Culture, Spirituality and Religious Literacy in Healthcare

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Chapter 6

Perceived religious discrimination in healthcare: A qualitative study of formal complaints

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6 Perceived religious discrimination in healthcare

A qualitative study of formal complaints

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Introduction

Hospitals are public spaces, where religions, beliefs, and values collide and are negotiated (Cadge, 2013). In such a context, perceived discrimination in healthcare on the grounds of religion and beliefs concerns several dimensions of tension between equal treatment and diversity. This includes challenges related to migrant healthcare and religious minorities in Swedish society – known to be among the most secular and the most religiously diverse societies (Sorgenfrei et al., 2021). Notably, there are no governing documents that explicitly regulate religion and religious diversity in Swedish healthcare. Instead, conflicts are often resolved with regard to individual circumstances (Sorgenfrei et al., 2021; Zillén, 2016). Therefore, it is thus relevant to study tensions between the healthcare system and patients' expectations in relation to religion, diversity, and equality by exploring individual cases where problems have been reported. In this chapter, we explore how these tensions are expressed in complaints about religious discrimination submitted to the Equality Ombudsman in Sweden, which is the Swedish Ombudsman against Discrimination. Interestingly, cases of discrimination reported to the Equality Ombudsman have rarely been analysed, despite its rich data on perceived discrimination (Bursell, 2021).

The aim of this chapter is to explore what characterizes patients' and their relatives' expectations in healthcare encounters that are perceived as religiously discriminatory in the culturally and religiously diverse Swedish healthcare system. We analyse the following research questions: (1) How do complainants express being discriminated against in relation to their religion or beliefs? (2) Which unfulfilled expectations in relation to religion and beliefs in healthcare encounters are expressed in the complaints? (3) How do these unfulfilled expectations relate to the Swedish Patient Act?

The Swedish Patient Act (2014: 821) established equal care, accessible care, patient participation, and evidence-based care as the guiding principles of healthcare. According to the Patient Act, the entire population should receive equal and accessible care with every person valued equally. In addition

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to the principle of equal care, the Act prioritizes vulnerable individuals: "Those who have the greatest need for healthcare must be given priority for care" (Patient Act 1 § 6). Additionally, the Act emphasizes patient participation: "Healthcare should, as far as possible, be designed and implemented in consultation with the patient" (Patient Act 5 § 1) and, at the same time, be of "good quality and in accordance with science and proven experience" (Patient Act 1 § 7).

Notably, in Sweden, the state is not allowed to register religious affiliations. Therefore, although some patients may want special treatment based on their beliefs, these religious needs cannot always be accommodated in healthcare (Nordin, 2018). While healthcare providers must comply with the Patient Act and the principle of equal care, on the one hand, they are expected to consider patients' religious backgrounds by offering culturally sensitive care on the other. Currently, the concept of culturally sensitive care is not clearly defined in Swedish policies and healthcare guidelines. However, overcoming communication barriers to establish culturally sensitive health communication has been suggested to reduce health inequities among vulnerable populations, such as migrants from low-income countries (Binder et al., 2012; Kreps, 2006). Furthermore, Svensson et al. (2017) suggest that the purpose of culturally sensitive care is to improve communication between healthcare providers and diverse populations, enhance migrants' health literacy, and acknowledge the impact of the migration process on health.

Sweden is considered an equality forerunner, where gender mainstreaming is a central strategy adopted to combat discrimination. Our previous research has found that person-centredness correlates well with multiculturalist ideologies that emphasize religious and cultural diversity, but conflicts may emerge between the promotion of cultural sensitivity and equality in healthcare (Arousell et al., 2017). Thus, healthcare professionals are expected to be sensitive towards patients in terms of their cultural or religious traditions, while also promoting gender and social equality. Unfortunately, these may imply conflicting ideals in everyday healthcare encounters. Additionally, there is a need to investigate the meaning of culturally sensitive care in relation to religious diversity and the ways in which healthcare professionals should be sensitive to patients' religious views and traditions.

