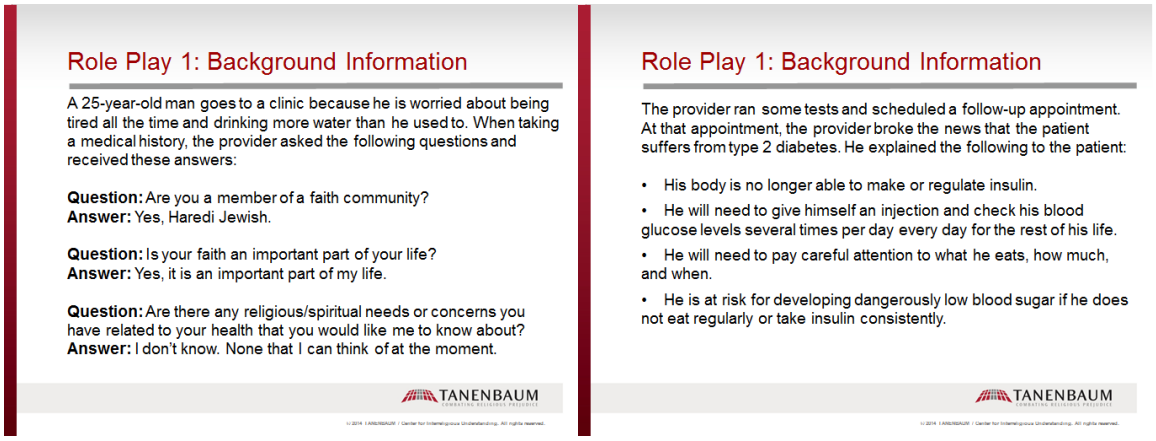
FOR EXAMPLE: An imam tore his medial meniscus (knee injury). His physician doesn't initially think that surgery to repair is worth the risk and recovery process, due to his age. However the imam explains "five times a day I have to kneel for prayer." When the physician asks "is there a possibility of sitting in a chair rather than kneeling?" the imam says "But I am imam. I must set example."[34]

h) **What do you fear most about the sickness?** This question will help identify the patient's main fears which may be very different from the provider's primary fears for the patient. Having a discussion with the patient about primary concerns provides an opportunity to discuss areas where these fears are different and develop a treatment plan that is consistent with the patient's goals for care.

FOR EXAMPLE: Generally physicians are trained to see death as the worst possible outcome of an illness. A Jehovah's Witness on the other hand may see risking their eternal life by accepting a blood transfusion as their greatest fear.

[34] Danielle Ofri – Medicine in Translation

Slide 41-42 – Role Play 1: Background Information



Rationale: **This process will give health care providers the opportunity to translate theory into practice and identify and discuss difficulties that they encounter communicating with patients and families about religious and cultural issues. The role play portion of the exercise will also drive home the fact that this is not an easy conversation. Having participants struggle with their initial attempts is an intentional piece of this exercise because it highlights an area of patient-provider interactions that they will need to practice over time in order to gain a certain comfort level.**

Objectives:

At the end of this activity, health care providers should be able to:

- Understand how to use the skill sets introduced for taking a spiritual history in their communications with patients.
- Identify their comfort level in communicating with patients about their religious beliefs as it relates to their care.

Time: 25 minutes (role play and discussion)

Materials:

- **Spiritual Histories: How Do I Ask?**
- **Jewish Patient: You Are the Patient**
- **Jewish Patient: You Are the Provider**

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Process:

1) Explain to participants that they will be practicing the skills that have been just reviewed through a role play exercise.

2) Review the role play background information that is on the screen:

A 25-year-old man goes to a clinic because he is worried about being tired all the time and drinking more water than he used to. When taking a medical history, the doctor asks the following questions and receives these answers:

- **Question: Are you a member of a faith community?**
- **Answer: Yes, Haredi Jewish.**

- **Question: Is your faith an important part of your life?**
- **Answer: Yes, it is an important part of my life.**

- **Question: Are there any religious/spiritual needs or concerns you have related to your health that you would like me to know about?**
- **Answer: I don't know. None that I can think of at the moment.**

The doctor runs some tests and schedules a follow-up appointment. At that appointment, the doctor breaks the news that the patient suffers from type 2 diabetes. He explains the following to his patient:

- **His body is no longer able to make or regulate insulin.**
- **He will need to give himself an injection and check his blood glucose levels several times per day every day for the rest of his life.**
- **He will need to pay careful attention to what he eats, how much and when.**
- **He is at risk for developing dangerously low blood sugar levels if he does not eat regularly or take insulin consistently.**

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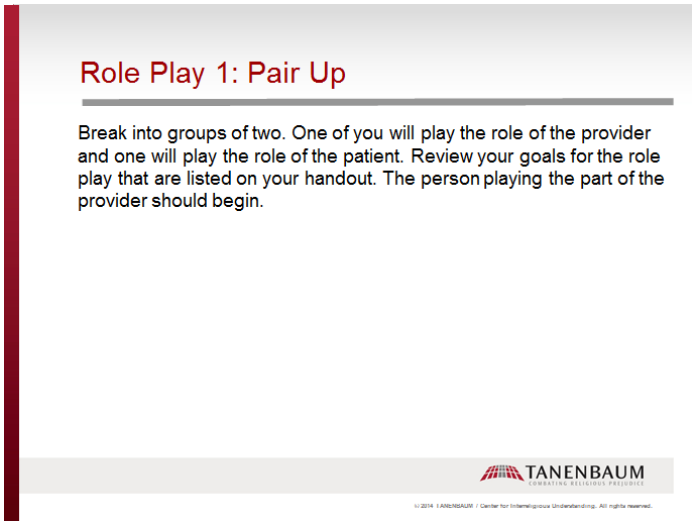
Slide 43 – Role Play 1: Pair Up



1) Ask the participants to break into groups of two. The person with the longer hair will be the provider. The person with the shorter hair will be the patient. Give the "providers" the **You Are the Provider handout** for the Jewish patient. Give the "patients" the **You Are the Patient handout**. **Give them a few minutes to review and ask questions.**

2) Emphasize to both groups not to share their role play "scenario" with the other group.

3) Inform participants that they will have 10 minutes to conduct a spiritual history and ask the participant playing the physician to begin using the instructions listed on the handout.

4) Walk around the room as these role plays are played out to get an idea of what is being said.

5) Provide a 1-minute warning for everyone to wrap up their conversations.

6) Ask participants to stop and then engage the audience in a group discussion.

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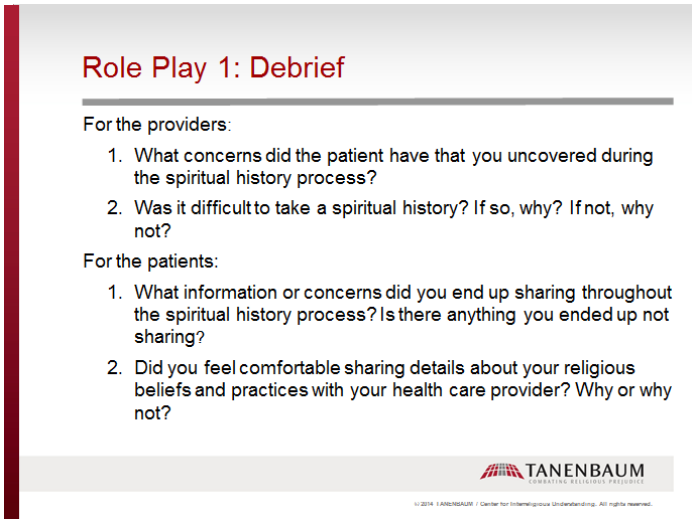
Slide 44 – Role Play 1: Debrief



1) Debrief the role play by asking the following questions:

   a) **For the providers:**

      - **What concerns did the patient have that you uncovered during the spiritual history process?**

      - **Was it difficult to take a spiritual history? If so, why? If not, why not?**

   b) **For the patients:**

      - **What information or concerns did you end up sharing throughout the spiritual history process? Is there anything you ended up not sharing?**

      - **Did you feel comfortable sharing details about your religious beliefs or practices with your health care provider? Why or why not?**

2) Be sure to draw out the following points from the discussion:

