CULTURE, SPIRITUALITY AND RELIGIOUS LITERACY IN HEALTHCARE

NORDIC PERSPECTIVES

Edited by Daniel Enstedt and Lisen Dellenborg

Culture, Spirituality and Religious Literacy in Healthcare

Elaborating with the concepts of culture and religious literacy, this volume examines theoretical, methodological, and empirical aspects of the practice and study of religion and non-religion, culture, spirituality, and worldviews within healthcare.

In modern multi-cultural and multi-religious societies, a host of new issues have arisen concerning culture, religion, and spirituality within healthcare, especially when people face serious and life-limiting illness. Healthcare professionals are faced with challenges addressing and handling patients' cultural expressions of religiosity, spirituality, and existential concerns. The variety needs to be met without essentializing the concepts of culture and religion and with an ability to include the non-religious as well as new types of spiritualities. This collection reflects on the tension between cultural, religious, and spiritual dimensions of care in a secularized healthcare institution and describes implications of this tension for healthcare professionals and patients. The book engages with an ongoing scholarly discussion about religious literacy in healthcare and contributes perspectives, experiences, and empirical examples from the Nordic countries, especially Sweden. It gives suggestions for practical application of research to healthcare practice, highlighting challenges and ideas for how to integrate religious, non-religious, and spiritual dimensions in care.

This is an important contribution to the literature on religious literacy and provides a vital reference for students, scholars, and healthcare professionals with an interest in the complex relationship between culture, spirituality, and religion in healthcare.

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1 Introducing perspectives on culture and religious literacy in healthcare

Lisen Dellenborg and Daniel Enstedt

Introduction

In modern multicultural and multi-religious societies, a whole host of issues has arisen concerning culture, religion, and spirituality in healthcare, issues that place demands on healthcare professionals to address patients' cultural expressions, religiosity, spirituality, and existential concerns. The migration flow of the past few decades is one reason for the current situation in which transcultural encounters shape everyday life, and people representing practically all the world's religious traditions are present in Nordic societies. At the same time, spirituality and religiosity are not, as commonly alleged, primarily expressions of "the other," but are very much expressed by the majority population as well. Also, with the presence of a substantial number of people of migrant background, many countries in Europe could be described as post-migrant societies in that the distinction commonly made in the literature and public debate between migrants and non-migrants is no longer relevant (Dahinden, 2016; Foroutan, 2019; Römhild, 2017). In this volume, we start from the premise that rather than understanding people in general as secularized, it is the state and healthcare institutions that are characterized by ideals of secularization. We reflect on the implications the secular ideal has for healthcare encounters between patients and their healthcare providers. For instance, existential issues and the need for spiritual dimensions of care often arise when people face serious and life-limiting illness, even among those who have not previously thought religion or spirituality to be important. At the same time, healthcare professionals may find it difficult to address such issues, and the competence required to administer spiritual care is generally considered to be primarily found among chaplains and religious representatives acting in hospitals. Therefore, spiritual dimensions of care and existential issues are generally excluded from current healthcare, even though such care is stipulated in the guidelines that healthcare providers should follow. This indicates that when questions about the meaning of life, suffering, and death arise for patients in the face of life's vulnerability, in relation to sudden ill-health or living with long-term or life-limiting illness, spiritual dimensions of care are seldom given attention in daily healthcare encounters. There is a

need for more knowledge of how religious and spiritual dimensions are addressed in the healthcare sector. We lack studies based on fieldwork among healthcare providers and patients, as well as theoretically driven examinations of central concepts such as "existential issues," "spiritual care," "culture," and "religion." This volume starts from contemporary debates about religious literacy (Dinham, 2020; Dinham & Francis, 2016; Pentaris, 2019) and seeks to further examine theoretical, methodological, and empirical issues concerning the practice and study of religion and non-religion, culture, spirituality, and other worldviews, such as alternative and complementary medicine, in contemporary healthcare.

Literacy is a concept that originated in the late 1800s, primarily in an educational context concerning reading, writing, and understanding *text*. More recently, the *literacy* concept has been used in a broader sense in relation to, for example, digital media and the ability to understand health-related issues, generally referred to as health literacy. Nowadays, what is considered text has been broadened, while the ability to understand text – the literacy aspect – remains largely unchanged. For instance, the terms "religious literacy" and its counterpart "religious *il*literacy" (Moore, 2007) concern the ability or inability to understand, read, and decipher cultural phenomena and human activities as "religious" – "religious" itself being both a constituting and a contested term in the field of religious studies (Cotter & Robertson, 2016; Enstedt, 2020).