Our assumption is that situations that are perceived as religious discrimination in healthcare are linked to social treatment, miscommunication, and lack of religious literacy. Among these, the concept of religious literacy challenges the perception that public institutions should be neutral in terms of religion. It builds on the acknowledgement that religion and beliefs are relevant in public institutions and that a proper understanding of the religious landscape is necessary for engaging in conversations about religion and beliefs (Dinham & Francis, 2016). Moore defines religious literacy as "the ability to discern and analyze the fundamental intersections of religion and social/political/cultural life through multiple lenses" (Moore, 2015: 30). Hence, religious literacy is increasingly important in diverse societies, because it includes

the basic understanding of religious beliefs and practices and how religious traditions shape political, cultural, and social expressions (Moore, 2015).

Notably, 25 percent of the Swedish population are either foreign-born or born in Sweden with both parents born abroad (SCB, 2020). Sweden has over the past decades received many migrants from Muslim-majority countries in the Middle East and the Horn of Africa (SCB, 2020), which previous research has described as traditional and collectivist-oriented regions with low tolerance for gender equality and women's rights (Kostenko et al., 2016; Norris & Inglehart, 2012). Given Sweden's demographic development and the increase in the proportion of immigrants with a Muslim background, it is important to explore the diversity of perceptions about healthcare among Muslims and members of other minority faiths. According to the results of the Swedish Immigrants' Values Survey (SIVS), newly arrived migrants in Sweden have fairly more conservative social values than people born in Sweden, with religiosity having the largest effect. In comparison to immigrants in Sweden belonging to other religions, Muslim immigrants generally hold a more conservative position on certain social values, particularly non-marital sexual practices and homosexuality. However, Muslims did not differ from other immigrants in terms of attitudes to violence and divorce (Tibajev et al., 2022). Healthcare providers' religious literacy in relation to Muslim patients should thus include an understanding of the diversity of social values, because Muslims do not migrate to Western countries with fixed attitudes (Norris & Inglehart, 2012). Hence, we assume that expectations on differences in social values between patients and healthcare providers in a religiously diverse society may be based on misconceptions, contributing to miscommunication and distrust – all of which are closely associated with increased risk of suboptimal care (Essén et al., 2002).

Perceived discrimination and religious diversity in Swedish healthcare

Sweden's demographic composition has changed dramatically since the 1990s due to increased migration, especially from countries where religion plays a public role, such as countries in the Middle East, North Africa, and the Horn of Africa (SCB, 2020). In 1975, Sweden adopted multiculturalism as a political approach to support ethnic and religious diversity in contrast to assimilationist approaches. The government's objective was that the immigration and minority policies should strive for equality between migrants and Swedes, which should characterize all sections of society (Prop. 1975: 26). The concept of diversity was further broadened in 1997 through an emphasis on tolerance, societal participation, as well as equal rights and opportunities, regardless of ethnic and cultural background as well as gender. This integration policy emphasized the need to safeguard ethnic and religious diversity to affirm equality. Additionally, the policy emphasized the society's responsibility to prevent and counter discrimination, xenophobia, and racism (Prop. 1997/98: 16). Both

policies included an objective of freedom of choice. Thus, immigrants could choose whether they wanted to become Swedes or preserve and develop their original culture or religion. These policies based on multiculturalism and diversity have significant consequences on how society deals with ethnic and religious diversity in public institutions, including healthcare. However, previous research has questioned whether these Swedish integration policies are truly pursuing equality or inculcating secondary social inclusion of non-Western migrants primarily having access to low paid work (Bursell, 2021).

Very little is known about the management of tensions between values, principles, and rights in relation to religion in Swedish healthcare, particularly with regard to how religious freedom and religious discrimination are handled (Enkvist et al., 2020). The Swedish Discrimination Act (2008: 567) lists the following types of discrimination: direct discrimination, indirect discrimination, lack of accessibility, harassment, sexual harassment, and instructions to discriminate. However, what individuals perceive as discrimination does not always overlap with the kinds of discrimination that can have legal consequences. Thus, perceived discrimination has been identified as a problem that leads to harmful effects on health and is more widespread than discrimination in the legal sense (Pascoe & Smart Richman, 2009).

Patients in the Swedish healthcare system have the right to submit complaints to the Health and Social Care Inspectorate (IVO), which supervises and controls the healthcare system, and care providers are bound to respond to complaints from patients and their relatives as soon as possible (Patient Act 11 §§ 1–2). However, complaints to the Equality Ombudsman are considered less urgent, with very few complaints becoming objects for further review and case supervision by the institution. Hence, discrimination complaints relating to healthcare encounters do not always reflect the actual extent of discrimination in healthcare in terms of the Discrimination Act (the Equality Ombudsman, 2022).