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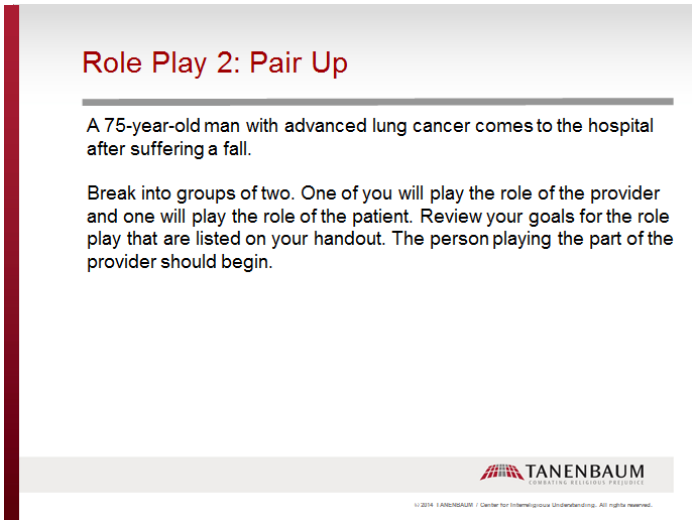
a) Patients may or may not be comfortable addressing religious concerns they have because they are worried that their concerns will be dismissed or even ridiculed. The more available the doctor makes himself or herself to the patient, the more willing the patient might be to share important information.

b) Like any skill, discussing religious concerns with a patient takes time to acquire. Clinicians should not expect this to immediately be a comfortable or easy process.

c) There is no one way to have these conversations. The most important thing is that the provider open the door for the patient and/or their family to ask questions and share information.

Slide 45 – Role Play 2: Background Information/Pair Up



Rationale: **This exercise will give participants a second opportunity to practice the guidelines and skill sets just reviewed. In this role play, less information is given to the provider at the beginning, so participants will need to ask a more robust set of questions to reveal the patient's religious concerns and begin developing a plan to address them. The second role play will also give participants the chance to switch roles (the people who were "patients" in the previous role play can now be "providers," and vice versa), helping participants to understand the spiritual history experience from both the patient and provider points of view and identify challenges around having these conversations in either role.**

Objectives:

At the end of this activity, health care providers should be able to:

- Understand how to use the skill sets introduced for taking a spiritual history in their communications with patients.
- Identify their comfort level in communicating with patients about their religious beliefs as it relates to their care.

Time: 20 minutes (role play and discussion)

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Materials:

- **Spiritual History: How Do I Ask?**
- **Muslim Patient: You Are the Patient**
- **Muslim Patient: You Are the Provider**

Process:

1) Explain to participants that they will now have a second opportunity to practice their spiritual history skills. This role play provides less information up front and may therefore be more challenging than the previous one. The role play will also give participants the chance to play the opposite role, therefore develop a sense of what the spiritual history process is like from both the patient and provider perspective.

2) Review the role play background information that is on the screen:

   A 75-year-old man with advanced lung cancer comes to the hospital after suffering a fall.

3) Ask the participants to break into groups of two. The person who previously played the provider will now play the patient and vice versa. Give the "providers" the **You Are the Provider handout** for the Muslim patient. Give the "patients" the **You Are the Patient handout**. Give them a few minutes to review and ask questions.

4) Emphasize that participants should not share the information on their handouts with their partners.

5) Inform participants that they will have 10 minutes to conduct a spiritual history and ask the participant playing the physician to begin using the instructions listed on the handout.

6) Walk around the room as these role plays are played out to get an idea of what is being said.

7) Provide a 1-minute warning for everyone to wrap up their conversations.

8) Ask participants to stop and then engage the audience in a group discussion.

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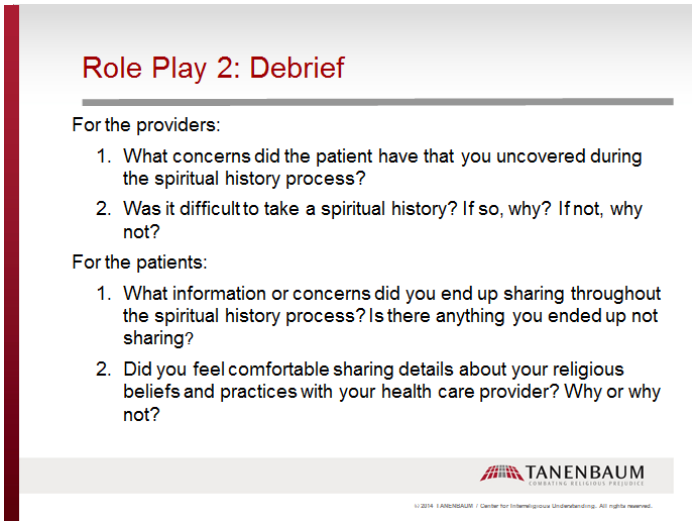
Slide 46 – Role Play 2: Debrief



1) Debrief the role play by asking the following questions. Less time is allotted for the debrief for this role play, since participants will likely have discussed at least some of their reactions to these questions during the previous role play debrief.

   a) **For the providers:**

      - **What concerns did the patient have that you uncovered during the spiritual history process?**

      - **Was it difficult to take a spiritual history? If so, why? If not, why not?**

   b) **For the patients:**

      - **What information or concerns did you end up sharing throughout the spiritual history process? Is there anything you ended up not sharing?**

      - **Did you feel comfortable sharing details about your religious beliefs or practices with your health care provider? Why or why not?**

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3) Be sure to draw out the following points from the discussion, particularly comparing and contrasting this role play with the previous one:

   a) Patients may or may not be comfortable addressing religious concerns they have because they are worried that their concerns will be dismissed or even ridiculed. The more available the provider makes himself or herself to the patient, the more willing the patient might be to share important information. This is particularly important to keep in mind if the patient's religion is one that the provider is less familiar with, or one that the patient assumes the provider does not share or may have assumptions about.

   b) Like any skill, discussing religious concerns with a patient takes time to acquire. Participants may experience the second role play differently from the first, either because they played a different role in the encounter, because they had experience doing a spiritual history role play, or because the first role play helped them to develop a greater awareness of the challenges and possible solutions for taking a spiritual history.

   c) There is no one way to have these conversations. The most important thing is that the provider open the door for the patient and/or their family to ask questions and share information.

SECTION 6 – IDENTIFY

How religious beliefs and practices intersect with employee interactions

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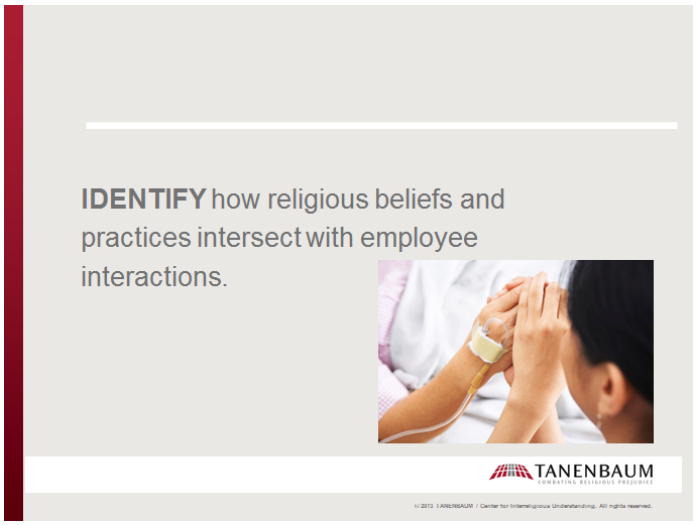
Section 6 – IDENTIFY how religious beliefs and practices intersect with employee interactions



Rationale: **This section will provide an overview of how religion emerges in the health care workplace, as well as communication skills for respectfully interacting with diverse colleagues around religion. The diversity within Israel's patient population extends to its employee population as well. Within diverse workplaces, employees need to respect and understand each other in order to work effectively as teams. Paying attention to religious diversity and taking the time to understand colleague's religious beliefs can help to ease tension in the workplace and improve collaboration and workplace effectiveness. This is a particularly key need in a health care setting where a lack of teamwork and communication can negatively impact the quality of care, patient satisfaction and even health outcomes. To that end, it is important for providers to have the skill sets to respectfully communicate about religious accommodations in the workplace. This section will provide participants with examples and communication skill sets and guidelines, and give them the opportunity to practice those skill sets.**

Objectives:

At the end of this section, health care providers should be able to:

- Identify the thematic areas where religion emerges in the workplace across religious traditions.

