

Extending the Spirit: A Qualitative Secondary Analysis on Nurses' Perspectives on Spirituality

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Abstract

Once laden with promise, modernization and secularization have not remedied the societal ills of our time. Individuals have begun to seek answers outside of the confines of traditional religion, often developing a personalized spirituality. At the same time, globalized migration has seen newcomers with strong ties to institutionalized religion settle in Canada. As Canadian society re/turns its attention to spirituality, nursing acts of spiritual care arguably gain importance. Appreciating the multifactorial nature of spiritual caregiving, the purpose of this study was to explore the influences on spirituality and spiritual caregiving in nursing practice. This qualitative secondary analysis explored the narratives of fourteen nurses from a variety of practice settings in Canada. Eight nurses' perspectives were obtained from acute settings: intensive care, orthopedics, emergency, geriatric emergency, labor and delivery/postpartum, medical surgical and perioperative. These perspectives were compared and contrasted with narratives from six community settings: public health, home care, midwifery, corrections (mental health), geriatrics, and pediatric home care. The participants self-identified their spiritual/religious affiliations: five as Christians, two Catholic, one Muslim, five as spiritual but not religious, and one not spiritual or religious. From an interpretative descriptive framework, five nested themes were identified as influencing spiritual caregiving in healthcare contexts: the nurse as custodian of spiritual caregiving, nursing acts of spiritual caregiving, professional and organizational silence, distinctive environments, and the Canadian milieu. The findings from this study present a constructive view of the interdependence of the personhood of the nurse and the environment, in-tending to the sacred. Spiritual caregiving was seen as both a discrete act which facilitated patients' spiritual practices and, in other situations, took the form of integrative spiritual caregiving which was part of the interpersonal connection in the nurse patient

relationship. The nurses' impetus for the provision of spiritual care determined if acts of care were seen as discrete or holistic, and when and how spiritual care was provided. Professional and organizational environments can inspire or impede this care of the sacred. As a result, spiritual care was found to be contingent upon the institutions climate of care. The Canadian milieu is laced throughout the narratives as tolerance, acceptance and pluralism.

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'Tis grace hath brought me safe thus far,
And grace will lead me home.
- John Newton

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Dedication

To my parents, who first believed.

Chapter One: Introduction

“Earth to God: We could use you right about now” was the title of a recent article in Canada’s leading *liberal* newspaper reflecting the evolution of the sociopolitical climate in our country. The journalist declared:

Faith is morphing and softening, drifting out of formal worship places and breaking down once-strict denominational and doctrinal walls, creating a modern syncretism that might just be capable of adapting the best parts into a new whole. After all, our reliance on pure reason and its secular institutions – government, the marketplace, even science itself – has failed, or, at minimum, disappointed, roughly 99 per cent of us. (Anderssen, 2011, para.4)

Modernization and secularization have been unable to address the sacredness of humanity (Kolakowski, cited in Sommerville, 2006), the relationship to the other (Sigurdson, 2010) or the evolution of society (Dillon, 2010). Thus, the “tide” of political and social interest is turning with a renewed fascination to spirituality.

This is an exciting point in history for the nursing profession, yet it has been difficult to develop a pragmatic approach to holistic care within a post-secular context, particularly in light of increased spiritual and religious plurality. In order for the profession of nursing to have a clearer vision for the future, an increased understanding about how spirituality is integrated into practice is required. The literature review produced only a modest number of studies which demonstrated *how* spirituality is being integrated into nursing practice. Therefore, this project was exploratory in nature, and attempted to discover the voice of nurses which has been habitually buried beneath the philosophical debates, waiting to be uncovered, heard, and enacted.