Our previous research about culture and religious beliefs in sexual and reproductive healthcare found that issues concerning human reproduction often involve collisions between religious and secular values, for example, in relation to prenatal diagnosis, assisted reproductive technologies, and religious counselling on abortion or contraception that clash with women's reproductive rights (Arousell & Carlbom, 2016). Additionally, women with migrant backgrounds face greater health disparities, which may be more noticeable among immigrants belonging to minority groups (Arousell & Carlbom, 2016). For example, a qualitative study of immigrant Muslim women in Canadian maternal healthcare noted that the informants experienced discrimination, insensitivity, and lack of knowledge about their religious practices (Reitmanova & Gustafson, 2008). Furthermore, in a study of formal complaints of discrimination in Swedish public institutions, Bursell (2021) found that Muslims experience discrimination in healthcare largely in the form of neglect. The complainants expressed that they lacked access to good healthcare because of not receiving treatment or not being listened to by healthcare providers.

Methods and material

Study setting and study design

This study implements a qualitative study design while using a phenomenological approach, which is best suited for research analysing people's experiences, ideas, and opinions. We explore perceived religious discrimination in healthcare through interpretative phenomenological analysis (IPA) (Smith et al., 2009) of complaints submitted to the Equality Ombudsman in Sweden. Ethical approval for this study was received by the Swedish Ethical Review Authority in November 2021 (dnr. 2021-05382-01). Complaints submitted to the Equality Ombudsman are public documents, with the institution possessing informed written consent from all complainants, who have received information that another party may request de-identified documents.

Data collection

As part of a larger study on perceived discrimination in Swedish healthcare, we made an official request to the Equality Ombudsman for complaints relating to discrimination based on religion or beliefs in healthcare from 2012 to 2021. The requested documents usually included a form, along with a written account of the situation or situations of perceived discrimination. We did not request the appendices to complaints, which may have included correspondence between the complainant and the notified party, images, extracts from patient records, court documents, or audio files. No data identifying persons were collected. Before the data were disclosed to us, the Equality Ombudsman conducted a confidentiality check and de-identified the complaints by masking directly identifiable personal data. During the ten-year period, 92 complaints were registered as religious discrimination in healthcare by the Equality Ombudsman, the majority of which described a specific event or a series of events in which a patient or the relative of a patient experienced religious discrimination. The analytical sample of 66 complaints was composed through data processing by excluding complaints that did not concern healthcare, as well as incoherent complaints. Our assessment of incoherency was based on difficulties in understanding the text, either linguistically or substantively, or extensive de-identification carried out by the Equality Ombudsman, which sometimes resulted in large parts of the text being masked. Additionally, the data also included the Equality Ombudsman's case supervision decisions that addressed four of the complaints in the analytical sample. These decisions are publicly available on the Equality Ombudsman's website.

Analysis method

We used the IPA method (Smith et al., 1999, 2009) to code and map the themes in the complaints about religious discrimination. Smith et al. (2009) describe that the aim of IPA is to explore how participants make sense of their personal and social world and to analyse participants' meaning making from experiences

and events by summarizing their ideas, thoughts, and emotions. IPA aims to get close to people's experiences to attain an insider perspective. Thus, it is an appropriate text analysis method for interpreting individuals' experiences and perceptions of discriminatory behaviour. Hence, the phenomenon under inquiry is religious discrimination in healthcare. In this study, we interpret how individuals perceive events or a series of events as discrimination, and how they interpret interactions in healthcare encounters that have taken a negative turn.

We used a systematic coding and analysis process. An interdisciplinary project group – a sociologist, psychologist of religion, social anthropologist, and a gynaecologist and obstetrician with medical and health system knowledge – participated in the analysis and assessment of data. We first categorized the discrimination complaints in Microsoft Excel according to a set of variables: gender of the complainant, role of the complainant (patient/relative/healthcare professional), where the perceived discrimination took place and whether the complaint led to further investigation by the Equality Ombudsman or a legal process. We continued open coding with an inductive approach by summarizing the content of the complaints without any theoretical pre-understanding. After several re-readings, we summed up the respondents' narratives, beginning with preliminary codes composed of a few words, and then locating patterns of themes.