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- Outline communication tools and frameworks for respectfully interacting with coworkers around the subject of religion.
- Apply relevant communication tools and frameworks when communicating with religiously diverse coworkers or about a religious concern in the workplace.

Time: 45 minutes

- 15 minutes (lecture)
- 30 minutes (activity)

Materials:

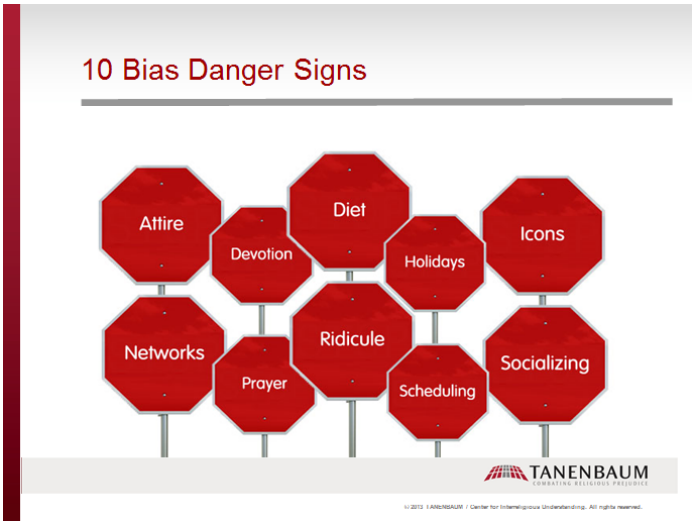
- **10 Bias Danger Signs**
- **LEARN Model/Respectful Communication**

Process:

1) Tell participants that this section will provide some practical tools and guidelines for respectfully communicating with coworkers about their beliefs and practices.

2) Note that at the end of this section they will have the opportunity to practice the skills being presented through a case study.

Slide 48 – 10 Bias Danger Signs



Rationale: **The 10 Bias Danger Signs are presented to participants as a simple and practical tool for identifying where and when they should be mindful of religion emerging as an issue in the workplace, so that they can better identify and be respectful of religious beliefs and needs that impact their professional relationships. As was demonstrated with the "trigger topics," it is impossible to learn everything there is to know about every religion that fellow colleagues might adhere to and therefore, it is better to approach religious accommodation and diversity in the workplace thematically.**

1) **Tell participants that this list represents 10 signs where religion often comes up in the workplace.**

2) Make the point that given the diversity between and within faith traditions, it is impossible to be familiar with every religion one might encounter. A more practical approach is to learn to identify specific areas within workplace interactions where differences in belief and practice can lead to misunderstandings or tensions between colleagues. Being proactive in identifying these different themes where religion can emerge for colleagues or employees facilitates a more cohesive and united workforce and makes it easier to understand and address conflicts and challenges as they arise.

3) Distribute the **10 Bias Danger Signs handout.** Let participants know that this handout can be used as a reference providing the definition of each bias danger sign as well as an

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example. If participants ask about a specific bias danger sign, definitions and examples are below (trainers should also feel free to use examples from their own experiences):

a) **Attire**– Employees are barred or discouraged from wearing facial hair, certain hairstyles, or garb – even if religiously motivated.

> FOR EXAMPLE: A Haredi Jewish nurse wishes to wear long sleeves due to religiously motivated modesty concerns, which violates a hospital's safety and hygiene policies.

b) **Devotion–** Employees encounter difficulties when requesting time off to pray, meditate, or reflect during the workday, or in locating a quiet, private space to pray.

> FOR EXAMPLE: A Muslim doctor ends up praying in the stairwell because there is no on-site quiet room for him to use and there are no nearby mosques that he can visit.

c) **Diet –** Work-sponsored gatherings offer limited kosher/halal/vegetarian options.

> FOR EXAMPLE: A Sikh employee cannot eat at a work party because all the food is kosher, and there are restrictions in Sikhism against eating food that has been ritually prepared.

d) **Holidays –** Employees have a difficult time securing vacation/paid time off for their religious holidays and observances.

> FOR EXAMPLE: A hospital denies time off requests around Passover and Easter/Good Friday because a large number of employees want time off for religious observance and the hospital would be short-staffed if all requests were granted.

e) **Icons –** Religious icons or devotional objects are discouraged or barred from personal workspaces.

> FOR EXAMPLE: A Christian nurse is told that she cannot leave her Bible at the nurses' station because it is too public.

f) **Networks –** Determining whether to establish individual faith groups, an interfaith group, or no religious groups at all poses a challenge.

> FOR EXAMPLE: A hospital creates an interfaith employee network and receives complaints from employees who want there to be individual faith groups for their particular faith instead.

g) **Prayer –** Mandatory company meetings and celebrations that include prayer.

FOR EXAMPLE: An employee who identifies as atheist is uncomfortable attending staff meetings that include a non-denomination prayer, but is unsure if arriving late to the meeting will negatively impact his performance review.

h) **Ridicule –** Employees are mocked because of their religious beliefs, practices, or garb.

FOR EXAMPLE: A Muslim man who wears a turban starts a new job. When his supervisor is introducing him to his new colleagues, she jokes, "It's alright, he isn't a terrorist."

i) **Scheduling –** Work shifts and meeting schedules disregard significant religious holidays.

FOR EXAMPLE: A hospital schedules mandatory staff trainings during Diwali, unaware that many of the hospital's Hindu employees will not be working that day in observance of their holiday.

j) **Socializing–** Employees are labeled as anti-social when they don't attend company-sponsored parties or religious celebrations.

FOR EXAMPLE: A Mormon employee who does not drink alcohol chooses not to attend office happy hours and feels like he is not considered "part of the team" by his coworkers.

4) Ask participants what examples of bias danger signs have come up in their own experience. Write examples on the white board.

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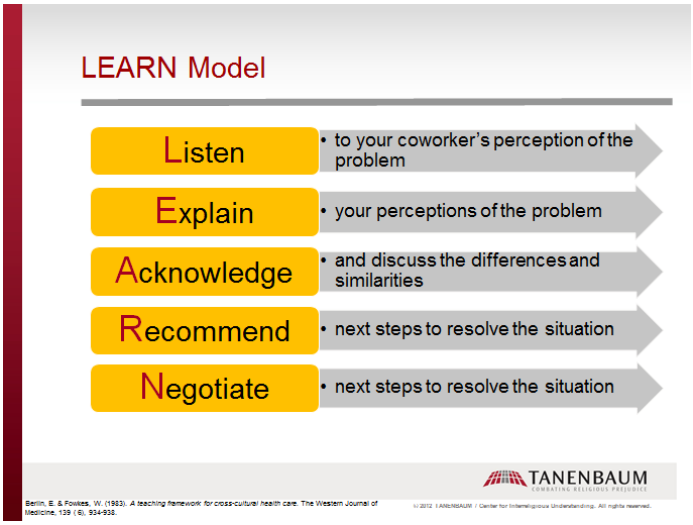
Slide 49 – LEARN Model



1) Distribute the **LEARN Model/Respectful Communication** handout.

2) The LEARN Model framework[35] can be used if a conflict or misunderstanding emerges with a coworker. It's a good model to use when conflicts come up around religion or culture, but it can be used in any situation where there is a misunderstanding between two coworkers.

3) Go over the steps that make up the LEARN Model:

   a) **Listen:** When a conflict emerges with a coworker, the first step is to truly listen and hear their concern. People should ask themselves the question "do we understand each other?" Your coworker's concern is real to him or her, and regardless of whether you share or agree with that concern, it needs to be acknowledged and addressed. As the training has previously mentioned, a key measure of when you have stopped listening to someone else is if you have started formulating a response in your head while the other person is still speaking.

   b) **Explain:** Once you have fully understood your coworker's perspective it is time to clearly outline *your* understanding of the issue and ensure that your coworker fully understands this perspective even if, at this point they don't agree with that perspective.

[35] Berlin, E. & Fowkes, W. (1983). *A teaching framework for cross-cultural health care.* The Western Journal of Medicine, 139 (6), 934-938.

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c) **Acknowledge:** The next step in a conflict is to verbally acknowledge that you've heard and understood your coworker's concerns and openly and respectfully discuss the differences between your understanding and his or her understanding.

d) **Recommend:** Once any differences in understanding have been put out on the table, the next step will be for you to recommend options and then **negotiate** a plan that you are both comfortable with. Depending on the circumstances, it may be valuable to involve a supervisor in these conversations.