Background

The role of religion in public institutions has been called into question, given the separation of church and state (Mendieta & Vanantwerpen, 2011; Reimer-Kirkham, 2012). Recent statistics confirm that spirituality/religion is important to 90 percent of the world's population (Koenig, 2009). The intersection of politics, culture and religion has become "one of the most urgent societal questions of our time" (Sigurdson, 2010, p. 177; see also Dillon, 2010; Reimer-Kirkham & Sharma, 2012). Religion and spirituality have become individual subjective concepts which allow one to construct beliefs in a global context (Reimer-Kirkham & Sharma, 2012). Spirituality and religion can no longer be treated as a simple division of personal and private realms. Spirituality and religion are multifaceted issues at the intersection of global migration, secularism and the rise of emergent spiritualities (Reimer-Kirkham, 2012).

The examination of spirituality within our current sociopolitical context is essential (Pesut, 2012a; Reimer-Kirkham, 2012). How is Canada being impacted by this paradigm shift? It is estimated that 85 percent of Canadians have some spiritual/religious beliefs (Koenig, 2009), supporting recent research findings which dispute Canada's label as a secularized country (Eagle, 2011). Religious demographics have evolved from European Christianity to incorporate multiculturalism, pluralism and tolerance as a result of increased immigration (Beyer, 2008; Fowler, 2012; Kelly, 2011; Reimer, 2008) and have set the stage for change. It is expected that Canada is positioned for a religious resurgence (Eagle, 2011; Reimer-Kirkham, 2012). Set within the current cultural context, it becomes clear that the "the tide has turned," such that discussions about religion and spirituality are increasingly no longer taboo. Canadian philosopher, Charles Taylor, and leading social and political theorist, Jürgen Habermas, observe the return of religion to the public sphere (Calhoun, 2011); and a post-secular age (Calhoun,

2011; Taylor, 2007). Sommerville (2006) summarizes this change as, “the secularist stage in history was dominated by epistemology and positivism...Now we are moving into a hermeneutic and personalist stage in which the task is to explore human meanings, where religion may again be relevant” (p. 13).

Canada mirrors worldwide religious and sociocultural diversity (Beyer, 2008; Bibby, 2011; Reimer-Kirkham, Pesut, Meyerhoff, & Sawatzky, 2004; Reimer-Kirkham, 2012). As religion is becoming polarized, interest in spirituality is growing (Bibby, 2011). Western concepts of spirituality have taken on an Eastern flare (Beyer, 2008; Bibby, 2011, Pesut, 2012a); for example, from an Eastern perspective “Karma is merely a (neutral) force that keeps balance in the world” (Spiritualism, 2012). However, when integrated into an individualistic western perspective Karma takes on new meaning: “We should seek “good karma” and avoid “bad karma,” because it effects whether we advance or regress in our next reincarnation” (Spiritualism, 2012). Spirituality is seen as subjective and “in the eye of the beholder” (Bibby, 2011); likened to shopping at a supermarket (Bibby, 2011) or dining at a smorgasbord (Benner Carson, & Stoll, 2008). Bibby (2011) discovered 87 percent of Canadians believe a person possesses a soul. Many are cognizant of their spiritual needs and are looking for fulfillment beyond traditional religion (Taylor, 2007); following personal spiritual journeys (Beyer, 2008; Sharma, Reimer-Kirkham, & Fowler, 2012; Taylor, 2007). These respective journeys can be defined as “believing without belonging” (Davie cited in Sigurdson, 2010, p. 188) where many individuals have moved beyond established religions and have begun the “sacralization of the subjective life” (Woodhead in Sharma et al, 2012, p. 297).

Historically, religion was the vehicle which enabled the development and expression of spirituality. Spirituality/religion and health/illness were intertwined in all aspects of life; this

impacted the development of healthcare practices in Canada. The inception of Western nursing remained faithful to its European Judeo-Christian values and beliefs, caring for the sick was based on religious ideals. Nightingale nursing schools were instituted on Christian principles. French Augustinian nuns espousing these values arrived in Canada in 1639. Since that time, these Christian principles have evolved into the humanistic perspective that provides foundation for current nursing practice and the quest to provide holistic care (Bruce, 2010).