The *lack* of religious literacy and of a critical view of the concept of culture in healthcare has been singled out as a particularly important area that policymakers and practitioners should reflect on and work with (see, e.g., Arousell, 2019). "Religious literacy" has recently attracted renewed attention (Dinham, 2020; Pentaris, 2019), and the concept of "cultural competence" has become central to healthcare policies, research, clinical practice, and nursing education (Curtis et al., 2019; Kleinman & Benson, 2006). An important and often neglected aspect of the discussion of cultural competence and religious literacy is the essentializing tendency in understanding "culture" and "religion" (Kleinman & Benson, 2006), that is, the tendency to ascribe certain characteristics to a cultural or religious identity or belonging that risks making the individual invisible. This tendency also generally leads to the overlooking of power structures (Curtis et al., 2019) and a failure to include the varieties of "nones" (Lee, 2015), that is, new types of spiritualities and non-religions that may be more difficult to recognize than what is sometimes allegedly taken as "religious identity." An important ontological stance in this volume is that culture and religion are about lived experience and meaning. Therefore, there are no formulas for how to meet patients' religious and spiritual needs. How to provide the spiritual and existential dimensions of care cannot be predicted but is a question of ongoing dialogue between the healthcare professional and the person suffering from ill-health. It is about processes of tuning into the individual and about a critical awareness of pre-understandings at the personal and institutional levels. This volume seeks to explore, challenge, and problematize these aspects in order to contribute to a broader understanding of the

concept of cultural and religious literacy than is common within healthcare. Another source of tension concerning spiritual dimensions of care in Nordic healthcare is, as mentioned, care institutions' liberal ideals of secularization as well as potential tension with the Christian heritage – as Christian ideals and practices are usually most visible in specialized forms of palliative care, especially hospice care (Pentaris, 2019). For this reason, a critical stance regarding and awareness of norms relating to both secularization and the Christian heritage are important prerequisites for this volume. How healthcare professionals *do* and *are given the opportunity to* approach and address patients' various cultural, religious, and spiritual expressions in the healthcare encounter is important, as is empirically based knowledge of how and what types of spiritual and religious needs may arise among patients.

In this volume, we have gathered texts by 17 scholars based in the Nordic countries who empirically, methodically, and theoretically explore questions related to the areas of inquiry described above. In this introduction, we present contemporary religious, cultural, and spiritual perspectives from which this publication departs and to which it relates, as well as ongoing scholarly discussion of religious literacy and the concept of culture.

Religious literacy as a dynamic understanding of religion, spirituality, and culture

The concepts of religion and spirituality are commonly distinguished, religion being characterized by its boundaries set by tradition, dogma, and established authority, while spirituality is usually defined as "a personal search for meaning and purpose in life, which may or may not be related to religion" (Edwards et al., 2010: 753). One characteristic of contemporary spirituality is the idea that every person carries an internal higher self, with potential for development (Heelas, 2002: 370). Similarly, Marta Trzebiatowska and Steve Bruce (2012: 64) described spirituality as an "enlightenment [that] involves becoming aware of what you already have, rather than subordinating oneself to some external force." When it comes to authority, Paul Heelas and Linda Woodhead (2005:61–82) elaborated on a distinction between internal and external forms of authority that makes recent developments in religion and spirituality somewhat clearer. Adjustment to *external* rules, roles, and expectations characterizes one way to be religious, while the "subjective turn" – the turn to a more individualized modern society (Stolz, 2016) – signifies an *internal* way to be religious today, in which one largely follows one's own judgments and convictions. Importantly, although spirituality is usually associated with internal authority and religion with external authority, one can be religious with an internal authority and spiritual with an external authority.