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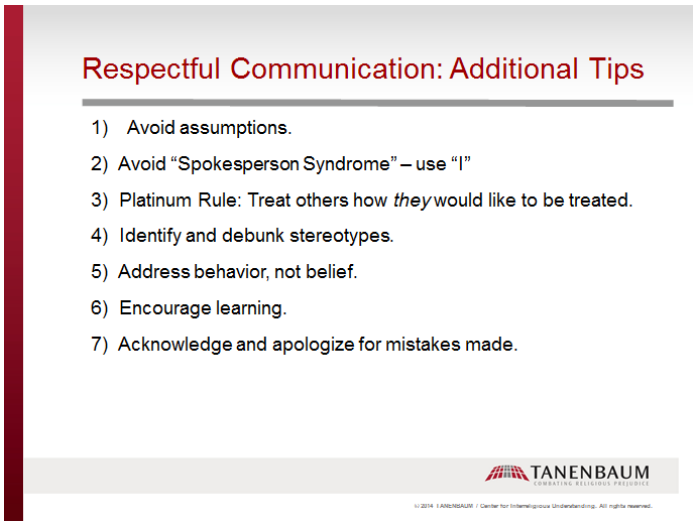
Slide 50 – Respectful Communication: Additional Tips



1) The LEARN Model is useful when a conflict has emerged or when there is a misunderstanding. However, there are some additional communication tips that can be used in all conversations about religion with your coworkers, regardless of whether or not there is a specific conflict.

2) Go over the following respectful communication tips:

   a) **Avoid assumptions:** The first rule when discussing any identifier, and certainly religious identity, is to avoid assumptions. When thinking about issues of religious diversity and interacting with colleagues, people should stop to consider whether they are missing any part of the picture and if there are any questions they can ask to help the situation.

   b) **Avoid Spokesperson Syndrome – use "I":** Don't assume that any individual speaks as the representative of an entire religious, ethnic or cultural group. All questions should be framed around what your coworker believes, not what every Jew, Muslim, Christian, etc. believes. When speaking about your own religion, speak from your own experiences and not on behalf of your entire religious group.

   c) **Platinum Rule:** People have usually heard of the Golden Rule, which is to treat other people the way *you* would want to be treated. The Platinum Rule asks people to go a step further and **treat other people the way *they* want to be**

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treated. The only way to know how people want to be treated and what respect looks to them is to ask.

d) **Identify and debunk stereotypes:** Be aware of keywords. When someone is speaking about a religious group of people and uses terms like "all," "always," "never," "them," and "those people" they are probably engaged in stereotyping. You might ask them if they have considered another point of view or whether they have met other people who practice the religion they are talking about. These questions may help the speaker or others who are participating in the conversation to begin thinking of a statement as an overly broad stereotype instead of something that is universally true.

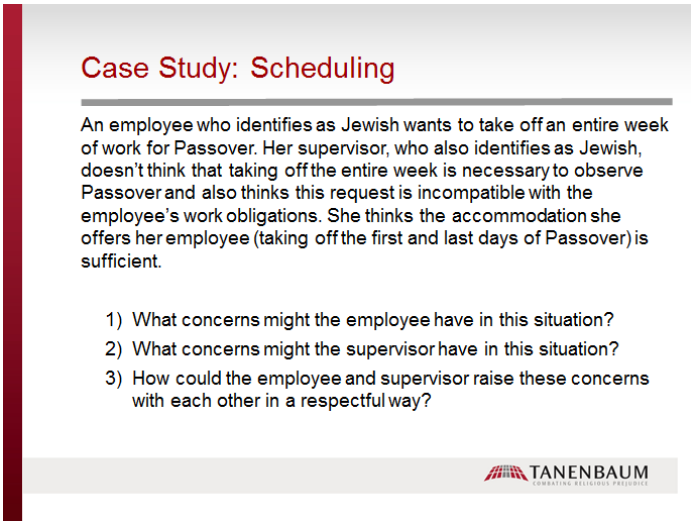
e) **Address behavior, not belief:** Explain to participants that we are all free to believe whatever we want, and no one in the workplace has the right to try to change those beliefs. However, it is important to behave respectfully in the workplace, and behaviors in the workplace should and can be managed to ensure that workplaces are inclusive and welcoming for all.

f) **Encourage learning:** You'll never learn everything there is to know about every religion, or even any one religion, but it's important to keep learning. It's easy to rely on generalizations for information about different religions—the more people learn, the more they can keep generalizations from turning into stereotypes.

g) **Acknowledge and apologize for mistakes:** We have to acknowledge that given the breadth and depth of this topic, we're all going to make mistakes. Mistakes can be important to make if you can learn from them and use them as an opportunity to deepen your understanding of your colleague. For mistakes to become learning opportunities, they need to be acknowledged. The person making the mistake must take ownership of their error, genuinely apologize for the mistake, and take steps to ensure that they do not make the same mistake again.

3) Distribute the **LEARN Model/Respectful Communication handout** to participants for their reference.

Slide 51 – Case Study: Scheduling



Rationale: **This exercise will give participants the opportunity to use the tools and skill sets just reviewed to practice addressing a situation where religion comes up within the workplace and identifying better practices to resolve conflicts. This process will allow participants to translate theory into practice and identify and discuss difficulties that they encounter in having conversations around religion and creating religious accommodations.**

Objectives:

At the end of this activity, health care providers should be able to:

- Effectively apply tools and skill sets needed to respectfully communicate with culturally and religiously diverse colleagues.
- Identify and address any challenges that they encounter related to respectfully interacting and communicating with colleagues in the workplace.

Time: 30 minutes

Process:

1) Read the case study that is on the screen:

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An employee who identifies as Jewish wants to take off an entire week of work for Passover. Her supervisor, who also identifies as Jewish, doesn't think that taking off the entire week is necessary to observe Passover and also thinks this request is incompatible with the employee's work obligations. She thinks the accommodation she offers her employee (taking off the first and last days of Passover) is sufficient.

2) Ask participants to consider the following questions. Also ask them to think about how the **LEARN Model/Respectful Communication handout** might help them address this conflict, and which of the Respectful Communication tips could be relevant here.

   a) **What concerns might the employee have in this situation?**

   b) **What concerns might the supervisor have in this situation?**

   c) **How could the employee and supervisor raise these concerns with each other in a respectful way?**

3) Take audience responses to these questions and write them on the white board. Let the discussion continue for approximately 10 minutes.

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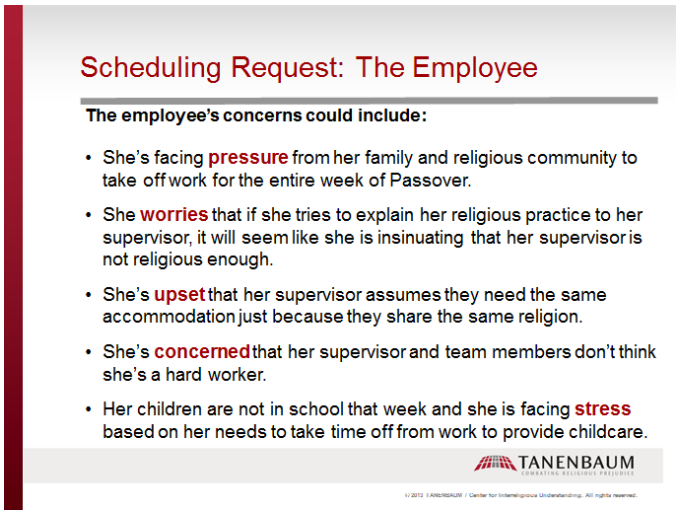
Slide 52 – Scheduling Request: The Employee



1) Once the participants have shared their thoughts to the case study, go over the following points about what the employee's concerns may be. Point out which of these potential concerns was already identified by the audience, and which were not.

   a) **The employee is facing pressure from her family and religious community to take off work for the entire week of Passover.** It is possible that the employee herself does not personally want to take off the entire week for Passover, but her family and religious community want her to do so, and she feels obligated to follow this practice. The fact that she has made this request does not necessarily tell her supervisor how she believes. Many times around holidays people juggle many competing interests that may influence their time off requests.

   b) **The employee worries that if she tries to explain her religious practice to her supervisor, it will seem like she is insinuating that her supervisor is not religious enough.** There can be a power dynamic in the workplace that influences how free employees feel they are to express their religiosity. An employee may be concerned that further articulating her need for a religious accommodation will be perceived as a critique of her supervisor's way of observing Passover.

   c) **The employee is upset that her supervisor assumes they need the same accommodation just because they share the same religion.** As the session has previously mentioned, there is great diversity within any one religious tradition. This

employee may feel angry or resentful that her supervisor has made an assumption about her based on the supervisor's own religious belief and practice.

d) **The employee is worried that her supervisor and team members do not think she is a hard worker.** Sometimes people may think that their coworkers who take time off of work for religious or other reasons are not working as hard because they are not in the workplace. With religiously motivated time off requests, employees may not realize that their coworkers' request is not vacation time. For example, the preparation required for Passover may be very extensive and require a great deal of hard work. However, employees may still be concerned that taking time off of work will contribute to an impression that they are not working hard enough or as committed to their work.

e) **Her children are not in school that week and she needs to take time off from work to provide childcare.** It is also possible that this employee's request has nothing whatsoever to do with religion. It could be that her children are not in school because of Passover, and she has not been able to find or afford childcare and has therefore made the time off request in order to spend the week looking after her children.