Until recently, modernization and secularization largely displaced spirituality and religion in Western society (McSherry, 2006). The shift became evident in healthcare as the emergence of the biomedical model pushed spirituality and many humanistic imperatives to the periphery (Carr, 2010; Freeman & Morrison, 2009; Puchalski & Ferrell, 2010). This peripheralization of spirituality is reflected in the World Health Organizations (WHO) definition of the person as merely a biopsychosocial being. Today, the unbalanced view of health is being challenged as conversations regarding holism are being revisited in society and healthcare (Meier, St. James O'Connor, & VanKatwyk, 2005; White, 2006). The current pursuit of holism realigns spiritual wholeness with health (Taylor, 2007), as noted by healthcare professionals increased interest in holistic/spiritual research (Narayanasamy, 2006; St. James O'Conner & Meakes, 2005). In addition, the concept of healing is regaining popularity as individuals seek to fill the gap left by the medical model (Freeman & Morrison, 2009; Puchalski & Ferrell, 2010). As well, a movement is underway to include "Spirituality as the 4th dimension of health," along with the biological, psychological and social dimensions (Steinman, 2010) thus, conceding the vast interaction between body and spirit.

Nursing's commitment to provide holistic culturally relevant care (Fowler, 2012; Pesut, 2012a; Robinson, Kendrick & Brown, 2003) situates it in the midst of the spirituality debate.

Canadian directives for nursing include holism and spiritual care; these mandates are found at an international North American Nursing Diagnosis Association (NANDA) and national Canadian Nurses Association (CNA) levels which are reaffirmed throughout provincial nursing associations. A summative position statement on Spirituality, Health and Nursing Practice was put forth in 2010:

The Canadian Nurses Association (CNA) believes that spirituality is an integral dimension of an individual's health. CNA recognizes that spiritual beliefs are diverse, reflecting both individual and cultural influences. To provide the best possible health outcomes, registered nurses are expected to respect this diversity in the same way they provide culturally competent care. Sensitivity to and respect for diversity in spiritual beliefs, support of spiritual preferences and attention to spiritual needs are recognized by CNA as required nurse competencies. CNA believes that being attentive to an individual's spirituality is a component of a holistic nursing assessment and nursing practice. When planning for and providing care, nurses have an ethical responsibility to be aware of and adjust for an individual's spiritual beliefs. CNA believes that through their practice, nurses are uniquely situated to ensure that an individual's spiritual values, beliefs and experiences are taken into account in the provision of ethically responsible health-care interventions and services (CNA, 2010, p.1).

Prior to 2010, the profession avoided serious contemplation of the role of spirituality/religion in practice, noting the challenges that arise out of globalization, empirical science and the desire to expand nursing as a profession (Fowler, 2012). Even so, Robinson et al. (2003) explained nursing is invested in spiritual/religious care: historically, theoretically (through holistic pursuits) and practically as nurses spend concentrated time interacting with

patients. In addition, some research findings have demonstrated most patients would like nurses to be aware of their spirituality (Taylor, 2012) as many experience their values and beliefs as lived-out in everyday life (Fowler, Reimer-Kirkham, Sawatzky, Taylor, & Pesut, 2012).

Rationale

The literature reviewed for this thesis revealed that spirituality is an ambivalent concept in nursing; it is unclear how nurses can address their spiritual directives. Bruce (2010) described this as a holistic tension for which nurses feel unprepared. Nurses' perceived lack of preparation for spiritual care is a common theme in the literature reviewed (Hwa Tiew & Creedy, 2010; Kociszewski, 2003; Narayanasamy, 2011; Pike, 2011).

As Canadian society moves into a post-secular paradigm (Taylor, 2007), it becomes paramount for nurses to approach spirituality in a collective, contextually pragmatic manner so as to create an environment for healing (Taylor, 2006). Yet, as definitions of spirituality become personal and dynamic, a cloud of confusion surrounds how to care for the patient's spiritual needs (Pesut, 2012a).

