PART 2

Religious Inequalities in Education, Health, and Economic Wellbeing

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Chapter 2

Intercultural Training, Interfaith Dialogue, and Religious Literacy: Minority Groups in the Israeli Health-Care System*†

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1 Introduction

This chapter seeks to analyse the extent to which intercultural competency training, delivered by interfaith practitioners, advances freedom of religion or belief (FoRB), and enhances patient and staff experiences and health outcomes for minority faith communities in Israel.

The Universal Declaration of Human Rights (UDHR) defines the right to FoRB as follows:

> Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance (UDHR, Article 18).[2]

Notwithstanding critiques and concerns about FoRB itself and the impact of interventions within FoRB-related issues,[3] recent years have seen a proliferation of initiatives working within this space.

Therefore, for the purposes of this study, understanding the broader context in Israel and the Palestinian Territories in terms of the wider human rights landscape is important. For many observers, the promotion and protection of FoRB in Israel and the Palestinian Territories is seen through the lens of unresolved conflicts (which include the intersection of religion, religious identity, and politics), the most notable example being the 2018 Nation-State Law which arguably entrenches discrimination and socioeconomic divisions between Jews and non-Jews in Israel (The Association for Civil Rights in Israel 2018).

One area of impact of those divisions is the health and wellbeing of minorities. This chapter's literature review (section 2) explores the evidence connecting the experiences of minorities in a society to poorer health outcomes. It seeks to rearticulate that experience within the context of the Israel and the Palestinian Territories conflict and explore whether religious differences in Israel predetermine poorer health outcomes for non-Jews and whether interventions can be delivered to reduce differences in outcomes. The latter question – whether interventions can enhance experiences of

minorities – is the focus of the remainder of this chapter. Section 3 sets out the purpose and method of the case study, including an examination of the Israeli health-care sector and the data-compiling process. Section 4 draws out themes and findings from the interviews, examining the impact of intercultural competency training in relation to the experience of individuals identifying with minority religions, and Section 5 offers conclusions.

2 Literature review

Because of the religious dimension in the Israeli–Palestinian conflict, an individual's experiences of the conflict are a result of their religion or belief, which possibly undermine an individual's rights to FoRB. As will be explored later in this chapter, patient and medical practitioner interviewees shared experiences of discrimination on the grounds of their minority faith backgrounds.

The Israeli–Palestinian conflict presents a challenging context from within which to disentangle or determine the extent to which FoRB is a human rights priority, or, conversely, a focus for human rights violations. The United States Department of State's *Israel 2019 International Religious Freedom Report* says: 'Because religious and national identities were often closely linked, it was often difficult to categorize many incidents as being solely based on religious identity' (Office of International Religious Freedom 2019: 32).

The challenge for the remainder of this literature review is to navigate this complex context to see how minority faith communities and individuals in Israel experience the health-care sector, and to what extent intercultural competency training can be understood as a tool to address inequality, particularly when experienced as a result of discrimination against those of minority faith identities.

In conducting this literature review we sought to explore three key areas. As this study explores the impact of intercultural competency training delivered by interfaith practitioners on the experience of individuals identifying with minority religions within the health-care system, we sought to first review the literature of existing such experiences, and second, the literature relating to intercultural competency interventions that are taking place in Israel and the impact these are having; and lastly, we looked specifically at the religious dimension and how interfaith dialogue as a cultural competency impacts the experiences of minorities in the health-care sector.

2.1 Health outcomes for minority religious groups

As part of a 2018 study exploring health-care disparities among vulnerable populations of Arabs and Jews in Israel, scholar Efrat Shadmi claimed that 'Arabs in Israel have been shown to present poorer health-care utilisation patterns and worse health outcomes in a wide variety of clinical domains' (Shadmi 2018). In her study, which includes significant volumes of data outlining disparities (*ibid.*), Shadmi also critiques other studies,[4] one of whose authors suggest that those disparities are not so acute. She suggests that a range of factors must be taken into account, notably 'the relative contributions of individual socioeconomic status, psychosocial and health behavioural factors' (Daoud *et al.* 2018). A 2018 national survey of ethnic differences in knowledge and understanding of supplementary health insurance found that,

> In spite of universal health care, there are inequalities between Arabs and Jews in health and health care… The Arab population has poorer health status compared to the Jewish population… and tend to reside in peripheral areas where the access to health professionals and services are lower. Together with language and cultural barriers, all these factors may contribute to inequalities in health.
> (Green *et al.* 2017: 2)

Accordingly, it is hard to determine whether those discrepancies are the result of poorer provision of health care in the areas in which those populations live, structural discrimination issues on the grounds of religious or ethnic differences within those institutions with existing health inequalities, or a combination of those factors.

Lastly, a recent study into the satisfaction with primary care physician performances conducted by Samah Hayek and others, found that 'Jews and Arabs were very satisfied with Primary Care Professionals' [PCPs] performance. However, there are ethnic differences in the extent of satisfaction level related to the performance of PCPs' (Hayek *et al.* 2020).