2) Note that these are only some of the reasons the employee could have made this time off request. There are many additional potential reasons that are not included on this list. It is also possible that a combination of these reasons has contributed to the time off request. Ask if anyone has additional thoughts about the reasons the employee may be requesting this time off.

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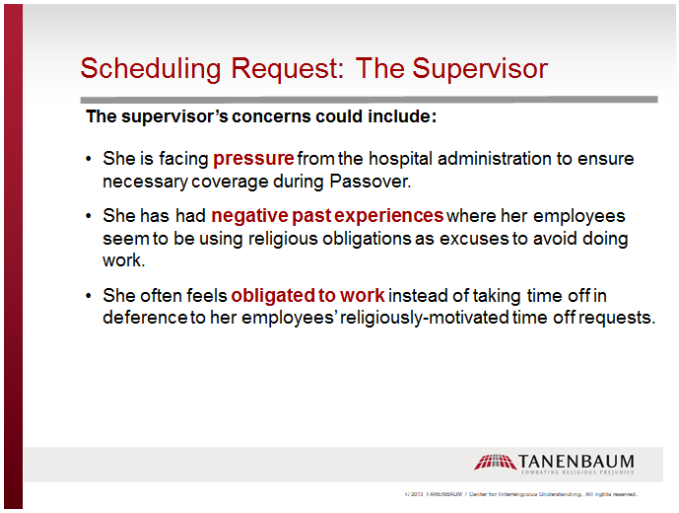
Slide 53 – Scheduling Request: The Supervisor



1) Go over the following points about what the supervisor's concerns may be. Point out which of these potential concerns was already identified by the audience, and which were not.

   a) **The supervisor is facing pressure from the hospital administration to ensure necessary coverage during Passover.** There are some times of year when many holidays collide and many employees make requests to take time off of work. In some industries this is less problematic, but in a health care workplace it is important that a hospital still provide necessary coverage. This may mean that some time off requests for religious observance do not get granted. Supervisors should try to communicate these concerns to their employees when appropriate to do so, so that employees have a better understanding of why a time off request was not granted. Otherwise it is possible that denying a time off request could be perceived as a personal slight or even religious discrimination.

   b) **The supervisor has had past experience where her employees seem to be using religious obligations as excuses to avoid doing work.** People are always influenced by their past experiences. If a supervisor has previously experienced employees who use religious obligations as a reason to avoid work, she may be less likely to grant religious time off requests even though the employee making the time off request is doing so based on a genuine religious need.

   c) **The supervisor often feels like she cannot take any time off in deference to her employees' religiously-motivated time off requests.** It is possible that

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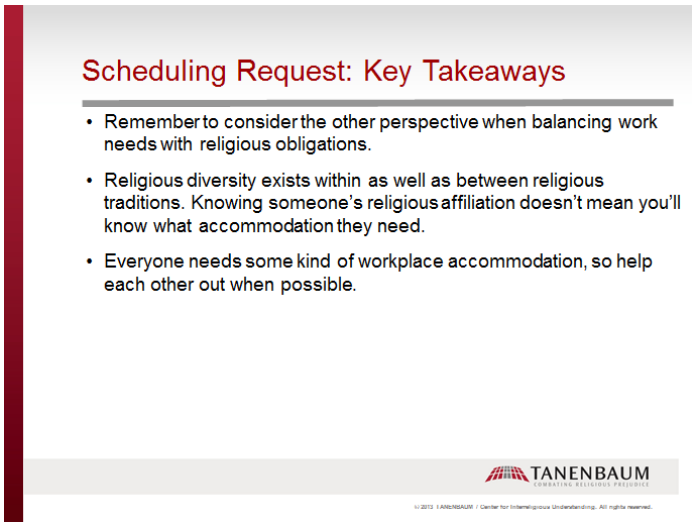
there are some days that the supervisor would like to take off work, and she feels she is never able to because of her employees' time off requests that are often made for religious reasons. She may feel as though her religious employees always get the first pick of days off, and may therefore feel frustrated or annoyed. This desire to manage competing interests and provide necessary coverage may be why she suggested an accommodation to her employee that, to her, seems reasonable and sufficient.

2) Note that these are some of the reasons the supervisor could have denied the initial time off request, but that there are many additional reasons not included on this list. It is also possible that a combination of these reasons has contributed to the supervisor's denial of the time off request and her suggested accommodation.

Slide 54 – Scheduling Request: Key Takeaways



1) Go over the following takeaways from this case study that can help manage religiously motivated scheduling requests:

   a) **Remember to consider the other perspective when balancing work needs with religious obligations.** In a conflict like the one presented here, people may have different priorities (i.e., taking a day off work to observe an important holiday versus making sure the hospital has enough coverage during a busy time). Following the LEARN Model can be a very helpful way to help establish what your coworker's perspective is, share your own perspective, and then discuss possible resolutions.

   b) **Religious diversity exists within, as well as between, religious traditions. Knowing someone's religious affiliation doesn't mean you'll know what accommodation they need.** One of the respectful communication tips is to avoid spokesperson syndrome and to speak from your own experiences instead of on behalf of an entire religious or cultural group. People should also work to avoid spokesperson syndrome by acknowledging that the religious accommodation they need might be different from the accommodation needed by others.

   c) **Everyone at some point in time will need some form of workplace accommodation. Collaborating with your colleagues/staff to ensure their needs are met as much as possible, makes it more likely that others will reciprocate when you are in need of an accommodation.** Sometimes religious accommodations are thought of as posing unique challenges in the workplace. In

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reality, people need workplace accommodations for many reasons besides religion—because of disability, childcare, conflicting school schedules, and many other factors. Since everyone will need an accommodation at some point in their career, it is important to grant accommodation requests whenever possible, find creative solutions to accommodation challenges, and be flexible in helping coworkers to meet their religious and other obligations.

SECTION 7 – WRAPPING UP

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Section 7 – WRAPPING UP

Objectives:

At the end of this section, health care providers should be able to:

- Articulate better practices and skill sets needed for treating patients and coworkers of religiously and culturally diverse backgrounds with respect.

Time: 10 minutes (lecture and question & answer)

Materials: **Post-Training Evaluation**

Process:

1) Conclude the presentation with the summary slide that follows.

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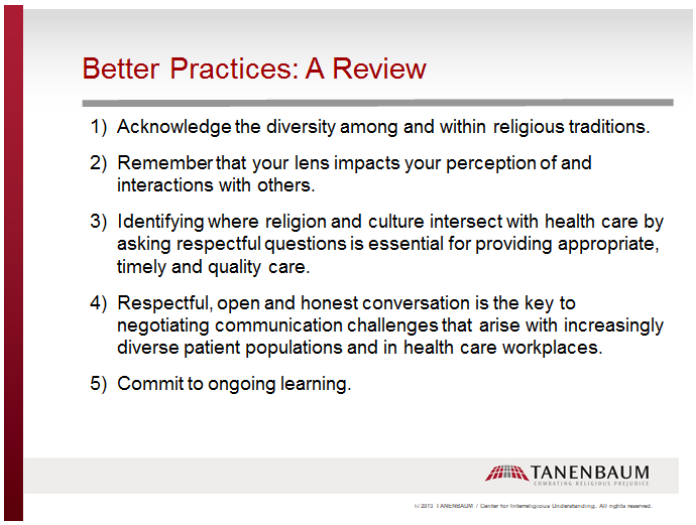
Slide 56 – Better Practices: A Review



1) Review the following better practices that were covered during the training:

   a) **Acknowledge the diversity among and within religious traditions** when interacting with patients and coworkers. Avoid making assumptions about someone's religiosity based on their attire, name, or even their formal religious affiliation.

   b) **Remember that your lens impacts your perception of and interactions with others.** In recognizing the influence of our identities on our behavior, we can minimize any potentially negative effects they can have on interactions with patients and coworkers.