In the next step, we continued categorizing the data deductively. This process corresponds to the IPA's emphasis on beginning with open coding, and later complementing it deductively to observe patterns through an interpretive process (Smith et al., 1999). By focusing on the research questions, we observed patterns in the expectations and situations that were perceived as discriminatory. To answer the first research question, we coded the data to investigate the complainants' descriptions of perceived discrimination with the aim of mapping recurring situations that were perceived as religious discrimination. To answer the second research question, we coded the data to identify expectations in relation to religion and beliefs in healthcare encounters. Finally, in response to the third research question, we compared the expectations expressed in complaints to the principles of equal care, accessible care, patient participation, and evidence-based care comprised in the Patient Act. In the final step, we theorized the analysis and selected quotations that were either representative of the data or represented "rich points" (Agar, 2006) that could be considered surprising or did not meet our expectations.

Complaints about discrimination in healthcare on the grounds of religion and beliefs

Unfulfilled expectations and legal consequences of submitted complaints

The complaints related to religious discrimination submitted to the Equality Ombudsman indicate patients' and relatives' expectations in healthcare encounters that were not met by healthcare providers. These unfulfilled expectations include (1) cultural and religious literacy, (2) equal treatment in

relation to religious symbols or clothing, (3) equal treatment in terms of patient medical records, and (4) affirmative action in medical treatment that takes beliefs into account. Additionally, the sample included a healthcare professional's unfulfilled expectation of a secular environment forbidding religious symbols in healthcare encounters.

Out of the 66 complaints relating to religious discrimination during over period of ten years, the Equality Ombudsman conducted case supervision of four cases and took only one of them to court. The case concerned a male physician refusing treatment to a woman who did not want to greet him with a handshake. For religious reasons, the patient put her hand to her chest and nodded in greeting. The complainant expected cultural and religious literacy in terms of a culturally and religiously sensitive understanding of her unwillingness to shake hands. However, the physician could not accept this and, as a result, refused to conduct the scheduled medical examination:

> Dr. NN comes out in the waiting room to receive me, and extends his hand in greeting. Since I according to my religion do not greet men in handshake, I bring my hand to my heart, greeting with a nod, at the same time as I explain my actions through the interpreter. Dr. NN gets upset, and tells me that here in Sweden we greet by handshake, and if I cannot accept this, he cannot perform the examination, and leaves. He goes his way and refuses to examine me!! First of all, I felt extremely offended and have never experienced any similar behaviour before, at the same time I am appalled that after 3 months of waiting and still with stomach pains, I do not get the examination that might be able to give answers on how to cure/alleviate my pains.
>
> (Complaint 2013/95)

The complainant details her behaviour, which gives a clear social signal of declining physical greeting through handshake. The complaint expresses her emotional reaction towards the rejection of care in the form of taking spontaneous offence at the social treatment and frustration at not being examined, which could otherwise have resulted in the pain relief she sought. Based on the case description, it appears that the physician did not act in accordance with the Patient Act's principles of equal and accessible care. When assessing this complaint, the Equality Ombudsman considered that this case exemplified discrimination due to the woman's religion, indicating that she was discriminated against by the wrongful restriction imposed on her right to healthcare. In effect, the male physician's referral of her case to a female physician, which the patient had not requested, risked delaying her treatment. According to the verdict by the District Court in 2015, it was adjudged a case of religious discrimination. However, in 2016, the Court of Appeal exempted the healthcare company from the charges of discrimination, arguing that the Equality Ombudsman could not successfully demonstrate that the physician's actions were motivated by the woman's religion.

A case where a woman and her partner, who desired a female physician at delivery, depicts another example of unfulfilled expectations with regard to cultural and religious literacy. The woman had mentioned this wish beforehand to her midwife, as narrated in the following quotation:

> I explained the whole situation to her as well, but her response was quite disturbing and shocking:
>
> Midwife: "Where are you from?"
> I answered: [Country in South Asia]
> Midwife: Is it how it is done in your country? Can you get to choose?
> I answered: Yes.
> Midwife: "Ok then you can go there and get your treatment done in your country."
>
> Midwife walks out from the room. […] Well after that my husband went to reception thinking that probably it's only the nurse who has a discriminating behaviour and he can discuss the situation with someone else at the reception or with doctor. The doctor was there, but he also replied the same "if you want a female doctor then go and get your treatment in your country. We are here to help you, it's up to you if you take it". We felt completely discriminated.
>
> (Complaint 2016/953)