Much of the research into *spiritual care* has been conducted in the United States and the United Kingdom, where the concept has enjoyed a longer tradition and has been given more consideration in healthcare than in the Nordic countries. Research also shows that in many Western countries, healthcare

professionals generally have difficulties addressing patients' religious and spiritual needs, as they lack skills to recognize expressions of spirituality and to support patient wishes for spiritual dimensions of care (Edwards et al., 2010; Norberg, 2018; Norberg et al., 2001; van der Weegen et al., 2019). Furthermore, there is a tendency to conflate spiritual needs with psychosocial needs or to lump them together (see, e.g., Hökkä et al., 2020). Pentaris (2019) described how in the years after the Second World War, spiritual care was absorbed into the category of psychosocial care. According to the healthcare scientist Katie Eriksson (1987), it is important to distinguish between psychological care needs and spiritual care needs: the latter extend psychological needs, being a dimension of care that all healthcare givers should have the ability and competency to address and, consequently, should be trained for. Eriksson's call concurs with Pentaris' call for religious literacy as an ability of all healthcare providers. Contemporary research highlights a great need for spiritual dimensions of care, showing that a significant number of seriously ill patients are not having their spiritual needs met. This has been shown to lead to depression, loss of purpose, and decreased peace of mind (Pearce et al., 2012). Studies have also found a lack of knowledge and skill in providing spiritual care. The care ethics researcher Carlo Leget (2017: 38) maintained that spiritual care, although an accepted dimension of palliative care, has shifted to the margins of the dying process and is the dimension "the least integrated into the medical framework and the one that is still most in development." Besides general discomfort in relation to religion and spirituality in healthcare institutions, feelings of inadequacy, uncertainty, fear, and stress also make it difficult for healthcare providers to integrate spiritual dimensions in their care of seriously ill and dying patients (Strang et al., 2002). In line with Pentaris (2019) and Eriksson (1987), Henoch et al. (2015) underscored the importance of healthcare professionals being trained to be attentive to patients' religious and spiritual needs. According to Andersson (2006), healthcare providers' skill set should be broadened to include the ability to identify and address patients' religious and spiritual needs, allowing providers to reflect on life perspectives with patients. Such conversations may be decisive for patients' comfort and be important for whether they accept or decline treatment that can restore health, reduce suffering, or enable them to survive (cf. Kolcaba & Kolcaba, 1991).

Edwards et al. (2010) found that spirituality is considered important by 87% of patients and religion by 51–77% of patients in the United Kingdom, the United States, Canada, and Australia. Spiritual and religious needs are most salient for people with life-limiting and long-term conditions, and, as noted, even among those who have not previously shown any interest in religion and spirituality. The relationship between religion, spirituality, and psychological well-being has been studied in chronically ill individuals, elderly people with no sickness (Bosworth et al., 2003; Norberg, 2018), individuals diagnosed with cancer (Cotton et al., 1999; Lundmark, 2017), patients with cardiovascular diseases (Ai et al., 2012; Chibnall et al., 2002), and survivors

of traumatic events (Cordova et al., 2001), and spiritual considerations have been shown to be essential to patients' well-being (Norberg, 2018; Pulchalski, 2001). Research shows that spiritual care also increases general well-being among the patients' closest caregivers (Sankhe et al., 2017). Research, policies, and practical guidelines for healthcare providers underline that the identification of spiritual needs is an important aspect of holistic care for ill people (McSherry, 2012). It is crucial that the healthcare professionals show an interest in understanding the patient's experiential world, in which spiritual and religious aspects of disease and health are often important. A meta-study of qualitative research on spiritual care showed that meaningful *relationships* with healthcare givers and family are at the centre in spiritual care, rather than just meaning making (Edwards et al., 2010).

The term "religious literacy" concerns the ability to understand, read, and decipher cultural phenomena and human activities considered "religious" – which, as noted, is itself a contested term in the field of religious studies (Enstedt, 2020). Like other types of literacies, religious literacy has mainly been discussed in relation to education (Brömssen et al., 2020; Moore, 2014), but there have been recent developments of religious literacy in hospice care and related areas of healthcare (Pentaris, 2019). In relation to hospice care, the thanatologist Panagiotis Pentaris has formulated a model of religious literacy that highlights three key factors for successful care encounters between healthcare professionals and patients expressing religious and spiritual needs: (1) knowledge of religion and spirituality, (2) a self-reflexive ability to understand one's own perceptions of religiosity, and (3) an ability to interact with religious patients in an appropriate manner (Pentaris, 2019). This model of religious literacy is based on a more general approach that he calls a *value-based approach*, which means that healthcare providers have the ability to be *self-aware*, which, according to Pentaris, can be developed through introspection; have an understanding of their own role and position (*self-understanding*) in the hospice organization; have an interactive, listening, and communicative ability (*interpersonal skill*); and possess an ability to empathize (Pentaris, 2019: 178–183). A central aspect is the professional ability to humanize the patient–caregiver encounter in a way that avoids dismissing patients or reducing them to religious or spiritual stereotypes. Hence, a more reflexive, context-sensitive, listening, holistic, and person-centred approach is advocated (cf. McCormack & McCance, 2010).