Canada's unique multicultural and pluralistic framework influences the integration of spirituality into our socialized medical system. What impacts this integration, intrinsic or extrinsic factors? What value (if any) do nurses place on spirituality? As we move into a post-secular era, the nursing profession will likely have more freedom to examine spirituality from the evidence based quantitative perspective. Perhaps there will even be an opportunity to study spirituality in its entirety; moving beyond the confines of science to explore its position within the realm of ethical care. The voices of nurses grappling with this concept in clinical settings can give insight into how spirituality is currently implemented in practice: what is working, what is not?

Purpose and Objectives

The literature reviewed demonstrated that spirituality is an ambivalent concept in nursing; it is unclear how nurses can address their spiritual mandates, and the nature of these mandates. The purpose of this project is to explore the perspectives of nurses in regards to spirituality in nursing practice. Research questions developed to meet this objective were: What are the influences on spirituality and spiritual care in nursing practice? How do nurses' perceptions of spirituality influence their descriptions of spiritual caregiving? How do nurses' practice environments influence their views on spiritual caregiving?

Method

These questions were addressed with a secondary analysis of an existing data set. The method of interpretative description provided the basis for this analysis. This method permitted the spiritual care perceptions of nurses to be explored for similarities and differences, and themes constructed to depict the experiences of these nurses (Thorne, Reimer-Kirkham & O'Flynn-Magee, 2004).

Definitions

A plethora of definitions exist for the concepts addressed in this study and therefore the definitions utilized for the purpose of this thesis must be explicated. In order to accurately interpret the meaning in the narratives, a hermeneutic distinction was made between spirituality and religion. Spirituality was viewed as "The power in a person's life that gives meaning purpose and fulfillment; the will to live; the beliefs or faith that person has in self, in others and in a power beyond self" (Renetzky cited in White, 2006, p. 19). Weaver, Pargament, Flannelly and Oppenheimer (2006) summarized this as a "subjective, individualized experience of transcendence" (p. 210). Religion was defined as an "institutionalized expression of belief and

practices” (Weaver, et al., 2006, p. 210). The purpose of this thesis was not to explore the distinctions between these terms and therefore the term “sacred” was often utilized to capture the meaning. The term sacred “refers to a divine being, divine object, Ultimate Reality, or Ultimate Truth as perceived by the individual” (Hill et al. cited in Taylor, 2012, p. 10). Spiritual caregiving was understood as, “recognizing and responding to the multifaceted expressions of spirituality we encounter in our patients and their families” (Ward, cited in Bratton, n.d., slide 12). Finally, the term post-secular was understood in light of Jürgen Habermas’ definition which calls for the return of religion into the public sphere, affirming political discussion:

[Post-secularism is] an approach that both reckons with the continuing global vitality of religion and emphasizes the importance of “translating” the ethical insights of religious traditions with a view to their incorporation into a “postmetaphysical” philosophical perspective (Mendieta & Vanantwerpen, 2011, p. 4).

Outline of Thesis

The goal of this research was to gain a greater understanding of the influences on spirituality and spiritual care within a health care context. The first chapter provides an introduction. The second chapter provides the foundation by describing the background on workplace spirituality, spirituality in healthcare and nursing, and spirituality in nursing care. The methodology will be discussed in the third chapter. The themes compiled from the narratives will be outlined in the fourth chapter with the discussion of the findings in the fifth chapter. Finally, chapter six discusses the implications of these findings for nursing practice, nursing education, nursing leadership and health policy.

Chapter Two: Literature Review

The purpose of this project was to explore the influences on spirituality in nursing practice from nurses' perspectives. A literary framework was constructed to provide background and an overview of the main concepts utilized in this thesis. A foundation for the review was provided with an initial outline of spirituality in the workplace to demonstrate interest surrounding spirituality in the marketplace is multiplying. The review then focused on spirituality within the healthcare context. The topics explored in this literature review were: spirituality in the workplace, spirituality in healthcare, spirituality in nursing, and spirituality in nursing care. This review is by no means an exhaustive attempt at summarizing the plethora of current literature. Multiple databases were researched (See Appendix A). The articles were intentionally selected to provide the reader with a general overview of the concepts.