Their wish for a female physician at delivery was not met, because a female physician was not available at the hospital's maternity ward. Furthermore, the healthcare staff neglected the woman's and her husband's suggestion that they would wait for the procedure until the following shift when a female physician might be available. According to the complainant, both the midwife and the physician gave the same ultimatum – to seek care in their country of origin if they wanted a female physician. Above all, this example appears as an example of deficient social treatment in a situation where the patient's beliefs and values differ from those of the healthcare staff. The Equality Ombudsman reviewed whether this was a case of ethnic discrimination and assessed it as a violation of the Discrimination Act, further directing the county council to take measures to prevent such discriminatory treatment in the future.

Minority faith symbols and garments and expectations of equal and respectful treatment

As might be expected in an analysis of perceived religious discrimination, presumed members of religious minority faiths were found to have filed a large proportion of the complaints. At least one-third of the complaints were submitted by Muslims or individuals presumed to be Muslim. This conclusion is based on our coding of the complaints that explicitly mentioned the patient either

being Muslim or wearing a hijab, niqab or veil. This is consistent with the Equality Ombudsman's analysis of complaints in relation to religious discrimination received from 2017 to 2021. In a random sample of 250 complaints, over 100 notifications had a clear connection with Islam (The Equality Ombudsman, 2022). A considerable amount of the complaints concerned healthcare providers' reactions towards patients wearing hijabs or other attributes displaying their religious affiliation or cultural background. These reactions were often perceived by patients and accompanying relatives as disrespectful and as unequal treatment, as exemplified by the following quotation:

> I wear a veil and he questioned at least 2 times why I wore it. He asked if it was for fashion reasons or if I have a boyfriend who is Muslim. He also said that the shawl "doesn't suit me". He started linking my headaches to the fact that I might have ADHD or another diagnosis and that's how he started discussing dopamine rushes. We mentioned some things earlier in my life that show that I used to focus a lot on things that give me temporary dopamine rushes. Suddenly the physician says that the reason I converted to Islam is probably also because I like these kicks, that my conversion is another dopamine kick for me. He also asked more questions like did I participate in any other sect? Things completely irrelevant to my headache.
>
> (Complaint 2021/539)

The above quotation details the experience of a woman wearing a veil while interacting with a physician, who commented on her appearance and speculated about the reasons for her wearing the veil, as well as possible connections between her beliefs and her health. The physician's suggestion that her religion was a sect indicates religiously insensitive communication. Meanwhile, the Equality Ombudsman's review of whether this incident was a case of religious discrimination assessed that it was not. In the following case, the complainant describes a physician's heavy-handed examination and poor treatment:

> I felt exposed, excluded and devalued in a situation I could not control. I don't know what the reason for her behaviour is. Maybe it's my origin, or my appearance because I wear a veil.
>
> (Complaint 2021/819)

The complainant says that she failed to understand why she was mistreated. She submitted a complaint alleging both religious and ethnic discrimination. She interprets that the mistreatment she faced was due to the veil or her origin, possibly based on her previous experiences of being perceived as different. Apart from this, we also assess that some complaints involving a hijab or other religious and cultural symbols or expressions may be the results of misunderstandings between the healthcare staff and the patient. Some

complainants described situations in which healthcare routines were interpreted as de-prioritizing the patient or relative, which, in turn, was construed as a matter of being discriminated against due to one's appearance – for example by wearing a niqab – as mentioned in the following quotation:

> My mother doesn't speak Swedish very well, so my brother's wife came along as an interpreter. My brother's wife wears a niqab, i.e. she covers her face. They sat waiting for their turn and when it was time for their turn, the nurse refused to let my brother's wife in. She told her that she has to wait outside and that are the rules, because she can only let the patient in. Before their turn, my mother and my brother's wife were able to watch another couple come out of the nurse's room and then there was no problem. My brother's wife felt offended and told the nurse and she just said "I don't care you can't come in". My family has felt bad about the incident because nothing like this has ever happened to us.
>
> (Complaint 2015/1999)

In this complaint, a misunderstanding might have caused the situation. The nurse refers to a rule that allows only patients to enter the consulting room, which suggests that the patient and the relative probably understood the situation differently than the nurse. Moreover, the complaint is unclear about whether the nurse realized that the relative accompanied the patient for the purpose of interpretation. In the two cases narrated above (Complaints 2021/819 and 2015/1999), it is difficult to find a causal connection between the veil or niqab and the experience of mistreatment or differential treatment. Due to this lack of causation, it would also be difficult to get a conviction in court for religious discrimination in these cases.