The renewed attention to religious literacy has drawn scholarly criticism, related to the risk of reducing religion to facts to be known that allegedly should improve the ability to understand and relate to "religion" in an increasingly diverse and global world (Wolfart, 2022). In this volume, we hold that religious literacy "concerns the ability to understand, read and decipher cultural phenomena and human activities seen as 'religious'" (Enstedt, 2022: 28). As such, religious literacy does not require that healthcare professionals should become specialists in religion, spirituality, or culture or that they need education about religion or allegedly shared modes of religious

thinking (Pentaris, 2019). Far from this, religious literacy, we suggest, calls for civic competence and an ability to engage with patients' and their families' religious, spiritual, and cultural expressions in relation to illness and care with openness and curiosity (Dinham & Francis, 2016; Pentaris, 2019; Seiple & Hoover, 2022). Pentaris (2019) proposed that this openness should include empathic listening in which the healthcare provider develops an ability to pose appropriate and timely questions in order to encourage dialogue with patients and their families. Central to Pentaris' model is developing knowledge and understanding of patients' understandings of religion and spirituality through listening to patients' narratives with a mind open to the possibility of diverse religious, spiritual, and cultural expressions, especially those that do not fit the stereotypes.

To support healthcare givers in finding out what is most important for their patients, and in being open, without preconceptions, to cultural diversity in understanding health and illness, the medical anthropologist and psychiatrist Arthur Kleinman developed a questionnaire based on ethnography, called the "explanatory models approach" (Kleinman & Benson, 2006; Kleinman et al., 1978) or "mini-ethnography" (Kleinman, 1988). We suggest that this questionnaire can be used to complement Pentaris' model. Kleinman's model supports healthcare providers in asking questions that may prompt conversations about broader cultural, social, and religious aspects of patients' health situations. Healthcare providers often state that they seldom have time to expand on conversations about life. In Kleinman's model, the questions are formulated so that they relate directly to the patient's health situation (see Table 1.1).

While Pentaris' model shows us *what* is needed for religious literacy, Kleinman's model shows healthcare professionals *how* they can behave in the actual healthcare encounter – from a position of openness and empathic listening, posing questions that might lead to the sort of dialogue sought by Pentaris (2019). In this dialogue, healthcare providers may gain valuable knowledge of how religion, spirituality, and culture matter for patients and their families in their specific health situations and care contexts.

As should be clear by now, we hold culture and religious literacy to be dynamic processes of lived experience rather than, as commonly alleged, knowledge of strict rules and traditions that people are expected to follow. However,

Table 1.1 The explanatory models approach.

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect it to take?
- How serious is it?
- What do you think this problem does inside your body?
- How does it affect your body and your mind?
- What do you most fear about this condition?
- What do you most fear about the treatment?

Source: From Kleinman and Benson (2006: 1674), extracted from Kleinman (1988).

in medicine and healthcare as in wider society in general, the concept of *culture* is commonly misunderstood as a static phenomenon that coincides with nationality, ethnicity, and language (Kleinman & Benson, 2006). Culture is also a key term in the justification of "otherness," making migrants "into the problematic 'ethnic others'" (Römhild, 2017: 69). Culture then can readily be used as an explanatory model of the acts of someone of an allegedly other nationality, ethnicity, or language than that of the majority population. The *cultural competence* concept, as mentioned earlier, generally follows such an understanding: it tends to be understood as a skill or technique that healthcare providers can acquire by learning more about certain "cultural groups" or "cultural traditions" (Curtis et al., 2019; Kleinman & Benson, 2006). Understood in that way, culture is often referred to as static: it reduces a person to a representative of a group, leading to stereotyping. In the social sciences, there is a more rewarding understanding of culture as dynamic: cultural values, perceptions, norms, and practices are negotiated between social actors and change with time. In the words of the American cultural anthropologist Clifford Geertz (1973: 14), "culture is not a force or a causal agent in the world [that causes people to do things] but a context in which people live their lives." A person who has lived for a period of time in a certain society has come to understand that society's practices, norms, and unspoken cultural codes – i.e., cultural context. Importantly, this does not mean that *everyone* living in this society, or that everyone in a certain sub-group, appreciates or adheres to these norms and practices in the same ways. It means that knowing a certain cultural context means knowing *how to act*, *to perform* according to the unspoken codes in that context, and, also, importantly, perceiving how to act counter to these codes, which is part of the process of how cultural values and practices change with time. A dynamic concept of culture feeds into a classical debate in the social sciences concerning the tension between actors and structure, individual and collective: culture is the context of an ongoing process of change that persons – individually and collectively – are interdependently forming and simultaneously being formed by. Accordingly, we are neither completely tied down by structure nor completely autonomous agents (Ortner, 1996).

