Good Practice in Person-Centred Intercultural Care

The principles of patient safety, quality care and value should Guide all interaction with people using health services.

Following are eight key pointers that all staff should keep in mind in all intercultural interactions in order to work to the principles of effective person-centred healthcare.

Working with cultural information

Cultural observers indicate that culture is 'dynamic and changing'. [16]

Many of us wish to have access to information that will indicate precisely how those from other cultures will behave in the belief that this information will help us be more competent in working with those from backgrounds different to ours. Cultural observers inform us that such information is unattainable, as each person is an individual who in normal circumstances has the capacity to conform to or deviate from the dictates of their culture. Each cultural norm is therefore best seen as a continuum rather than a fixed point.

Many complex and interrelated factors determine a person's relationship to any particular cultural or religious norm. These include the resources available to a person to live outside the norms of their culture, the actual or perceived consequences of deviating from cultural expectations and the person's willingness to exercise the freedom that they actually have. For example, in the 1950s Irish people tended to conform to societal expectations, while in the present era changed circumstances have allowed for considerably more freedom for deviating from family, social and religious expectations.

16 See for example, Ting-Toomey, S. (1999) *Communicating Across Cultures* and Bennett, M.J. (Ed) (1998) *Basic Concepts in Intercultural Communication:* Selected Readings.

Equally, a person's closeness to or divergence from the norms of their social, ethnic or religious group is part of a dynamic process that changes over time. This is particularly true of immigrants adapting to the way of life in a new country. For example, immigrant parents often find that their children struggle between the dominant culture of the new homeland and the traditional norms of their ethnic group.

An important distinction exists between *generalising* and *stereotyping*. In order to present information relating to the various cultures and religions we use *generalisations.* These indicate patterns *likely to present* in particular contexts, while recognising that the behaviour of any individual is not fixed in relation to those particular norms.

In providing this information, we cannot assume or imply that each individual member of a particular group will definitely conform to a particular pattern, which would be to *stereotype*.

We recommend that staff keep these cultural dynamics in mind in all intercultural interactions.

Person as individual

Some religions and cultures are more prescriptive about the expected behaviour of followers. At the same time each person is an individual with specific needs.

Our overall starting point must therefore be to clarify the wishes of each person so that the care plan reflects their individual wishes. Where necessary, we can consult with family or designated religious representatives, while recognising that the person has individual needs.

In all interactions we need to keep in mind that the person is an individual with specific needs irrespective of cultural, societal or religious obligations.

Individual versus family needs

It is not uncommon that where a person changes from the religion that they were born into to another that family may not be aware of the change or approve of it. This can be a sensitive issue among Irish people who have changed from one tradition of Christianity to another or who leave a Christian church and follow another religion. This can sometimes cause conflict between the person and family.

We need keep in mind that the wishes of the person being cared for are paramount, irrespective of family.

Assumptions about religion

We cannot make assumptions about a person's religion. For example, despite the fact that the majority of the Irish population indicated in Census 2006 that they are Roman Catholic or Christian, we cannot assume that a white Irish person will be a Catholic or a Christian.

It is equally inappropriate to assume, for example, that a white Irish person who declares a religious preference other than Catholic or Christian is a lapsed Catholic or Christian.

We should always enquire about the person's religion in a private respectful space (see next shaded point) rather than assume it based on subjective criteria.

Identifying an appropriate religious or personal contact

It is a common practice in Irish healthcare settings to ask the person their religion, often in a public area at the point of admission. One of reasons for asking the question is to ascertain pastoral needs. There are some fundamental issues with approaching the identification of pastoral needs in this way.

- The second largest response to the religion category in Census 2006 after *Roman Catholic* was *No Religion* (186 thousand people). Representatives of this group have indicated the embarrassment caused to their members at having to *opt out* of a preconception in Irish healthcare settings.
- Others may have spiritual beliefs without being a member of any of the main world religions. From the research for this publication we are aware that this is a feature of both the dominant ethic group (i.e. the White Irish) and some Minority Ethnic Communities.
- Members of indigenous and ethnic religions, for example Witchcraft or Druidry, may be unwilling to disclose their spiritual affiliation in public settings due to preconceived and erroneous notions about the nature of their religious practices.
- Even where the person has a specific religious affiliation, in many cases this will not enable us to understand who to contact should the person wish to avail of guidance, religious or otherwise. The reasons for this include:
    - Some recognised religions listed in this Guide do not have formal religious leaders.
    - Others have enormous diversity in practice within the religion itself. For example knowing a person is Buddhist may not be useful as there is more than one tradition of Buddhism practised in Ireland.