> I am a religious person. My religion is Sikh. As a Sikh you wear five Ks, so called Kakar. They are very important to us. Without them, we are not Sikh. […] In the meantime, a man in white clothes, who looked quite strong, came and said that you are not allowed to carry a knife in public. I tried to explain that it is not a knife and I have the right to carry it because it is my religious mark, but he did not seem to understand. He said you have to put it on our shelf there, you can take it later. But I said it is not possible. I also said that I can put the Kirpan underneath the clothes, and I usually wear Kirpan in underwear but forgot today, but he didn't listen. He said "If you don't do it then we will call the police."
>
> (Complaint 2018/576)

In this example, the kirpan was not acknowledged by hospital security or healthcare staff as a religious symbol of central relevance to the person's beliefs, but was instead misunderstood as a weapon. The man had hurried

to the hospital to visit his sick daughter and thus forgot to hide it beneath his clothes. Despite explaining, firstly, that the kirpan was not a knife, and secondly, its importance with regard to his beliefs and religious identity, he was not met with a proper understanding of his faith and felt that he was not listened to.

Equal treatment in patient medical records

Another recurring complaint of negative treatment involves individuals' perceptions towards healthcare providers' mentioning the patients' religious affiliation and the use of specific religious symbols or clothing in patient medical records. The following example involves a psychologist mentioning the patient's religious affiliation in the medical records of Child and Adolescent Psychiatry.

> It must require quite an extensive and detailed effort to obtain information about our religious affiliation, if you do not have a separate register of families' religious affiliation at the Child and Adolescent Psychiatry. […] By stating our religious affiliation, NN has tried to allude to the fact that our son's poor well-being would be related to our religion, while at the same time she should be well aware of his situation at school, which was the reason why he wanted to kill himself. However, she omits this from the report.
>
> (Complaint 2014/1940)

According to the complainant, the psychologist interpreted the son's ill health as the result of religious factors. The complainant further asked for the source from where the psychologist received the information about their religious affiliation. However, the medical records are not a register that the healthcare staff creates; rather, they are notes of medical and psychosocial history, i.e. anamnesis. The following example involved a physician mentioning the hijab in a patient's medical records:

> A physician subjected me to a discriminatory and profiling statement in my medical records. […] She wrote as my somatic status: "Unaffected. Has full-covering clothes and veil." I consider the writing to be unnecessary, indicatory, offensive, (racial) profiling and discriminatory. What I wear has no bearing whatsoever on my state of health. Nor does the comment have any relevance to my treatment. Note that I informed the physician that I take vitamin D from September until the summer, if she now felt that would be relevant. I also question whether you ever would write "Has a miniskirt" or "Is a man but is dressed in a skirt" as a somatic status. All these cases should also be considered similar to the statement about me.
>
> (Complaint 2021/3997)

By comparing herself to hypothetical situations referring to other people's clothing, the complainant expressed a request for equal treatment, which was her right according to the Patient Act. The complainant in the example above preferred neutrality towards her clothing and did not see how her clothing affected her somatic health, except possible vitamin D deficiency. She felt being racially profiled and discriminated against. In the following example, a woman filed a complaint about her father's medical records mentioning his Jewish origin:

> 76-year-old of Jewish origin with a traumatic childhood from Poland in the 30s […]. I interpret [the physician] as giving dad this diagnosis because of his Jewish origin, this is discrimination, and has no support by dad's other physicians. I only take this to mean that [the physician] dislikes Jews. Enclosing a copy of the medical record to prove that [the physician] discriminated against dad because of his origin.
>
> (Complaint 2015/474)

The woman found that the physician had mentioned her father's Jewish origin for no particular reason, using it as an explanatory factor for his diagnosis. She claimed that her father had also been neglected because of his religion or ethnicity. Although the Equality Ombudsman had selected this complaint for case supervision, the investigation could not sufficiently demonstrate that discrimination had occurred. The healthcare centre rejected the claim that mentioning one's religion in the anamnesis would have had any negative impact on care. However, the Equality Ombudsman pointed out that caution should be exercised in writing journal entries that may be perceived as discriminatory.