As society evolves, so do conceptual definitions of spirituality (Zinnbauer et al., 1997). Past definitions intertwined spirituality and religion but, with secularization, the two have become distinct. Sigurdson (2010) stated,

The liberal distinction between religion and politics, and the subsequent privatization of faith, has some historical affinity with the Lutheran doctrine of the two kingdoms. In a very general form, this doctrine distinguishes between the realm of the "outward human being" and the "inner human being", where the "outward human being" is a citizen in the worldly and political realm whereas the "inner human being" is a citizen in the spiritual and private realm (p. 186).

A study exploring the hermeneutic distinction in a western context determined:

spirituality was most often described in personal or experiential terms, God or a higher power. Definitions of religiousness concluded both personal beliefs, such as a belief in

God or a higher power, and organizational or institutional beliefs and practices such as church membership, church attendance, and commitment to the beliefs system of a church or organized religion. (Zinnbauer et al., 1997, p. 561)

Weaver et al. (2006) affirmed this distinction: “Spirituality has been reserved for the subjective, individualized experience of transcendence. In contrast, religiousness has, for many people, become synonymous with institutionalized expressions of belief and practices” (p. 210). This thesis recognizes the hermeneutic distinction.

With 90 percent of the world valuing some form of spirituality/religion (Koenig, 2009), it is elemental to reintegrate this concept into postmodern culture. Many disciplines are assigning meaning to this concept as they recognize the progression of spirituality/religion back into the public sphere. How are other health related disciplines addressing spirituality?

Workplace Spirituality

As nursing is situated in a clinical context, as a practice discipline, it is beneficial to begin with an overview of what spirituality means in the workplace. While interest in workplace spirituality is gaining esteem, an absolute definition does not exist (Vasconcelos, 2010). Laabs stated, “defining spirituality in the workplace is like capturing an angel-it’s ethereal and beautiful, but perplexing” (cited in Karakas, 2010, p. 91). Altaf and Awan (2011) asserted, despite different operational definitions:

Workplace spirituality is the spiritual well-being of an individual in working conditions...Workplace spirituality means that employees are satisfied with the categories of spiritual well-being as set by Hungelman (1985)...they find fulfillment of both the vertical and horizontal dimensions of the spirituality” (p. 94).

Marque (2008) contended that:

workplace spirituality is a process that is instigated by personal growth and nourished by connection. Although spirituality is not necessarily religiously driven, the basic concepts of the spiritual mind-set: acceptance, understanding, consciousness and peace are embedded in the majority of world religions (p. 24).

Giacalone and Jurkiewicz (cited in Marques, 2008) describe workplace spirituality “as a framework of organizational values evidenced in the culture that promotes employees’ experience of transcendence through the work process, facilitating their sense of being connected to others in a way that provides feelings of completeness and joy” (p. 24). In contrast, others refuse to define workplace spirituality, recognizing categorizing may divide instead of unifying (Lambert, 2009). Nevertheless, it is acknowledged that spirituality is often expressed through universal values and practices with spiritual roots (Lambert, 2009).

Spirituality in Healthcare

Healthcare consists of a multidisciplinary approach; interaction between disciplines is routine. Nursing has both a distinct and borrowed knowledge base (Rogers, 2005): recognizing how other health disciplines define spirituality may assist nursing to explicate a definition of spirituality situated within the healthcare context. Interest in spirituality has been increasing and this is evidenced by the growing number of empirical studies on spirituality and health (Weaver et al., 2006). Thus, demonstrating nursing is not alone in its quest, but is joined by other healthcare disciplines such as physicians, social workers and occupational therapists (Koenig, 2007; White, 2006). Swinton and Pattison (2010) claimed, “What is needed is an interdisciplinary (or multidisciplinary) approach that recognizes the general area of spirituality as

it has been identified in the literature and notices and takes heed of the family resemblance between the various definitions and perspectives” (p. 235).