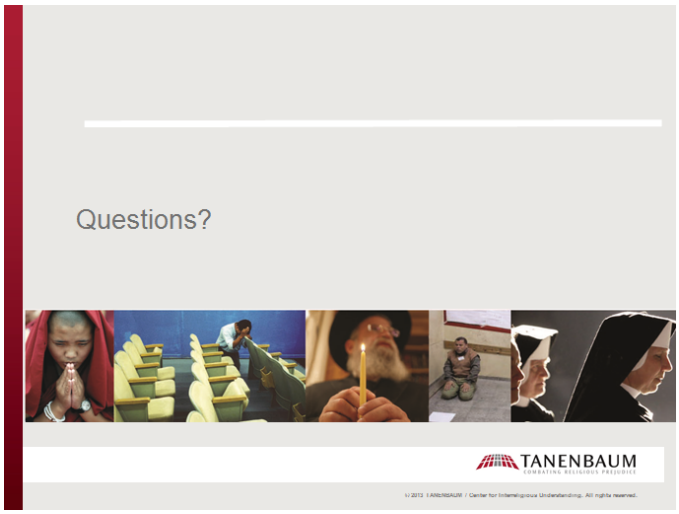
   c) **Identifying where religion and culture intersect with health care by asking respectful questions is essential for providing appropriate, timely and quality care.** Start to familiarize yourself with the list of trigger topics and pay particular attention to religious and cultural beliefs when these topics come up. Also familiarize yourself with the questions to ask during a spiritual history. These questions should become a standard part of your communication with patients, rather than an afterthought.

   d) **Respectful, open and honest conversation is the key to negotiating communication challenges that arise with increasingly diverse patient populations and in health care workplaces.** Managing the medical needs of a patient and/or family while simultaneously addressing any religious concerns that have

come up can be challenging and even frustrating at times. Similar challenges can emerge when working with religiously diverse employee populations and trying to balance religious accommodation requests with maintaining hospital operations and providing necessary coverage. Maintaining an open and honest channel of dialogue with patients/families or coworkers is the most effective way to overcome these potential challenges.

e) **Commit to ongoing learning.** It is important to continue learning about the traditions and practices that most impact the work you do and the people you interact with. It is also important to continue learning about the skills and strategies to become religio-culturally competent when interacting with patients and coworkers.

Slide 57 – Questions?



1) Thank participants for their participation and address any final concerns or questions they may have.

2) For measurement and evaluation purposes, distribute the **Post-Training Evaluation** and have participants fill it out. These evaluations are designed to measure the efficacy and impact of this training.

HANDOUTS

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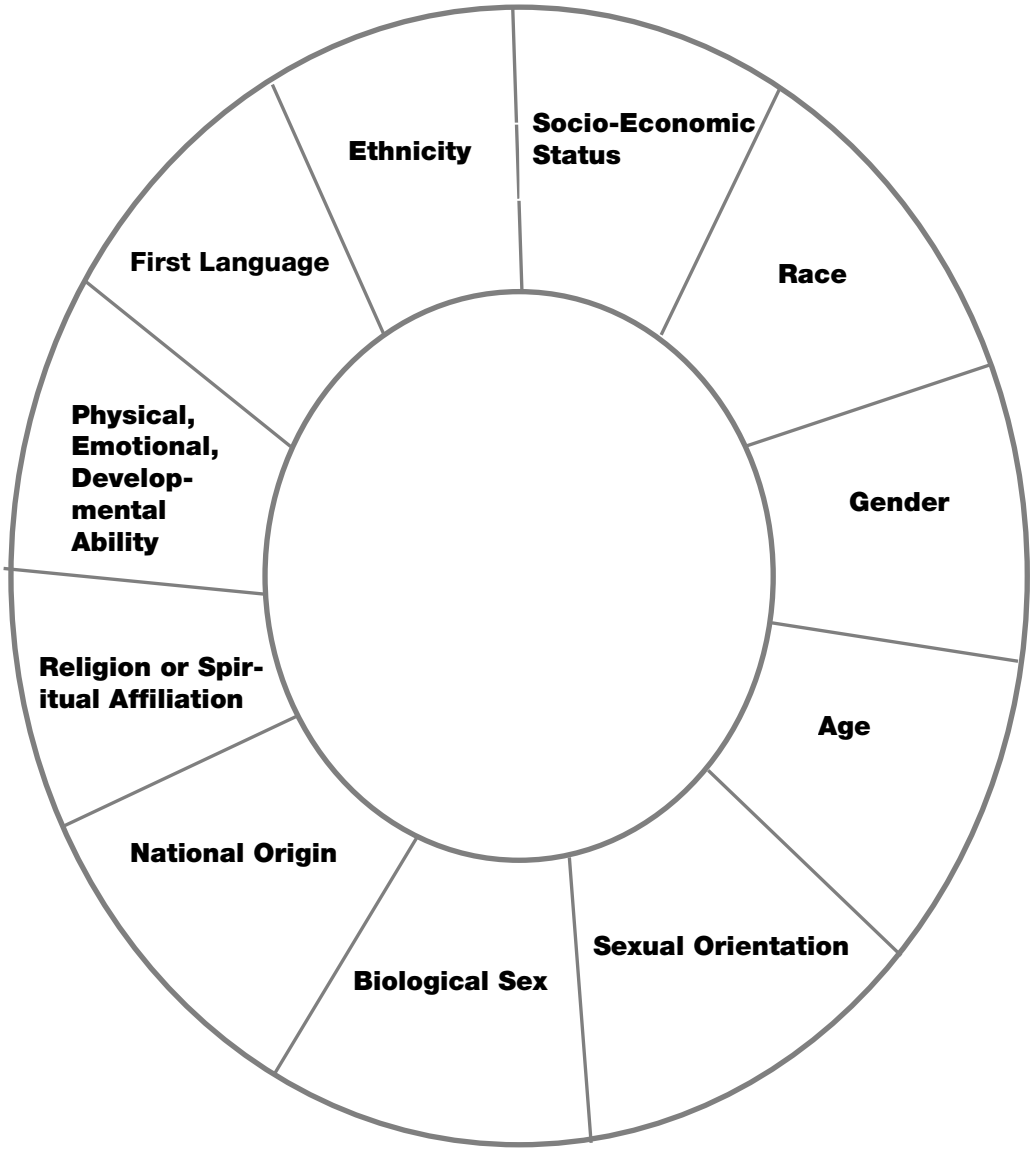
Social Identity Wheel



Adapted from Marcella Runell, Social Justice Education Umass-Amherst and "Voices of Discovery," Intergroup Relations Center, Arizona State University

Provider Values

Distinguishing Objections

Personal Preference	
Example	A family wishes to perform an exorcism.
Indicator	Thinking, "This request is silly, ineffective, inconvenient and/or unnecessary."
Suggested Actions	Accommodate or compromise

Professional Integrity	
Example	The parents of a child with sickle-cell anemia refuse a blood transfusion.
Indicator	Thinking, "I would not be meeting my ethical obligations to the patient if I…"
Suggested Actions	Inform/educate, compromise, consult, or refuse

Personal Conscience	
Example	The patient requests the termination of a pregnancy.
Indicator	Thinking, "I would be unable to live with myself if I participated."
Suggested Actions	Inform, consult, or transfer care[1]

[1] Culhane-Pera, K., Vawter, D., Xion, P., Babbitt, B., & Solberg, M. (2003). *Healing by heart.* U.S.A: Vanderbilt University Press.