2.2 Intercultural competency interventions

The need to work towards improved cultural competency in the Israeli health sector has been an objective of the Israeli Ministry of Health (MoH) for many years: between 2011 and 2014, ILS 2.2bn (US$65m[5]) was invested in infrastructure and manpower and ILS 1.6bn (US$48m) on reduction of economic and cultural barriers to health-care services so as to 'mitigate health inequity' (Horev, Averbuch and Kedar (2013) cited in Horev and Avni (2016)). During and since that period, a range of MoH publications have highlighted progress made, including:

- Policy around language in the public space and in interpersonal communication (MoH 2016).[6] This includes ensuring hospital signage in multiple languages.[7] It also includes written resources, in wards for medical professionals, as well as communication between practitioner and patient.[8]
- Setting up and running a telephone call centre providing real-time translation services from Hebrew into Arabic, Russian, Amharic, and French for people who undergo community and inpatient medical care. The centre started as a pilot project in 2013 and reached full speed in 2014. Between 2013 and 2015, the number of calls to the translation service in Russian grew by 464 per cent, Amharic by 75 per cent, and Arabic by 35 per cent (MoH 2016).
- Publication in 2011 of cultural competency training in all hospitals in Israel, including a directive for hospitals to appoint a staff member as responsible for 'cultural competency' (MoH 2011).
- The annual strategic plan, and its national implementation of cultural competency 'Coping with Health Inequality' by the Israeli MoH.[9]
- Tracking and analysing patient satisfaction by the MoH in relation to cultural and ethnic interpersonal relations (Hayek *et al.* 2020).

- Orit Eldar Regev (2013) has researched the specific role of nurses and nursing schools in this field.[10] One of her main research questions is the extent to which 'Israeli nurses meet and care for patients of various cultural backgrounds', and the ways they measure their 'preparedness, sensitivity, efficiency and awareness of all these issues' (*ibid.*). Her results point to sentiments, based on interviews with 690 hospital nurses, that

  > most hospital nurses in Israel feel only partially competent to deliver cultural care properly to their diverse patients, and that cultural competence largely depends on previous experience with culturally different patients, and also on preparedness for training courses. For future health-care policies it is important to mention that the data clearly showed the need to introduce training of cultural competence in nursing schools (*ibid.*).

  Further,

  > despite the moral duty and the social, medical, and economic logic behind this goal, much difficulty surfaces when implementing national policies that propose to attain it. This is mainly due to an implementation gap that originates in the complex interventions that are needed and the lack of practical ability to translate knowledge into practices and policy tools (*ibid.*)

One case study focuses on the time it takes to prepare and implement strategies for improving intercultural engagement. A recent case study concludes that: 'In the meantime, efforts should be focused on PCP–patient interactions including interventions to increase patient's [*sic.*] health literacy, improve PCPs' interpersonal skills (e.g. listening, empathy toward patients, emotional support, and friendliness), increase the time spent with the patients, and training professionals to be culturally competent and understand their patients' needs' (Hayek *et al.* 2020).

Some of the most thorough research determining what constitutes intercultural competence has been conducted by Michal Schuster, who focuses on minority needs and accessibility in Israeli health care.[11] In one study into the level of cultural competency (CC) existing within Israeli hospitals and what helps to promote it (in which 35 of 36 general hospitals participated), it was found that

> CC is mainly perceived as 'language accessibility' (i.e. providing the linguistic needs of patients) and less as broader cultural adaptations… Despite the awareness to the importance of CC and the willingness to promote it, the subject is competing with other relevant issues on the agenda of hospital leaders, and in practice, implementation is low to middle (Schuster, Elroy and Rosen 2018).

It is therefore evident that to the extent delineated above, interventions are being delivered to embed CC practices within the health-care sector. However, the extent of intentional engagement with the religious diversity of patient populations remains unresearched to date. A potential gap in

the research could be identified here, where a specific focus on questions as to how interventions delivered actually encourage and enable religious minorities to feel as if their concerns are being addressed.

2.3 Interfaith dialogue as intercultural competency

In the aforementioned study conducted by Schuster *et al.* (2018), ten different CC aspects were ranked across hospitals in terms of how well they were being implemented. Topics included: appointment and development of the CC coordinator; cultural adaptation of human resources policy; adaptation of the physical environment; and translation. There was one aspect which related directly to the question of religion (religious and cultural services). Hospital managers were asked to self-score their institutions' preparedness of each topic. Religious and cultural services was the topic that ranked highest across the survey. It is worth noting, however, that respondents had to answer three questions regarding religious and cultural services relating to the provision of prayer spaces, accommodation of religious holidays, and taking a patient's religious identity into account when providing care. The survey did not differentiate between majority and minority provision and it is hard to draw conclusions about the extent to which the needs of minority religious groups are fully considered.