Affirmative action in medical treatment that takes beliefs into account

A few complaints called for affirmative action due to care interventions that were in conflict with the patients' beliefs. The following complaint alleging religious discrimination most likely concerned a member of Jehovah's Witnesses, as it mentioned the cell saver, which is a machine collecting blood lost during surgery for reuse and autotransfusion:

> I entered the hospital urgently on November 6, 2013 due to irritable bowel syndrome. Surgery was scheduled for Wednesday, November 13. Went to anaesthesia assessment on November 12. During the anaesthesia assessment, there was no indication whatsoever that certain machines could not be used. I asked the physician on a later occasion if he objected because of my religious position, to which he replied without looking me in the eyes: No. […] The physician comes to me and says that he cannot operate on me (sitting in the waiting room with visitors). Asking why. Answer: We do not have a cell saver. Strange,

> I answer. In 2011 and 2012, it was used on me. […] Yes, we have it, but it is at the women's clinic and it cannot be moved.
>
> (Complaint 2014/212)

Jehovah's Witnesses' right to medical self-determination in relation to blood transfusions is a well-known controversy concerning religious beliefs in healthcare. The physician responded factually, after assessing that the requested special treatment would not be possible as the machine is unavailable. Consistent with the Patient Act (5 § 1), the physician implemented the planned surgery in consultation with the patient, with the final consequence being transferring the patient to another nearby hospital. This does not seem to be a case of religious discrimination. Instead, the case involved a lack of communication and equipment, which resulted in delayed care.

Request for a secular environment

Most complaints to the Equality Ombudsman were submitted by patients or accompanying relatives. This reflects the inherent power relations within discrimination, which signifies that the one who is discriminated against by definition has a subordinate role in relation to the one who discriminates. However, the following complaint was filed by a psychiatrist, who reported religious discrimination from the point of view of the patients' and healthcare professionals' right to a secular environment. In this case, the complainant reported the discrimination or disadvantage he faced in the workplace after losing his job:

> I believe that the interests of employees and patients should come before the individual who, due to religious-political convictions, wants to wear such visible symbols. Because of my opinion and conviction, I cannot imagine making an assessment together with, side by side, with a person wearing a hijab or other religio-political symbol, to reinforce, confirm and become part of that manifestation.
>
> (Complaint 2017/719)

The complainant refused to make medical assessments along with a colleague wearing a hijab. He believed that forbidding religious symbols was an expression of his own and his patients' freedom from religion or negative religious freedom. Additionally, this was his proviso to continue his employment, contributing to his contract being discontinued. This situation indicates that his employer judged his demand for healthcare to be free from religious symbols and clothing as illegitimate. The complainant interpreted religious garments and symbols as equivalent to political symbols, and as manifestations, rather than expressions of religious beliefs or cultural traditions. In his complaint, he emphasized the importance of being as neutral as possible in consultations. He had previously advised medical students and

future medical specialists to hide their religious symbols, such as Christian crosses, or political symbols. Thus, he interpreted "religio-political symbols" as harmful in medical consultations with reference to psychiatric patients' vulnerability:

> The patient should not be exposed to signals about religiosity and moral views in a situation that is often sensitive and where it often involves revealing information about oneself and others that one perceives as deviant and full of shame.
>
> (Complaint 2017/719)

Although the desire for neutrality may have some relevance in relation to the vulnerability of psychiatric patients, his argumentation is reminiscent of the French constitutional secularist principle of *laïcité*, which refers to the absence of religion in public life. This principle discourages religious influences in the public sphere and has been particularly polarizing in relation to Islam and Muslims in recent decades. However, due to Europeanization and increasing religious and cultural diversity, the neutrality of the state has become increasingly difficult, leading to the transformation of the principle of *laïcité* into including a broader recognition of religion (Portier & Willaime, 2022). In the context of the Swedish principles of multiculturalism and culturally sensitive care, the physician's demand for the absence of religious symbols in healthcare encounters, exemplified by the hijab, becomes a demand that cannot be met.