Possible Actions:

Accommodate	If a health care provider's objection to a patient's and/or family's wishes are based solely on personal preference, a good faith effort should be made to accommodate the patient's request.
Compromise	In some instances, a compromise can be reached that accommodates the patient's/family's request without violating the health care provider's obligations to the patient.
Inform/Educate:	Providers should help patients/families understand their professional objection. The patient and/or family should be given the opportunity to educate the provider in the religious/cultural beliefs and/or practices that are shaping their decision.
Consult:	Providers faced with a situation where their professional integrity or personal conscience conflicts with the request of a patient and/or family should consult with their supervisors for guidance. In addition, bringing pastoral care and, if appropriate, the hospital ethics committee into the conversation to provide support and guidance, can be helpful for both patient and provider.
Refuse:	When all other avenues have been exhausted, the patient and/or family must be informed in as respectful and tactful a manner as possible that their request cannot be accommodated. While legal action should always be a last resort it may, in rare instances, be necessary.
Transfer Care:	If it is established that a genuine conflict exists between the needs/requests of the patient and the personal conscience of the provider, it is appropriate to transfer care.

Trigger Topics

DIETARY REQUIREMENTS	The patient has religiously motivated food restrictions that impact meals and/or medication.
DRESS	The patient wears religious garb or symbols that need to be removed for examination and/or treatment.
MODESTY	The patient's religious beliefs dictate specific behavior relating to modesty, such as preferring to be examined by practitioners of the same sex.
HYGIENE	The patient has religious practices relating to washing prior to prayers and mealtimes or has religious concerns pertaining to maintaining a beard or other grooming needs.
INFORMED CONSENT	The patient requires the consultation and/or consent of a family member or religious leader to approve a course of treatment.
HOLY DAYS AND RITUALS	The patient observes certain holy days or performs religious rituals that require accommodations around scheduling of procedures or modifying treatments for fasting.
ALTERNATIVE REMEDIES	The patient uses religiously or culturally indicated alternative remedies or seeks the assistance of a traditional healer.
CONSCIENCE RULES	The religious beliefs of the health care provider conflict with the needs or requests of the patient.
REPRODUCTIVE HEALTH	The patient has religious views on contraception, abortion, or fertility procedures such as in vitro fertilization or sterilization.
PREGNANCY & BIRTH	The patient has religion-specific practices associated with labor and birth, such as particular foods, rituals, or traditional remedies.
END OF LIFE	The patient's religious beliefs require performing particular rituals before or after death or dictate particular perspectives on withdrawing care or prolonging life.

DRUGS AND PROCEDURES	The patient refuses specific drugs and procedures due to various religious restrictions such as fasting, exhibits a preference to use alternative medicine, or has religious dietary objections.
PROSELYTIZING	The patient experiences inappropriate religious expression from staff in a health care setting.
PRAYER WITH PATIENTS	The patient and/or family of the patient requests that a member of their health care team pray with them.
ORGAN TRANSPLANTS	The patient and/or their family have religious beliefs that influence their willingness to accept a donor organ or agree to donate an organ.
BLOOD PRODUCTS	The patient has religious beliefs that restrict the use of blood or blood products.

Tip Sheet

Spiritual Histories: How Do I Ask?

INITIAL QUESTIONS:

- Are you a member of a faith community?
- Is your faith an important part of your life?
- Are there any religious/spiritual concerns you have related to your health that you would like me to know about?
- Is there anything I should know about your religious beliefs/practices that would impact your daily activities while you're here at the hospital?

CONTINUING THE CONVERSATION:

ADMISSION	Do you have any religious/spiritual needs or concerns related to your health that you would like me to know about?
CONCERNS	What concerns you most about your condition?
EXAMINATION	Is there any way I can help make you more comfortable while I examine you?
DIAGNOSIS	Have you tried any kinds of medicines, vitamins, herbs, or teas, or sought help from a healer or other type of doctor to cure this illness?
TREATMENT	Do you have any religious beliefs or practices that would be important for us to take into consideration regarding the treatment options I just explained to you?
OBJECTIONS	I understand that you have certain religious objections to this treatment and I respect that. Can you tell me a little more about your objection? I want to understand your concerns fully.
SUPPORT	Would it be helpful for you to speak to your spiritual leader about what we've discussed?
MANAGEMENT	Do you have any religious practices or religious holidays coming up that we need to consider in managing your care? For example, do you fast as a part of your religious practice?

Role Play Exercise 1

You are the patient…

BACKGROUND:

- You are a 25-year-old man. You went to a clinic because you were worried about being tired all of the time and drinking a lot more water than you used to. While taking a medical history, your health care provider included the following questions to which you responded as follows:

QUESTION: Are you a member of a faith community?
ANSWER: Yes, Haredi Jewish.

QUESTION: Is your faith an important part of your life?
ANSWER: Yes, it is an important part of my life.

QUESTION: Are there any religious/spiritual needs or concerns you have related to your health that you would like me to know about?
ANSWER: I don't know. None that I can think of at the moment.

- Your provider ran some tests and asked you to schedule a follow-up appointment.
- When you returned your provider shared the news that you suffer from type 2 diabetes. Your provider explains:

  - Your body is no longer able to make or regulate insulin.
  - You will need to give yourself an injection and check your blood glucose level several times per day, every day for the rest of your life.
  - You will need to pay careful attention to what you eat, how much, and when.
  - You are also at risk for developing dangerously low blood sugar if you do not eat regularly or take insulin consistently.

THE GOAL:

You have now thought about the medical information (listed above) shared with you and have some additional concerns to discuss with your provider. Ask your provider about the issues listed below:

1) You are worried that the medication you will be taking will not be kosher. You want to know the brand of the medication so that you can ask your rabbi if it is kosher.

2) You do not know if your illness means you cannot fast on High Holy days such as Yom Kippur.

3) You are anxious to talk to your Rabbi about some of these questions because you are not sure what is allowed within the context of your faith.

Role Play Exercise 1

You are the provider…

BACKGROUND:

- A 25-year-old man comes to see you. His symptoms are frequent urination, increased thirst, and fatigue. You ask the patient the questions below as part of your assessment.

> **QUESTION:** Are you a member of a faith community?
> **ANSWER:** Yes, I am Haredi Jewish.
>
> **QUESTION:** Is your faith an important part of your life?
> **ANSWER:** Yes, it is an important part of my life.
>
> **QUESTION:** Are there any religious/spiritual needs or concerns you have related to your health that you would like me to know about?
> **ANSWER:** I don't know. None that I can think of at the moment.

- You ran a series of tests and asked the patient to schedule an appointment for a follow-up visit to discuss the results.
- The tests show that your patient has type 2 diabetes.
- The patient returns for his follow-up visit and you share the news to him. You also explain the following:

> - His body is no longer able to make or regulate insulin.
> - He will need to give himself an insulin injection and check his blood sugar level several times per day, every day for the rest of his life.
> - He will need to pay careful attention to what he eats, how much, and when.
> - He is at risk for developing dangerously low blood sugar if he does not eat regularly or take insulin consistently.

THE GOAL:

1) Ask the patient if he has any concerns about the treatment you have just described.
2) Determine what those concerns are.
3) Address those concerns or develop a plan of action to do so.

Role Play Exercise 2

You are the patient…

BACKGROUND:

- You are a 75 year old man diagnosed with advanced lung cancer. The cancer was diagnosed a year earlier. You are currently at the hospital because you recently suffered a fall.
- You self-identify as Muslim. You didn't consider religion to be a particularly important part of your life until you were diagnosed with cancer. Since then you have found your faith a source of strength in supporting you through this illness.
- You have started praying 5 times a day which requires washing your hands and feet before prayer and kneeling on a prayer rug while you perform prayers. This has become increasingly difficult as your illness has progressed and was ultimately the cause of the fall that brought you into the hospital.
- Ramadan is coming up and you want to participate in the fast, at least in some way. You know that, being ill, you are not required to participate in the fast but nonetheless it is something you feel compelled to do. You're not sure if this will be possible. You suspect that your health care providers will object.

THE GOAL:

1) Your health care provider is taking a spiritual history. Respond to his/her questions.
2) You are eager to discuss the concerns listed above but, before opening up, need some assurance (explicit or implied) that this is a topic that is appropriate/safe to discuss with this person.

Role Play Exercise 2

You are the provider…

BACKGROUND:

- Your patient is a 75 year old man with advanced lung cancer. The cancer was diagnosed a year earlier.
- He comes into the hospital after a fall.

THE GOAL:

1) Take a spiritual history to establish any concerns this patient may have around his religious beliefs and practices.
2) Begin to develop a plan to address those concerns.