It is interesting to note that, despite religion and politics being deeply intertwined in the Israeli context, the Schuster *et al.* (2018) study makes relatively little reference to religion. Even though the hospital management is aware of the need to enhance CC within their institutions, religion as a component of CC is perceived as relatively unimportant. Indeed, it suggests that religion and religious diversity is poorly integrated into mainstream notions of CC. As a result of this element of CC being under-explored, interventions that emerge from the analyses detailed in this chapter will be less able to deal with the religious diversity within hospitals and, as such, less able to ensure that all individual rights to FoRB are protected.

It is this gap which the intervention delivered by the Faith & Belief Forum (F&BF) seeks to address, namely that by delivering CC within an explicitly interfaith context and framing, participants are given a clear opportunity to reflect on that diversity and to begin to listen to the experiences of patients and colleagues. Having done so, they are then in a better position to develop collaborative solutions to the question of religious discrimination.

3 Methodology and approach

3.1 The interviews

To explore the question of what impact intercultural competency training delivered by interfaith practitioners had on the experience of individuals identifying with minority religions, at least one person from the following categories was interviewed:

- F&BF intercultural training facilitators;
- Caregivers who participated in intercultural training; and
- Senior staff in managerial teams who oversaw training events.

This enabled the study to, firstly, gain some indicative reflections from a cross-section of trainings; secondly, hear about the impact of the training on caregivers themselves; and thirdly, find out about the institutional impact.

Giving a platform to the voices of, and understanding the experience of, minority individuals was a priority, but it was felt especially pertinent for the caregiver interviewees to be from minority backgrounds, so as to explore how the training impacted their experience of working in the sector as a minority.

To this end, the following professionals were interviewed according to these three categories:

- Two Muslim Palestinian caregivers: one working in the maternity section and the other in orthopaedics. These two caregivers were selected as they had participated in intercultural competency trainings and could provide reflections from a Muslim and Palestinian perspective. They were interviewed in Arabic by a Palestinian Muslim consultant to F&BF who carried out some of the interviews.
- Two Israeli Jews were interviewed: one working in paediatrics and the other in an emergency trauma unit. Both were interviewed in Hebrew by the lead researcher.
- In addition, two senior managerial hospital staff were interviewed, both of whom were Israeli Jewish women. They were interviewed in English by a Palestinian Muslim consultant to F&BF.
- A Muslim Bedouin intercultural training facilitator was interviewed out of the pool of facilitators. The selection was made because she could present a minority voice required for this case study. Additionally, she was able to provide important reflections for this case study both as one who runs F&BF sessions, and also in her capacity as a medical professional in the Negev region.
- The Jerusalem Intercultural Center,[12] which pioneered intercultural competency training in hospitals, was also consulted.

The researcher conducted interviews in Hebrew, Arabic, and English, which was critical to ensuring accessibility and to mitigate, as far as possible, self-censorship on the part of interviewees from minority backgrounds.

It was important to interview caregivers from a majority background in order to explore the impact that training had on their relations with minority colleagues and also their care towards minority patients. This means that any impact on patients is described through the perspective of the practitioner who gave the treatment.

The interviews aimed to collect the reflections of those involved in intercultural training from different perspectives: whether participation had changed their level of competency in dealing with colleagues and patients in a manner sensitive to their cultural and religious needs, and if there have been changes in hospital practices in relation to support and engagement with minorities.

The Covid-19 pandemic made it impossible to meet interviewees in person as this is a challenging time for hospitals, and because during late April and early May 2020 Israel was in lockdown. This affected methodological choices as face-to-face meetings could not be carried out. It also reduced the number of interviews conducted. All interviews

were therefore conducted through one or more phone calls, in the period February–June 2020, following the same questions with each interviewee as outlined in Annexe 1 – but with room for additional elaboration if interviewees felt inclined.

3.2 Positionality of researchers

There are limitations that accompany all qualitative research, notably the inevitability of subjective interpretation and researcher bias. We sought to balance bias by involving researchers from both majority and minority backgrounds.

The lead researcher holds an MA in Intercultural Therapy from Goldsmiths' College, University of London, a PhD in philosophy from University of Haifa, and is a researcher in comparative religion at Bar Ilan University. She is also project manager of F&BF Middle East and is a Jewish Israeli resident of West Jerusalem. Others involved in the research process were a Muslim Palestinian F&BF facilitator PhD candidate at the Hebrew University of Jerusalem, and a Jewish Israeli academic reviewer from the Nursing School of Hebrew University of Jerusalem Hadassah Hospital.

3.3 The hospitals and health-care system

The intercultural competency training, the impact of which this case study seeks to examine, has been delivered in different hospitals, each with different demographics. The hospitals where the interviewees had experiences were as follows:

- Hadassah Ein Karem: with 600 beds, situated in West Jerusalem, this hospital provides 'medical services to Palestinians who live in the West Bank and Gaza Strip'.[13]
- Hadassah Mount Scopus: with 300 beds, this hospital is based in East Jerusalem and, given its locality in a primarily Arab neighbourhood, and proximity to Palestine, has around 30 per cent patients of Arab background (compared to the national Arab population of approximately 21 per cent[14]).
- Tel Aviv Sourasky Medical Center – Ichilov: with 1,500 beds, this is the main hospital complex serving Tel Aviv and the third-largest hospital complex in the country.[15]
- Kaplan Hospital: with 625 beds, this hospital is in the central Israel city of Rehovot and treats patients from a broad range of religions and cultures; it serves residents in central and Southern Israel.[16]
- Barzilai Hospital: with 617 beds, situated six miles from Gaza, this hospital is occasionally the site of reported discriminatory racial profiling of Arabs, and also exclusion of non-citizens (ACRI 2020).