Conclusion

This study found that complaints of perceived religious discrimination in Swedish healthcare include the following unfulfilled expectations: cultural and religious literacy, equal treatment in relation to religious symbols or clothing, equal treatment in patient medical records, affirmative action in medical treatment that takes beliefs into account, and a secular environment that forbids religious symbols in healthcare encounters.

The complaints about patient medical records mentioning one's religious affiliation, religious symbols or clothing particularly concern expectations related to equal treatment. Some healthcare professionals may consider mentioning patients' religious affiliation in medical records as a matter of cultural sensitivity. However, the question remains as to how one decides when it is helpful to mention the patient's religion and when it is not? The complaints illustrated above signify the need for further reflection on healthcare routines regarding what is mentioned in medical records and the reasons for which it is useful to include religious affiliations. For example, there might be an appropriate reason to mention religious affiliation if healthcare staff assume its connection with the risk of harm, although this does not apply to the veil. However, the niqab and the burka covering the face can be considered a risk

or an obstacle to administering equal care because it can prevent correct observation, which contributes to suboptimal care and, in turn, unequal care as a result of the patient's choice.

Religious literacy requires awareness of the religious diversity of societies, including knowledge about the majority faith, minority faiths, and non-religions (Dinham & Francis, 2016). Moreover, claims that healthcare should be a neutral space without any religious symbols or garments are not in line with the perspective of religious literacy. The concept of religious literacy has commonly been associated with cultural competency, although this does not correspond to this book's interpretation. Cultural competency has been criticized for reducing cultures to skills that healthcare providers can learn, including lists of technical guidelines regarding the "do's and don'ts" in encounters with migrants (Kleinman & Benson, 2016). Kleinman and Benson (2016) recommend that healthcare providers should take an interest in patients by asking "what matters the most to them in the experience of illness and treatment" (Kleinman & Benson, 2016: 1676). This question might be an example of combining cultural sensitivity and person-centred care, thus reflecting the emphasis on patient participation in the Swedish Patient Act (5 § 1).

According to the results of the MigraMed Healthcare Providers Survey conducted by our research group, 71 percent of healthcare providers in the Swedish sexual and reproductive healthcare were not members of any religious community in 2021, which makes them more secular than the Swedish population as a whole (Eriksson et al., 2022). Hence, healthcare encounters between religious patients – particularly foreign-born patients from countries that are less secular than Sweden – and a healthcare system based on an evidence-based approach may unintentionally contribute to tensions, perceived discrimination, and suboptimal care, all of which deviate from the patients' expectations.

The strengths of this study lie in the rich data of perceived discrimination on the grounds of religion or beliefs. The consistency in interpretations and the reliability of the results was strengthened by the interdisciplinary composition of the project group. IPA is often used to analyse interview data. However, when analysing larger samples, such as the complaints to the Equality Ombudsman, the analysis is conducted at group level, but illustrated by individual cases (Smith et al., 2009: 106–107).

We conclude that healthcare providers may encounter difficulties in maintaining the partially contradictory ideals of equal treatment and cultural sensitivity. Additionally, the principle of cultural sensitivity is not clearly defined in relation to religious diversity. Another pertinent question is with regard to the meaning of the concept of religious literacy in relation to value collisions and the mission of healthcare: Whose interpretation of religion should healthcare providers adopt while practicing religious literacy? Religious literacy does not necessarily mean that, for example, healthcare providers in sexual and reproductive healthcare need to possess knowledge about specific approaches to abortion in different faiths; rather, it points at developing a sensitivity to patients' religious beliefs, practices, and values that may differ

from the liberal and secular values of most Swedish healthcare providers. However, this sensitivity to the patient's culture, religion, and beliefs should not compromise with optimal care and the importance of having a shared language (Binder et al., 2012; Essén et al., 2002; Esscher et al., 2014). Therefore, to avoid conflicts, healthcare providers need to reflect on which differences are worth paying attention to in dialogues with patients and in the patient medical records. Additionally, many conflicts could be avoided by directly discussing any misunderstandings and communication issues that may arise in the situation at hand.

Conflicts of interest

We declare no conflicts of interest.

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Author contributions

BE and AC had the original idea. VD and LE conducted data collection. LE was responsible for data analysis together with BE. LE wrote the first draft and revisions of the manuscript. All authors contributed to interpretation of data and manuscript writing.

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