The cornerstone of modern medicine, the Hippocratic Oath affirms a commitment to holistic care (White, 2006). However, the biomedical model developed an overreliance on “mind-body dualism” which discounts the human spirit (McGuire, 2008, p. 136). From this perspective “the body can be understood and treated separately from the person inhabiting it” (McGuire, 2008, p. 136). Medicine’s disregard for the spirit was two-fold: its worship of the empirics and its denial of the divine (Puchalski & Ferrell, 2010). Nevertheless, physicians have begun to recognize the error of discounting the spirit and moving beyond the novel emphasis on “cure or fixing” (Puchalski & Ferrell, 2010, p. 12), returning to a holistic perspective (Koenig, 2007) and “meaning making in the midst of suffering” (Puchalski & Ferrell, 2010, p. 12). This return is evidenced by the renewed interest in incorporating spiritual training in medical schools (Koenig, 2008). Koenig’s (2009) study on spirituality in healthcare noted its ambiguous meaning, “Spirituality is considered more personal, something people define for themselves that is largely free of rules, regulations, and responsibilities associated with religion (p. 284).” The medical profession is challenged by this lack of conceptual definition when striving to integrate spirituality into practice and education. “Individuals often approach spirituality as the proverbial blind men explored the elephant, each using a favored paradigm (Peteet & D’Ambra, 2011, p. x).” Physicians’ desire, ability and responsibility to address spiritual health is contested (Koenig, 2007; Koenig, 2008); those who address the issue with patients are more likely to be spiritual/religious themselves (Benner Carson & Stoll, 2008). Levitt (2005) stipulated that, “Spirituality is an important part of a holistic approach to the “art” of healing, and it should be routinely considered as a cause of illness and distress in patients” (p. 71). Guilfoyle and St.

Pierre-Hansen (2012) affirmed spiritual care fits with holistic medicine; however, its public ties to religion are often acrimonious and create an uneasiness that may cause practitioners to avoid spiritual needs altogether. White (2006) illuminated possible explanations for the distance between medicine and its holistic roots stated as, “The awkwardness about spirituality is as much a legacy of western history as it is of the medical model of health care” (p. 17).

Chaplains were once an integral part of the healthcare system. However, many healthcare professions are uncertain what role chaplains play in the postmodern pluralistic healthcare context (Robinson et al., 2003). Reimer-Kirkham et al., (2011) stated, “The secularization of healthcare contexts within Canada has not meant the demise of religion or spirituality, but its re-negotiation and re-emergence in how chaplains are defined (e.g. spiritual care providers), chapels are carved out in hospitals (multifaith rooms)...(Gilmour 2006)” (p. 8). It is within this context, that chaplains are also working to re-conceptualize spirituality (Harding, Flannelley, Galek & Tannenbaum, 2008). The desire to re-conceptualize spirituality is evident in an appeal by some chaplains to move towards a “a humanistic-phenomenological definition of spirituality”, such that spirituality could be defined as “a way of being and experiencing that comes through awareness of a transcendent dimension and that is characterized by certain identifiable values in regard to self, others, nature, life, and whatever one considers to be the Ultimate” (Elkin, Hestorm, Hughes, Leaf, & Saunders as cited in Nolan, 2009, p. 212). The semantics of chaplaincy (i.e. spiritual care) have been borrowed by most health care professionals; there is a call within the discipline to redefine the seminal concepts that make the profession distinct, beginning with changing the title “chaplaincy” to “pastoral care” (Orton, 2008), and more recently in the Canadian context, “spiritual care practitioners” (Pesut, Reimer-Kirkham, Sawatzky, Woodland, & Peverall, 2010). In an attempt to define itself as a profession

(Orton, 2008), one scholar has suggested abandoning spiritual language and refocusing on the theological (Harding et al., 2008). Other scholars are considering how spiritual care providers can adapt to the business model of health care; suggesting quantification of spiritual care is essential and feasible (Smeets, Gribnau & van der Ven, 2011).

Spirituality in Nursing

Literature searches of nursing databases produced numerous articles on spirituality, which demonstrated the profession is concerned with the spirit. How, then, is spirituality defined in the context of nursing? What is the role of spirituality in nursing? Two schools of thoughts emerged: one which sought to concisely conceptualize and measure spirituality and one which embraced a loose conceptualization out of reference for the transcendent.