10 Bias Danger Signs

1.	**ATTIRE**	Employees are barred or discouraged from wearing facial hair, certain hairstyles, or garb – even if religiously motivated.
2.	**DEVOTION**	Employees encounter difficulties when requesting time off to pray, meditate, or reflect during the workday, or in locating a quiet, private space.
3.	**DIET**	Work-sponsored gatherings do offer limited kosher/halal/vegetarian options.
4.	**HOLIDAYS**	Employees have a difficult time securing vacation/paid time off for their religious holidays or observances.
5.	**ICONS**	Religious icons or devotional objects are discouraged or barred from personal workspaces.
6.	**NETWORKS**	Determining whether to establish individual faith groups, an interfaith group, or no religious groups at all poses a challenge.
7.	**PRAYER**	Mandatory company meetings and celebrations include prayer.
8.	**RIDICULE**	Employees are mocked because of their religious beliefs, practices, or garb.
9.	**SCHEDULING**	Work shifts and meeting schedules disregard significant religious holidays.
10.	**SOCIALIZING**	Employees are labeled as anti-social when they don't attend company-sponsored parties or religious celebrations.

Tip Sheet

Respectful Communication

AVOID ASSUMPTIONS

When thinking about issues of religious diversity and interacting with colleagues, always check yourself by asking yourself questions: Am I missing any part of the picture? What do I *think* I know, and what do I *actually* know? Challenge those assumptions!

AVOID SPOKESPERSON SYNDROME

Use "I" language. Ensure that individuals speak from their own experience and not as the representative of an entire religious group. Be careful that you don't become a spokesperson yourself…

PLATINUM RULE

Treat others the way *they* would want to be treated. And the only way to know how respect "looks" to someone is to ask.

DEBUNK STEREOTYPES

Stereotypes can be the worst culprit in creating conflicts and misunderstandings. If you hear key words such as "all," "always," "never," "them," and "those people."

ADDRESS BEHAVIOR, NOT BELIEF

All individuals are free to *believe* whatever it is that they believe. However, it's critical that all employees *behave* respectfully toward one another in the workplace.

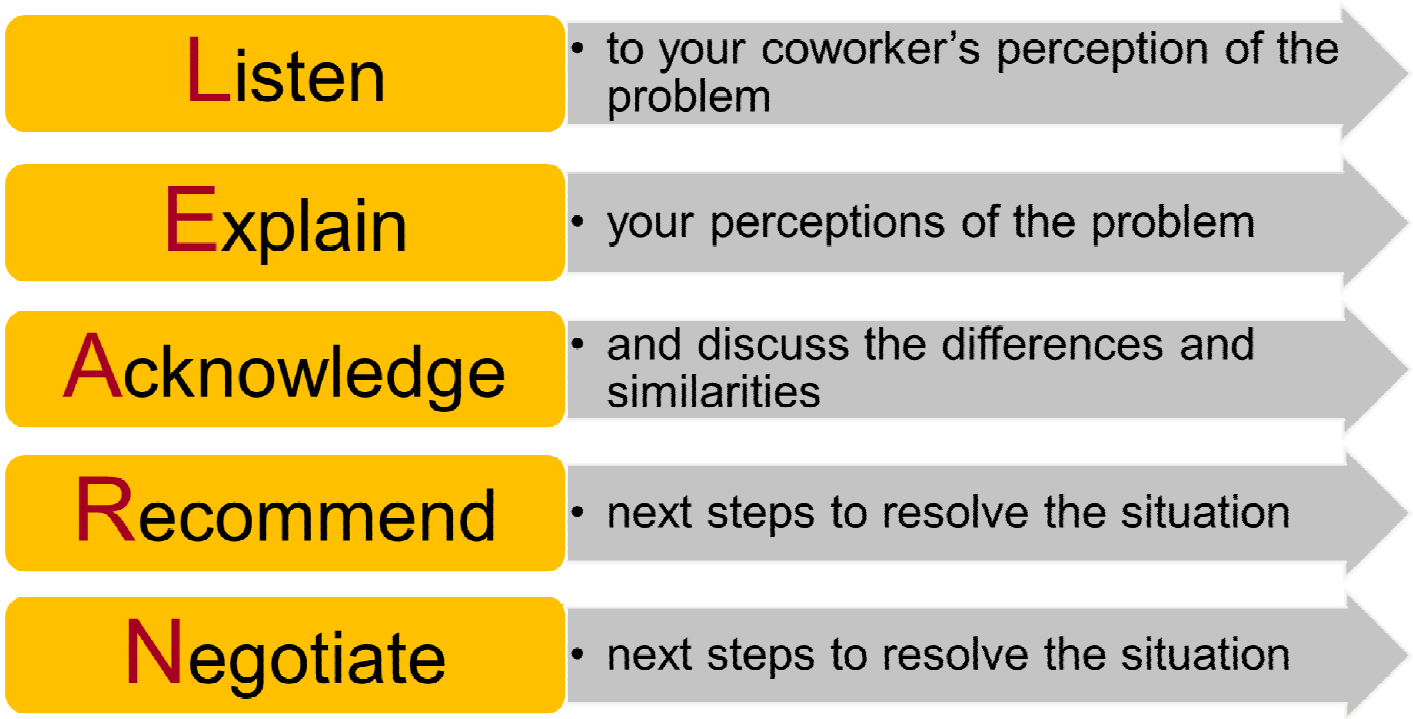
ENCOURAGE LEARNING

Learn from every encounter with someone of an unfamiliar religious faith, and use those insights to continue building your knowledge base.

ACKNOWLEDGE AND APOLOGIZE FOR MISTAKES

We have to acknowledge that given the breadth and depth of religious diversity, we're all going to make mistakes. But mistakes are important to make – you can learn from them and they provide an opportunity to deepen our understanding of one another – so long as they are dealt with properly. They must first be acknowledged and then you must then take ownership and genuinely apologize for the mistake made.

LEARN Model: A communication framework used to resolve cross-cultural communication barriers and help individuals develop culturally respectful solutions to potential conflicts.[1]



[1] Berlin, E. & Fowkes, W. (1983). A teaching framework for cross-cultural health care. *The Western Journal of Medicine*, 139 (6), 934-938.

Post-Training Evaluation

Please take 5-10 minutes to fill out the evaluation below.

1. **My professional role is:**

   - ❑ Practicing Physician
   - ❑ Medical student/physician-in-training
   - ❑ Nurse
   - ❑ Social worker
   - ❑ Spiritual care counsellor/pastoral care/clergy
   - ❑ Other (please specify) _____

2. **When should physicians ask patients the following question: "Do you have any religious/spiritual beliefs related to your health and healthcare that I should know about?"**

   - ❑ This should be a standard question asked of every patient.
   - ❑ This question should only be asked in end-of-life situations.
   - ❑ This question should be asked only if the patient brings up the topic first.
   - ❑ This is not an appropriate question to ask of a patient under any circumstances.

3. **Before this training, I could comfortably speak with patients and/or their family about their religious beliefs as it relates to their health care and identify concerns based on religion or culture:**

   - ❑ Extremely well
   - ❑ Somewhat well
   - ❑ Not very well
   - ❑ Not at all

4. **After this training, I can comfortably speaking with patients and/or their family about their religious beliefs as it relates to their health care and identify concerns based on religion or culture:**

   - ❑ Extremely well
   - ❑ Somewhat well
   - ❑ Not very well
   - ❑ Not at all

5. **Please share any additional thoughts you have about how religion has come up in your professional experience.**

6. **Please rate the following on a scale from 1 to 5.**

	1 Poor	2 Fair	3 Good	4 Above Average	5 Excellent
Quality of Facilitator					
Met Expectations					
Relevant to My Role					
Overall Quality					
Fulfilled Session Objectives					

7. **What was the most useful part of the presentation?**

_____

_____

_____

8. **What was the least useful part of the presentation?**

_____

_____

_____

9. **What other information would you have liked this presentation to include?**

_____

_____

_____

10. **I intend to use the following skills and/or knowledge I gained in this presentation in my future practice (please selected up to three of the listed tools/recommendations that you are most likely to use).**

- ❑ Social identity wheel
- ❑ Provider values recommendations
- ❑ Trigger Topics
- ❑ Kleinman Explanatory Model
- ❑ Spiritual History questions
- ❑ 10 Bias Danger Signs
- ❑ LEARN Model/Respectful Communication