F&BF currently works only in the Israeli health-care system and not in hospitals in the Palestinian Territories. Hence the reason the interviewees were selected from these hospitals and why only the impact on experiences within the Israeli health-care system is being explored, despite the participation of Palestinian interviewees.

Health-care professionals in Israel encounter patients from a variety of ethnic and cultural backgrounds daily, and at moments of acute need.

These groups include Israeli Jews from a range of ethnic backgrounds (European, African, Middle Eastern), Israeli Arabs, Palestinians (including Muslims and Christians), Druze and Bedouins, as well as smaller but significant communities from East Africa, South Asia, and Southeast Asia.

Providing health-care professionals with the skills and necessary understanding to deal with the different needs (e.g. relating to end of life, organ donation, decision-making protocols, blood transfusions, modesty, etc.) of their diverse patients, is crucial to both patient outcomes and broader societal relations.

Though hospitals may be a place where people come together, this does not imply that interactions in hospitals are free from the broader societal dynamics, such as segregation between groups outside the health-care setting. Indeed, the medical sphere could actually present

> context[s] where a sense of superficial coexistence already exists – where the assumption is that their being together every day implies that they are integrated. Yet in these spheres there remains a cognitive segregation where, even though professional integration is desirable, anything deeper than this rarely occurs (Feldmann Kaye 2012).

Those working in hospitals can have doubts and uncertainties about the freedom to express their religious or cultural identity, claiming that the role assumes the relinquishing of strong religious and cultural identities on the part of those entering the institution, leaving religious differences unacknowledged and unaddressed (ACRI 2020). At the same time, this type of coexistence in an Israeli hospital can provide fertile ground for conducting dialogue groups (*ibid.*). It is against this backdrop that this case study has been developed.

3.4 Intercultural training

The case study is based on an exploration of intercultural training and the impact of this on health outcomes for minority faith groups. F&BF is one of several providers of this training in Israel. Trainings are run by the F&BF team based in Jerusalem, which consists of a project manager, and six freelance facilitators; three are Israeli Jewish, one is Israeli Arab Bedouin, and two are Palestinian.

The trainings use a hybrid model combining study cases, interactive dialogues, discussions, and Scriptural Reasoning (SR). SR is a form of inter-faith dialogue which bases learning about other religions and cultures on group readings of selected scriptural texts.[17] Religious texts provide opportunities for discussion on issues of ethics and human behaviour and demonstrate the multiple layers of interpretation over centuries of engagement with intersections between health care and culture. The trainings do not promote religion and are designed to be inclusive of those who do not hold religious beliefs. One aim of the training is for health-care professionals to be able to recognise their own religious and cultural prejudice in their practice.

SR as used in health-care settings can enable deeper forms of engagement and cohesion between participants by: allowing them to enter into dialogue with one another; acknowledging their respective backgrounds and

identities; and reflecting on how these play out in their practice as medical professionals (Feldmann Kaye 2012). The trainings also use elements of training materials developed with Tanenbaum Center for Interreligious

Understanding,[18] which focus on intercultural competency, allowing for the development of culturally competent communication skills.

In these ways, the following areas of health care are covered during F&BF intercultural trainings: dietary requirements; dress and modesty; hygiene; informed consent; observance of holy days and rituals; complementary and alternative medicine; organ transplants and donations; reproductive health; pregnancy and birth; end-of-life care; acceptance of drugs and procedures; blood and blood products; conscience rules; prayer with patients; and proselytising.

4 Interviews and analysis

As discussed earlier, the responses of the interviewees were collected with a view to assessing their understanding of how intercultural competency training delivered by Muslim and Jewish interfaith practitioners influenced and enhanced the experiences of faith minorities within the selected Israeli hospitals. The interviews related experiences of both patients and health-care providers from minority backgrounds. The bulk of the following analysis is therefore split into two sections, namely: patient experiences and health-care provider experiences. Section 4.3 explores the challenges relating to FoRB within the context of the Israeli–Palestinian conflict.