A concept that has been developed in the endeavour to grapple with the wide diversity of people in society is *super-diversity* (Vertovec, 2007). It aims to slice culture into ever finer intersecting categorizations, experiences, identities, and positionalities such as gender, age, sexuality, educational level, habitation, migration experience, socioeconomic standard, ethnicity, citizenship, legal status, religion, and language. Although valuable in highlighting social complexity, the concept can be criticized for representing a view from the perspective of a homogeneous majority society, whereas many researchers now note the importance of not analysing society from the perspective of diversity and minorities, but rather of understanding society as fundamentally formed by migration – as post-migrant society – and of understanding migration not as a subject for research, but as a perspective from which to analyse society at large (Römhild, 2017).

Referring back to the problematic tendency in healthcare to quickly explain behaviours and acts in terms of culture if a person is understood to have a national or ethnic belonging or to speak a language different from that of the majority population (Kleinman & Benson, 2006), Smith Wahlström emphasized in line with Clifford Geertz that culture does not explain why a person behaves in a certain way, but is something to be operationalized by "embracing an open-ended and explorative anthropological stance" (Smith Wahlström, 2020: 37). To talk about the concept of culture beyond a taken-for-granted notion, it is important to recognize that

> "Culture" is created and negotiated in encounters, and that cultural identity intersects with other differences, for example, class, education, gender, and age, in complex ways … the dilemma of a static understanding of culture, that is culture understood as traits, behaviors, and traditions … make[s] persons from certain "cultures" essentially different from oneself.
> (Dellenborg et al., 2012: 347)

As noted, using the culture concept as a single explanatory framework is therefore of limited value. Cultural values, norms, and practices intersect unevenly and are blurred as people, ideas, and practices move in space, and as global processes influence local understandings (cf. Brettell, 2000; see also Dellenborg, 2004; Dellenborg & Malmström, 2020). To understand how various identities and circumstances interact at multiple levels and simultaneously with other forms of socially and culturally constructed categories, the concept of intersectionality (Crenshaw, 2002; Nayel, 2017) can be useful. Intersectionality importantly speaks to power relations. We live in a postcolonial world, and encounters between people in healthcare are inevitably filtered through global power relations that are commonly invisible to those who, in shifting ways, fit the various norms of society, leading to minority stress, racialization processes, and structural racism in our institutions and social relationships (Ahmed, 2012; Hamed et al., 2022).

The criticism of an essentialist understanding of culture is in line with the criticism that has been directed towards the concept of religion in recent decades, not least in the discourse-theory-informed research field of *critical religion*, where notions of stable and fixed religious identities have endured sharp criticism (Horii, 2018). A crucial assumption is that neither religion nor spirituality is a stable or homogenous concept, although there are plenty of normative expressions that apply to what religion and spirituality are or *should be* within religious groups as well as outside them. To overcome the problems concerning essentialist notions of religion – which at the same time risk being the basis for prejudice and stereotypes – the three central assumptions that the American Academy of Religion emphasizes are well worth considering: "religions are internally diverse; religions are dynamic; and religions are embedded in culture" (AAR Guidelines, 2010: 1). These may appear obvious at first glance, but the internal variation, potential changeability, and importance of

the social and cultural contexts of religion and spirituality are crucial. The turn from a more static understanding of culture, religion, and spirituality is also connected to the research field of *lived religion* in which religion is understood as something that is *done* (Ammerman, 2021; Enstedt & Plank, 2018, 2021). Religion and spirituality are thus done in different life situations and contexts – such as healthcare institutions – and at the same time shape and are shaped by, these situations and contexts. From a lived religion perspective, informed by the concept of dynamic culture, we examine the various roles and meanings of religiosity and spirituality in the healthcare situation.