Sessana, Finnell and Jezewski (2007) pointed to the lack of conceptual clarity in nursing practice, “Spirituality is an intricate, enigmatic, abstract and ambiguous concept” (p. 252). The authors’ concept analysis revealed four themes: spirituality as religion, spirituality as meaning in life, spirituality as nonreligious values and beliefs, spirituality as metaphysical. They called for a definition of spirituality that incorporates these categories. A literature review by Clarke (2009) also noted the lack of conceptual clarity and found when current definitions of spirituality are applied in practice, the interventions mimic psychosocial care. The use of “broad, generic, existential definitions” (Clarke, 2009, p. 1666) coupled with the separation of spirituality and religion have led to ambiguous concepts that do not translate to practice. Alternatively, Paley (2008; 2010) recommended viewing spirituality from a naturalistic perspective; in a scientific way. Hussey (2009) supported this naturalistic paradigm claiming nurses operating from this perspective are more effective care in palliative care.

However, the desire for a succinct definition of spirituality is not shared by all. A review by Pesut, Fowler, Taylor, Reimer-Kirkham and Sawatzky (2008) also established existing definitions of spirituality in nursing are insufficient and not applicable to practice. However, they concluded that contemporary definitions: are without theological and philosophical grounding; elitist; prevent critique as the focus becomes individualistic; and allow exploitation by economic and political self-interest. They called for a contextual definition of spirituality created specifically for the nursing profession that develops out of philosophical and theological history being grounded in moral practice.

Pesut (2010) also rejected the need for a unified ontology of spirituality within nursing; observing definitions become exclusive in a pluralistic society. The focus should be on the ethics of care which center on respect, dignity and sensitivity. Swinton and Pattison (2010) shared the aspiration for a broad and vague definition of spirituality: it is an inclusive concept which eliminates the radical and political connotations of concrete definitions. They argued that a vague definition “relates to the way people perceive and *actually* respond to all aspects of the context of contemporary healthcare” (p. 233).

An overarching concern of how spirituality has been defined in nursing was explicated by Reimer-Kirkham and Sharma (2012) who contend,

Until very recently, religion and spirituality have been typically portrayed as “stand alone” phenomena or social categories, studied in isolation from ethnicity, race, gender, and class. This is particularly so in nursing. Nursing literature has tended to promote acontextual interpretations of spirituality and religion that hold spirituality as a highly personalized phenomenon that is either so transcendent that it is not contaminated with ‘earthly’ realities such as race, class, and gender or so immanent that it is everywhere and

everything, making other social categories essentially meaningless. As for religion, many nursing texts, for example, subsume religion under culture or spirituality. When deemed a subcategory of culture, religion is seen as a set of static cultural practices. When subsumed within spirituality, religion is often made invisible (p. 116).

Defining spirituality and spiritual care is fundamental to nursing in the 21st Century.

Spirituality in Nursing Care

As there is little agreement on how to define spirituality, how are nurses attending to the elusive spiritual needs of patients? North American Nursing Diagnostic Association provides a method to assess and diagnose spiritual issues (Doenges, Moorhouse & Geissler-Murr, 2006). Pesut and Sawatzky (2006) challenged the diagnostic method by asserting ethical concerns about the prescriptive nature of this nursing approach. They found spiritual diagnoses demean the patients' spirituality and therefore advocated for a descriptive approach to allow the nurse to know how to support patients in their unique journey. There is agreement that a "cookbook" approach should be avoided as "spirituality in the wrong hands could be dangerous to patients' well-being" (Narayanasamy, 2011, p. 915). Therefore, Sawatzky & Pesut (2005) propose:

that spiritual nursing care is an intuitive, interpersonal, altruistic, and integrative expression that is contingent on the nurse's awareness of the transcendent dimension of life but that reflects the patient's reality. At its foundational level, spiritual nursing care is an expression of self (p. 23)... We agree that just as spiritual nursing care must reflect the patient's reality, so should the outcomes... This means that, at times, we may have to live with the absence of observable outcomes. As uncomfortable as this may feel, the work of the spirit is often hidden and only revealed to those in whom the work is being done... (p. 29-30).