4.1 Perceptions of patients' experience among health-care workers

To understand the impact of the intercultural training, perspectives on the pre-existing situation in their given workplace were sought from health-care workers as per their anecdotes of situations they witnessed on the ground – patients themselves were not interviewed. The situations described below are therefore of a second-hand nature as told by health-care workers and managerial staff. They spoke about general difficulties faced by minority patients due to a lack of cultural understanding and perceived discrimination and gave examples of incidences where this led to poor or fatal health outcomes. Three examples were: (1) a Jewish girl of Ethiopian descent who was re-hospitalised apparently due to her father mistakenly believing her skin medication should be taken orally; (2) a non-Hebrew-speaking pregnant patient who was given instructions for what to do if her baby stopped moving – neither she nor her husband understood the instructions, however, and a week later she suffered a stillbirth; and (3) refusal of a Jewish hospital manager to take advice from a Bedouin Muslim colleague around provision of a breast cancer awareness programme in her community. '[She] doesn't speak Arabic, she decided on the programme from her office without visiting the community.'[19]

There were also examples which spoke to unconscious biases and touched on examples of religious intolerance. One participant spoke about patients wearing niqab and said that health-care professionals 'might judge her by her appearance and say that she's uneducated or extremist'. These were juxtaposed with responses from participants from majority backgrounds who recognised the need for improved understanding of each other's religious practices and languages; the impact of the training was a

deeper appreciation of the importance of religious literacy and how it can impact outcomes for patients. One participant said: 'We need to learn a lot more about each religion in depth', while another conceded that 'I now recognise how important religion can be for a patient as it defines how they respond to medical matters.' This goes beyond simply knowing the religious identity of a patient but rather being able to endeavour to interpret the clinical experience of the patient through their religious identity – what their aversions or concerns may be, how they might make certain decisions, and what barriers they may be facing in the hospital.

Training delivered by a multifaith team with the use of SR as a method, in separate sessions from the general intercultural competency training, allowed for a deeper understanding: 'The texts help to understand the sources of religions, and therefore, how religious people will make decisions.' Participants gave specific examples of improved religious literacy and how this influences their provision as health-care professionals: 'A [patient] in danger can be treated on Shabbat or break their fast [during Ramadan] because I tell them that this is important for their wellbeing, and I try to use religious arguments because this is what's important for them.' In this specific case, a Muslim health-care professional suggested helping her Muslim patient through the use of religious language. The same Muslim health-care worker had also gleaned the knowledge of the Jewish ritual of Shabbat, and the concurrent problems related to working on the Shabbat, and used this for the apparent benefit of the patient, i.e. to demonstrate her awareness of the problem which would then enable her to respond on a level and with the relevance of the issue at stake, e.g. knowing which machinery and tests are prohibited on Shabbat.

Participants also spoke specifically about skills developed in trainings, such as dialogue and scriptural reasoning as highlighted above. Another was empathy: 'It's important to be empathetic even if the patients' decision contradicts our own beliefs.' Therefore, training established an understanding not only of the patients but also of themselves, their own biases and behaviours, and how to prevent complicity in discrimination to whatever extent possible. Interviewees noted that improved cultural competency served to enable health-care staff to take initiatives to raise and address the religiosity of patients even where the latter had felt wary of doing so: 'Some patients will keep their faith to themselves because they're in a hospital. Yes, it seems that their personal faith is in fact relevant and important to their treatment and relationships with us.' It therefore seems that the training empowers staff to become more aware of the complex and sensitive ways in which religion influences patients' engagements with the health services.

4.2 Health-care provider experience

As previously mentioned, a great deal of the responses from the interviewees touched upon the impact that the training had on health-care providers themselves. Again, interviews gave an insight into the existing conditions from which the impact of the trainings was understood.

There were examples of Muslim professionals facing a lack of understanding from colleagues borne of religious illiteracy: '… the supervisor kept telling us to eat and drink, but she didn't understand what

Ramadan means'. Notably, there were references to the understanding towards Muslim colleagues being less than that of the understanding they showed for Jewish counterparts:

> *In Ramadan, it's very difficult for* [colleagues] *to understand that we have been fasting all day long, so they give me evening and night shifts… they don't understand that we need a break for Iftar. At Kippur it's different; they don't have to do anything, so we do everything.*

This frames this issue not only as one of general lack of cultural competency but one which disproportionately affects minority religious communities within the health-care system.

This disparity was also referenced in terms of spoken language. One Arab health-care interviewee noted that:

> *In my ward, there's only me and another Arab nurse. Once we were at the front desk talking in Arabic about personal issues, then one of the older nurses who was sitting not too far away slammed her hand on the desk and told us that we live in Israel and we should speak the language of the country, Hebrew, and that she didn't want to hear Arabic. I didn't reply but when we complained to the head nurse, who agreed with them, she said not to speak Arabic, and said that some of the patients complained about hearing us speak Arabic. On the other hand, Russian nurses speak Russian even when they give information to the nurses in the next shift, they do it in Russian, even when I am with them.*

Health-care staff from minority backgrounds also referenced discrimination and 'prejudices and misconceptions… microaggressions' from patients. One Muslim nurse who was interviewed noted that,

> *One patient I had in the maternity ward was racist, and the other Arab nurse warned me about her before she went home. I went to take her temperature and blood pressure, she wouldn't even look at me… the patient was crying hysterically, and she accused me of wanting to kill her and her son… she even called security and told them that I wanted to kill her.*

The interviewee did not state the religious affiliation of the person she was treating. Arab staff turn to others from their ethnic group for support where the institutions fail them:

> *The supervisors came and talk*[ed] *to her, but what was really upsetting for me is that they told her that she can file an official complaint… I felt like I had no backup, I did not feel protected… I went to the head nurse… she wouldn't allow me to complain about what happened… she told me that no one will listen to me.*

Examples such as these go some way in explaining why trainings might alleviate prejudice or disrespect experienced by staff and patients. One F&BF training facilitator commented that:

> *For an Arab to open up in a dominant group, we need to give them more time so they feel at ease and participate in the discussion; they know that we're a minority. We're voiceless and we don't want to face problems, or talk about politics or how I am discriminated against.*

One possible inference from the above is that this could also link to the fear of repercussion if someone from a minority group expresses an interest in taking action, and in turn raises the issue of the extent to which they would receive institutional support. This was a point that was merely hinted at, and the participants said that they had not sought to take further action.

Lastly, interviewees referenced examples of how an absence of minority language learning not only results in poorer health outcomes but also disproportionately burdens staff from minority backgrounds who are native speakers and thus required to do extra work:

> *I believe that Jewish nurses should learn some Arabic, some patients don't speak a word of Hebrew, and they need to know how to communicate with them without asking the only Arab nurse to come translate all the time despite having my own patients and my own responsibilities.*

The interviewees reported a positive impact of the training, both on their own understanding – 'It's like holding a mirror up to ourselves and being forced to look at our own prejudices' – as well as overall intercultural relations between colleagues – 'I had the first chance to consider whether who I am affects my relationships with people on my team' – and this was common across responses from both minority and majority background interviewees.

The interfaith element of the trainings as well as the focus on religion in the training methods seemed to lead to increased religious literacy as well as a greater appreciation of the importance for intercultural relations. One training participant stated: 'This whole activity opened my eyes; they had been closed to people of other religions… I need to now be able to use knowledge of religions to work with people in a more understanding way'; while another commented: 'Now we're in Ramadan, we come together to eat Iftar, the non-Muslims help us sometimes and cover the time we go out to eat.'

One hospital manager interviewee was asked whether she believes that intercultural training has had an impact on her staff. She responded that 'afterwards, sometimes months afterwards, their language is more developed, they're more open', signifying more empathy and willingness to develop deeper relationships with colleagues from different backgrounds. She can see that 'things were internalised'. Another hospital manager said: 'They are open to learning. They talk about it afterwards.' And a third hospital manager reflected that now they 'only witnessed the positive aspects of working in a multicultural team', and that meetings between

them 'become richer'. It seems that the training opens up space for health-care staff from all backgrounds to reflect on the role their faith identity plays in their professional relationships and to consider both the challenges and opportunities.

4.3 The Israeli–Palestinian conflict

In the divided and contested context of Israeli society, hospitals and health-care settings remain one of the few spaces where patients and staff interact and work side by side on a daily basis. It is not uncommon to observe Arab doctors treating Jewish patients, and vice versa. Despite the sensitivities associated with talking about the Israeli–Palestinian conflict and the reluctance among health workers to bring this into their workplace, it is impossible to ignore the context in which their work is carried out. Even where the topic is deliberately avoided, it can be perceived in the hostility that the training approach is sometimes met with, as the facilitator interviewee explained:

> *In our training, we try not to blame anyone. People talked about racism and discrimination, but we did what works best to keep it professional and away from politics. If we only give examples about the Arab sector, people will assume we're leftists, that's why we've bring more examples from every sector.*

This might present one reason why several different religious minority groups' beliefs and faith are brought into the discussion (e.g. Christian, Arab, Druze); however, it is clear that this broader picture includes a variety of minority groups out of a recognition that they also need to be acknowledged and addressed. The trainings often serve as an opening into necessary conversations about the conflict dynamics within the health-care sector, although from experience on the ground, there is not a simple answer as to whether the conflict is palpable in the health-care sector. Sometimes it is viewed as neutral ground where people come together to save lives, and sometimes it is seen as ignoring the situation in a supposed 'neutral' environment. The trainings delivered have often given voice to these different opinions, as to how far the conflict is sensed. One interviewee felt that such conversations would otherwise not take place: 'We ignore all this stuff about the conflict. It was hard to admit that those feelings were really there simmering underneath our pretend friendships.' The result of these conversations is that participants are able to separate the identity of their colleague or patient from the particulars of or their feelings about the conflict, as explained by one interviewee: 'I need to learn to respect people of other religions, and to recognise that what happens around us, is not a result of their beliefs or actions.'

It appears that this in turn leads to improved relations between colleagues and increased solidarity among team members, and goes some way in providing the much-needed support from the majority for health-care staff from minority backgrounds in the face of prejudice and discrimination. As described by one Jewish Israeli interviewee:

> *During the second* intifada *in one of my shifts in the trauma unit, I was working with a nurse called Muhammad, and people were protesting and saying that they did not want him to take care of their loved ones, we were treating victims of a bus bombing at that time. I told them that he is a competent nurse and he will take care of the patient, but I had to be very sensitive and understanding of their pain. Standing up for my colleague and defending him is important.*

The response of this nurse combined with the timing of the incident shows a strong shared humanity in the face of the live conflict and any personal responses it may evoke.