The contributions to this book

This book consists of three sections, beginning with case studies from the Nordic countries to shed light on experiences and tensions in healthcare encounters, followed by a section on central concepts relevant to healthcare, and ending with a third section that explores ways to overcome religious illiteracy in healthcare. The first section begins with a chapter by Tone Lindheim that explores learning in the everyday work of multicultural, multi-religious healthcare employees through a case study of three nursing homes in Oslo, Norway. By sharing healthcare providers' experiences of perceived cultural and religious differences in everyday conversations, Lindheim argues that the workplace is a site for developing religious literacy and cultural understanding. She points to organizational structures and a milieu that fosters psychological safety as factors favouring the development of an ability among healthcare providers to better meet the needs of residents of minority background.

In the next chapter, Lisen Dellenborg and Daniel Enstedt further explore obstacles to and opportunities for religious literacy in relation to healthcare encounters between physicians, nurses, and patients and their families in palliative homecare in Sweden. Based on participant observation and short-term exploratory fieldwork, Dellenborg and Enstedt show that healthcare professionals experience communication problems in relation to language, culture, and religion as hindrances in healthcare encounters. The authors explore how religious literacy could help improve these healthcare situations, and how it could strengthen a person-centred approach to palliative homecare.

Mikael Lundmark's chapter applies the patient perspective and provides examples of how religiosity informs perceptions of healthcare interventions among persons who are Christian and living with cancer in Sweden. Lundmark emphasizes theories of coping and focuses his research on what he calls the "sanctification of health care interventions," meaning aspects of life ascribed a divine character or significance. Based on empirical examples, Lundmark offers a discussion of how religiously informed perceptions of healthcare interventions can be understood and explained within a framework of religious literacy. He suggests that religious literacy could include knowledge of the functions of religiosity in coping.

Turning to childbirth, midwifery, and spirituality in the Icelandic context, Ólöf Ásta Ólafsdóttir explores the cultural and spiritual aspects of midwifery care. Based on an ethnographic narrative study conducted in Iceland, the narrative analysis shows that when midwives told their stories, tacit norms and notions concerning spirituality came to light. Ólafsdóttir relates religion and spirituality surrounding childbirth to the larger context of midwifery care as being holistic, providing space for calmness as well as physical and psychological well-being that is challenged in the contemporary medicalized and industrial model of maternity care. She argues that the spiritual qualities of care need to be valued in maternity care organizations.

Swedish healthcare providers are bound to comply with the Patient Act's principles of equal and accessible care and to account for patients' religious backgrounds by offering culturally sensitive care. Lise Eriksson, Victor Dudas, Aje Carlbom, and Birgitta Essén's chapter analyses perceived religious discrimination in healthcare through an interpretative phenomenological analysis of complaints submitted to the Equality Ombudsman in Sweden from 2012 to 2021. One-third of the complaints were submitted by Muslims and several complaints concerned healthcare providers' reactions to patients wearing hijabs or other ethnic or religious attributes. The study indicates that healthcare providers face difficulties in conforming to the partially contradictory ideals of equal treatment and cultural sensitivity, whose relationships to religious diversity have not yet been clearly defined.

Discrimination and racism in healthcare is also the topic of Shahnaj Begum's chapter about the experiences of Muslim immigrant care providers in the elderly care sector in Finland. Based on interviews with Muslim and non-Muslim care providers from different areas in Finland, Begum identifies discriminatory practices and perceptions among colleagues based on religion, country of origin, and skin colour, primarily directed against Muslim care providers. Begum argues that care providers need guidance in how to increase cultural and religious awareness, to counteract racism and discrimination in elderly care organizations.

The next section of the book comprises two chapters focusing on central concepts in healthcare related to spirituality, culture, and religion. Erika Willander scrutinizes the concept of existential care in hospital chaplaincy in Sweden, while Emma Lundberg discusses the concept of religious literacy in relation to person-centred care. Willander observes two dominant ways of understanding the "existential," that is, "existential security" following Inglehart, which positions the existential as something outside religion, and an understanding of the "existential" as something akin to religion, but not necessarily religious. In contrast to these two dominant views, Willander brings in a functional approach based on Milton Y. Yinger's definition of religion, arguing that the latter may be seen as an approach to understanding the "existential" as something at the heart of both religion and secular care practices.