We recommended that the person is asked for the name and contact details of who they wish to have contacted should they need religious guidance or personal support. This should be asked for in a private respectful space so that people do not feel uncomfortable disclosing this very personal information. Clarifying the name and contact details of a religious/personal contact is particularly important for those whose religion is not represented among the chaplaincy team, those who do not have formal religious leaders and those who do not have religious belief.

Establishing relationships with diverse religions

The chaplaincy department can be a resource in establishing contacts for many religions other than those represented on the chaplaincy team who can be contacted for information, guidance and if necessary religious intervention. In some of the healthcare settings that contributed to this resource the chaplaincy department compiled a list of religious contacts, which is a good starting point. Others have both compiled a list of contacts and invested time in establishing a mutually beneficial working relationship.

We recommend that each setting compiles a list of contacts for and establishes working relations with diverse religious groups locally, as relationship building is an essential component in ensuring that religious representatives will be available when needed.

At the end of each section we have listed information sources that could be used to establish relations with the religions that are more established and structured. In some cases the contact will have to be sourced from the person and we have indicated where this is the case.

Diversity within religious traditions

Many religious groups, particularly the larger ones, are diverse in themselves, making the process of describing the expectations of their members quite complex.

For example, Figure 1 below gives examples of some of the national and ethnic backgrounds that make up Roman Catholicism, the main religious affiliation of respondents in Census 2006.

The figure indicates that Catholic practitioners may come from Ireland, EU countries including recent accession states, Asia, Africa, Oceania and the Americas. The same diversity is represented within the other larger Christian Churches including the Church of Ireland, Methodism, Orthodox Churches and Presbyterianism all of whom have greater numbers of followers from the new communities.

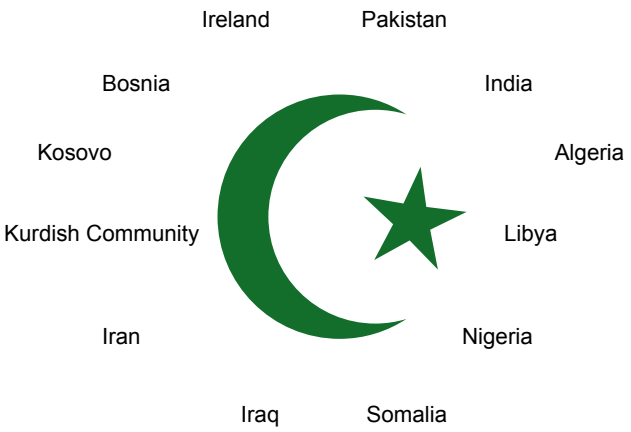
Figure1: Roman Catholicism and national / ethnic background

Figure 2 presents some of the national and ethnic backgrounds of followers of Islam currently living in Ireland, now the third largest religious affiliation in the State.

The figure clearly indicates that Muslims in Ireland come from a number of cultural backgrounds. Hence, while Islam was founded in the area now referred to as Middle East among an ethnic group referred to as Arab, it is inaccurate to associate

Islam solely with the Middle East and/or Arab culture.

Figure 2: Islam and national / ethnic background



In dealing with religious groups, staff need to remain open to additional cultural requests that may have their origins in national or ethnic culture.

Healthcare setting approach to diversity

Respect for the cultural and religious beliefs of diverse groups needs to be established and reinforced in the ethos of each healthcare organisation that is providing health services to the public. This ethos needs to be embodied in all aspects of healthcare practice.

A particular issue is the use of religious icons and symbols in the mortuary area, which is the sole facility for all religions in healthcare settings.

Some healthcare settings are already leading in the area of being sensitive to and respectful of all traditions. One example is the Children's University Hospital, Temple Street. The facility has developed an icon-free multifaith facility with the entrance door displaying symbols of several religions on a *Tree of Life*, which is displayed in Figure 3. The *Tree of Life* is the only emblem on the mortuary door and family space has been set aside in the vicinity of the mortuary to allow the bereaved the space they need at these vulnerable times. Other healthcare settings are following a similar approach. All of these settings testify to the value of this approach in promoting dignity and respect for the family and community mourning a deceased loved one.

We suggest that it is not appropriate to display icons of one religion when a deceased person and bereaved family from another religion are present in the mortuary. An alternative respectful practice is to store the crucifix, cross, candles, other traditionally used icons such as that of Mary, Mother of Jesus, as well as icons recommended by religious leaders from other diverse religions and use them as needed. At a minimum, where an icon such as the crucifix or cross is fixed to a mortuary wall and cannot be removed it should be covered when a deceased person and family from another religion are present in the facilities.

The same respectful approach should be used for any nearby family facilities.

The Executive of the National Association of Hospital Chaplains supports the need to be sensitive and respectful to everyone who avails of the mortuary facilities.

Figure 3: Tree of Life at the Children's University Hospital, Temple Street displaying symbols of several religions