Once conversations can be carried out about religious identity and needs as per the trainings, the empathy and cultural understanding derived from dialogue can translate into improved feelings across groups who may otherwise see themselves as being situated along conflict fault lines. It seemed that interviewees spoke about improved relations between groups where the conflict is concerned, in terms of religious tolerance:

> *In one case, this patient who was a religious Jewish man was praying and a nurse who is a Palestinian woman wearing a hijab stood by the door until he finished his prayer to give him his medication. The same happened with a Muslim man and his Jewish nurse. The patient said that he felt more humanised, that religion was important for the patient and the nurse and this unified them. The nurse knew that medications are not the only part of healing, and that following cultural and religious rituals was as important.*

This link supports the idea that improved intercultural relations improves FoRB, and also that increased religious literacy and critical thinking around one's own identity contributes to improved relations in Israeli society, of which the hospitals are an element.

Conversely, intercultural competency trainings that omit the faith or belief element may suffer from a decontextualisation from the power dynamics at play. A Jewish Israeli senior member of hospital staff said: '[T]he hospital [is] very multicultural… I don't see challenges or negatives when we get together, only the positive things… but politics is very complicated and is not a part of the conversation.' This approach, while it may lead to increased cultural competency, does not necessarily provide space for challenging admissions to take place and for the level of critical reflection and unpacking of unconscious bias required for institutional change and enhanced experience for staff or patients from minority backgrounds.

5 Conclusions

This case study set out to explore the extent to which intercultural competency training, delivered in interfaith settings within health-care institutions in Israel, enhances the experience of religious minorities in particular.

The case study was limited in that interviewees did not reflect a broad population group and, therefore, statements on the medical sector in the

Israeli society could not be gained. One example is that interviewees were either Muslim or Jewish, meaning that other minority groups, such as Christians and Druze, were not reached. In future research, it would be important to ensure that those of other minority faiths are included in the research. Improved research would ideally collect testimonies from a broader cross-section of society. This would require giving further attention to accessing other sectors of society as they are represented in hospitals. Those interviewed, and the hospitals involved, were all well-known hospitals in cities or large towns. Smaller medical centres were not represented, and nor were those of peripheral geographic areas. In future research, we would want to collect testimonies from a cross-section of hospitals and medical centres in locations around the country.

This case study was limited to research addressing minority religious groups. Given this focus, other important issues that arose through this study could not be addressed thoroughly – one main example is that of spoken languages. In all the interviews, the issues of language, translation, and interpretation were raised. It is recommended that future research considers the inter-connections between religion and language.

An additional recommendation for further research is related to the inter-religious study method, Scriptural Reasoning (SR). It would be worthwhile exploring further the contexts in which SR is practised, such as prisons and schools, and then aiming for a greater understanding of the specific nature of SR in the health-care context. It is hoped that these issues can be addressed in future research, as contributions to this case study.

Overall, findings of this study can be summarised as follows:

It has been shown that health outcomes are connected to group and individual identities, which could be enhanced by investment in improving the intercultural competencies in hospitals. However, in spite of the fact that the ongoing conflict can be and is seen as having a religious element, religious affiliation for those on the margins is poorly expressed in the narrative relating to those differential outcomes or to the experiences of professionals working in the health-care sector.

While there are robust frameworks within which cultural competency interventions are designed and delivered, religion is poorly integrated into the analysis and frameworks, with hospital managers left to determine for themselves how and what their priorities should be in terms of enhancing culturally competent practices within their institutions.

An interfaith approach to cultural competency, part of which includes an interfaith dialogue component, provides a space to raise incidences of discrimination and violations of FoRB, and thus enables all participants to reflect on their own experiences of how religion is handled in the workplace. In particular, these spaces have been effective at enabling health-care staff to reflect on the intersection between identity and patient relationships. Understanding the religious and cultural needs and practices of patients from different minority faith backgrounds enables health workers to adopt strategies that can lead to better decision making and treatment, thus creating the conditions for enhancing health outcomes for minority patients.

While the focus of the trainings delivered by F&BF is to improve participants' understanding of the needs of different groups of patients as

defined by their religion, in actuality, one of the significant outcomes of the training is the building of awareness of the multiple and serious challenges faced by health-care professionals from religious minorities in terms of the discrimination which they face on a daily basis, both from patients and colleagues. Trainings delivered by multifaith teams allow professionals from minority backgrounds to vocally reflect on any barriers to FoRB which may otherwise be taken for granted. Being heard in this way is a key outcome for interfaith training and can assist in improving the workplace experience for staff from minority backgrounds (as well as the effectiveness of teams within hospitals – leading to improved health outcomes for patients). Developing strategies to protect workers from minority backgrounds would certainly enhance FoRB outcomes for those individuals.