Emma Lundberg reflects in her chapter on religious literacy and illiteracy in relation to the general idea and consensus that holistic and spiritual care

is to be provided by healthcare professionals, particularly in palliative care settings. Based on fieldwork including participant observations, narrative interviews, and informal interviews at a hospice in Sweden, Lundberg identifies four main challenges in providing spiritual care and becoming more religiously literate: time, knowledge, professional responsibilities, and organization. She describes religious literacy as integral to person-centred care and argues that increased religious literacy can be a means to achieve improved person-centred, holistic, and equal care.

The third section of this book explores suggestions for constructive ways to overcome religious illiteracy and the use of a static concept of culture in healthcare. The Swedish DöBra cards, an adaption of the original US GoWish cards, are designed to be a tool to support conversations about values and preferences for end-of-life care, supporting "death literacy" in healthcare. Malin Eneslätt, Therese Johansson, Krister Stoor, and Carol Tishelman's contribution discusses lessons learned from using the cards in research with older community-dwelling adults, in residential elder care, and in an Indigenous Sámi context. The authors argue that using the DöBra cards can be a generic way to systematically include the values of various cultural and religious groups while remaining flexible enough to allow for heterogeneity in groups, by recognizing individual interpretations of important cultural values. The card deck may, the authors suggest, potentially support care encounters characterized by cultural humility, a prerequisite for "culturally safe" care for everyone.

Lisen Dellenborg's chapter explores how healthcare professionals can draw on anthropological knowledge to integrate spiritual comfort and care into their professional healthcare practices in collaboration with patients and, when relevant, their family members. Turning the anthropological gaze on contemporary healthcare settings in Sweden, Dellenborg describes how healthcare practices, although marked by secular norms and generally seen as strictly scientific and objective, are in many ways permeated with symbols and rituals that can be seen as religious and even "magical" as they comfort patients and fill them with hope. The chapter is based on ethnographic fieldwork in various Swedish healthcare settings and on students' narratives. The author suggests that training healthcare professionals in an anthropological, relativistic, culturally comparative approach that fosters an understanding of the insider perspective, the context, and themselves in their context, together with care science knowledge of comfort and "consoling presence," could help them become more comfortable with creating a space for explorative play in the mediation of spiritual comfort and care.

In the next chapter, Daniel Enstedt argues that a *lived religion* perspective enables us to move away from a static, essentialist, textual, and dogmatic understanding of religion and spirituality, towards a more empirically grounded understanding of religion and spirituality as acted out and performed in different ways in different situations by different social actors. This explorative chapter is based on fieldwork and empirical studies conducted over the last decade. Based on the empirical examples, Enstedt suggests ways

for healthcare providers to discern and address new expressions of religion in their everyday encounters with patients.

Concerning spiritual care and existential issues in healthcare, the focus has primarily been on approaches and understandings developed in the psychological, religious, sociological, and anthropological disciplines. In the final chapter of this section, Finn Thorbjørn Hansen suggests a fourth possibility: philosophy and the practice of a hospice and hospital philosopher. Hansen elaborates on why "philosophical literacy" is important and needed for training healthcare professionals in how to provide spiritual care, and why person-centred healthcare needs to be supplemented with "phenomenon-centred healthcare." Hansen describes how he, in relation to nurses at a Danish hospice and hospital, through empirical studies has developed what he calls "Wonder Labs" and the "Wonder Compass." Informed by theoretical studies based on the apophatic tradition in philosophy, Hansen focuses on the dialogical community of wonder between healthcare professionals and persons in care as central to "philosophical literacy" in healthcare.

This book is completed with an afterword by thanatologist Panagiotis Pentaris, author of *Religious Literacy in Hospice Care* (2019) and *Death, Grief and Loss in the Context of Covid-19* (2021). Based on his and others' previous work, Pentaris reflects on the contributions in this volume and identifies further directions for future studies of cultural and religious literacies in healthcare and elsewhere.

The chapters of this book have all addressed important conceptual, empirical, and theoretical issues related to religious literacy and culture in healthcare and have also suggested ways forward. As editors, we hope that the contributions included in this volume will stimulate readers as much as they have stimulated us to conduct further research in the field. In the long run, they may also provide a solid basis from which healthcare providers can reflect on how to organize and conduct their everyday practices in healthcare.

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