Understanding how the situation within the health-care sector relates to the wider context (of a conflict in which religion and politics are intertwined) is made all the more challenging because the religious element of the conflict is poorly understood and articulated. Nonetheless, what this study supports is that patients and health-care staff suffer religious discrimination for a variety of reasons, primarily due to a lack of knowledge of the other. As such, imagining a society in Israel where FoRB is universally respected and upheld requires imagining a society where the conflict is fully and justly resolved.

Despite the complexities of the wider context, developing strategies and approaches to enable an analysis of the context which recognises and acknowledges the religious diversity is critical in order to address existing religious discrimination.

Annexe 1 Interview questions

Group 1: Caregivers and participants of intercultural training

Questions for participants *vis-à-vis* (a) patients (b) within their teams:

- Can you tell me more about yourself (where you work, your role)?
- In which ways, if any, do you face intercultural issues in your line of work?
- Can you give a couple of examples of those issues (i.e. where you see them play out)?
- How are/were these issues handled? Is this considered the typical approach to dealing with them?
- What are the relations like in your line of work between peoples of different religions and cultures?
- What are the main challenges?
- What are the negative and positive aspects of such interaction?
- How do you think religious/cultural minority groups are treated in your department or hospital?
- Have you ever participated in or facilitated an intercultural or cultural competency training in your institution or other institutions?
- In which ways, if at all, has your participation in intercultural training changed the way you think, behave or relate to people?
- Can you give examples? (Ask for more until you get 2 or 3.)
- What would you want to change if you could, to improve intercultural relations in the health-care system?

Group 2: Managerial staff

- Can you tell me more about yourself (where you work, your role)?
- What are the relations like in your line of work between peoples of different religions and cultures?
- What are the main challenges?
- What are the negative and positive aspects of such interaction?
- How do you think religious/cultural minority patients are treated in your department or hospital?
- Does the Ministry of Health offer guidelines and training on intercultural training?
- Does the hospital itself provide intercultural training?
- Why do you encourage intercultural training?
- In which ways can training have an impact on the ways in which caregivers respond to the needs of patients?
- Can you give examples? (Ask for more until you get 2 or 3.)
- What would you want to change if you could, to improve intercultural relations in your hospital?

Group 3: External bodies

- Which projects do they run in hospital? (See their website and blog on this area first, which has information.)
- What are the challenges, in their view, in Jerusalem hospitals?
- Are there issues in Jerusalem health-care institutions which are different to those in other parts of the country?
- What do they feel the effects of their programmes are, and what change is made – some reflections? (Does not necessarily require data.)
- Does the Ministry of Health offer guidelines and training on intercultural training? Has this changed in the last 2–3 years?
- What would you want to change if you could, to improve intercultural relations in Israeli hospitals?

Group 4: F&BF Middle East facilitators

- Can you describe some of the work you've done in health care with a focus on intercultural relations? With the F&BF?
- In which ways is the work in hospitals important? For example, including minority faith communities, trying to improve relations between medics and patients?
- Can you share any thoughts on the content and delivery of F&BF methods?
- In which ways, if any, are they reflective of the way you'd want to run a training?
- What might you change about the training? Or do differently?
- In which ways, if any, do you think participants are influenced by the training?
- Can you name two examples of changes they've seen.
- Would you be willing to share reflections on changes they experience during the process?

Notes

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2 **Universal Declaration of Human Rights**.

3 See, for instance, Hurd (2015) for critiques exploring the tension between international legal, political, and societal interventions delivered under the banner of FoRB promotion and the critical realities of how those communities and individuals receive and experience those interventions.

4 *Ibid*.

5 According to a September 2020 exchange rate.

6 Commitment to translation services by the Ministry of Health can be viewed at MoH (2016).

7 This has been addressed in Schuster, Elroy and Elmakias (2016).

8 This has been well researched in Elroy, Schuster and Elmakias (2016).

9 This has been described as a report 'published by MoH ahead of the national conference and includes data on MoH and HMO activities to narrow gaps. Hospitals are also invited to contribute to the report; occasionally they, too, describe what they have done to mitigate disparities. The annual reports, along with MoH publications on health inequality and ways of dealing with it as well as other MoH publications on additional aspects of this issue over the years, have kept the struggle against health inequality on the agenda, furthered the sharing of relevant information, and incentivized and promoted competition so to continuously improve organizational action against health inequality' (Horev and Avni 2016).

10 See also Noble *et al*. (2009), which examined cultural competence and ethnic attitudes of Israeli midwives.

11 **Dr Michal Schuster, Department of Translation and Interpreting Studies**, Bar-Ilan University.

12 **About the Jerusalem Intercultural Center**.

13 **Who We Are, Hadassah International**.

14 **Central Bureau of Statistics** (in Hebrew).

15 **Tel Aviv Sourasky Medical Center Wikipedia page**.

16 **Kaplan Medical Center website**.

17 See Feldmann Kaye (2012). See also **Cambridge Interfaith Programme** and the **Scriptural Reasoning website**.

18 **Improved Patient Care publications, Tanenbaum.**

19 Citations are from key informant interviews conducted during the period February–June 2020.

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