As the postmodern age is ushered in, nursing and other health professionals have begun to emphasize “how to” perform spiritual care and develop models to integrate spirituality into practice. Narayamasamy (2006) created the five C model to spiritual care: caring, compassion, connection, commitment and communication. McSherry (2006) advocated for spiritual care to be provided within the systematic nursing process; assessment, plan, implementation and evaluation. Koenig (2008) offered tools for spiritual assessment and called for nurses to support patients beliefs, pray with patient if requested, provide spiritual care (auspice of compassion), and refer. Pulchalski and Ferrell (2010) provided numerous assessment models accompanied by interdisciplinary inpatient and outpatient models of spiritual care. Finally, Taylor (2012) placed spiritual care within the relational context of nurse and patient; the nurse uses therapeutic use of self to support the patients exploration of the impact of [spiritual]/religious beliefs on health.

While much nursing literature has focused on spirituality, a disproportionate number of studies have focused on the integration of spiritual care into practice. A recent literature review by Hwa Tiew and Creedy (2010) found the integration of spiritual care into practice to be impacted by: the nurse’s understanding of spirituality, lack of emphasis on spirituality in nursing education, attitudes, organizational and cultural factors and individuality. The organizational factors were expounded on by Carr (2010) who explicated how the healthcare system moved from caring to rational. Limited time, objectification of the body and social distance created through professionalism were all found to influence the nurse’s ability to provide spiritual care (Carr, 2010).

Bailey, Moran and Graham (2009) saw spiritual care is tantamount to psychological care. Nurses weave their own spiritual tapestry: “The nurses actively used (‘weaved’) the

knowledge and skill of embracing spiritual care through their self-awareness, empathy and commitment to embracing holistic nursing care in end-of-life care” (p. 48).

Dunn, Handley and Dunkin (2009) illustrated spiritual care as the therapeutic use of self in a maternity setting; reaching out (presence, listening, conversing) and reaching up (refer, pray, baptize) (p. 25). This concept supported earlier findings by Pembroke and Pembroke (2006) who found presence as key to spiritual care in obstetrical practice.

In addition, three pilot studies were reviewed for the sake of this literature review. The first pilot study found a positive relationship between nurses’ spiritual awareness and spiritual care and called for increased education to enhance the way in which spiritual care is provided (Chan, 2009). These finding built on a previous pilot study which determined nurses’ own spirituality determined the level of comfort in the provision of spiritual care thus identifying the need for informal and formal spiritual education (Kociszewski, 2003). A third small pilot study of nurses giving spiritual care (Deal, 2010) produced the following conclusion: “spiritual care is patient-centered, an important part of nursing, can be simple to give, is unexpected but welcomed by patients, and spiritual care is given by diverse caregivers” (p.852). Finally, one Canadian study by Carr (2008) described spiritual care in palliative settings as: developing a caring relationship and fostering connections and the sub-processes of expressing our X-factor (sharing of self), exchanging healing energy, and honoring the sacred and transcendent (p. 690).

Chapter Summary: State of Knowledge

This review of the literature found numerous articles debating ontology and epistemology of spirituality in nursing care, articles that described how to give spiritual care, when spiritual care was appropriate and why it is important to a patient’s wellbeing to integrate this into nursing care. In summary, the literature revealed that spirituality apart from religion is subjective;

without a consensual definition that can be applied in clinical practices nurses are often confused in how to attend to the spiritual dimension of patients.

Few articles were found that explored how nurses are currently delivering spiritual care and what impacts the delivery of spiritual care. A gap in the literature is also apparent when exploring how spiritual care is realized across the health care continuum and in a variety of acute and community nursing sites. This thesis begins to address these gaps.

Chapter Three: Method

Introduction

The methodology utilized for this study was unique to qualitative secondary analysis and a synopsis of the method employed to analyze the preexisting data set is provided in this chapter. The first section provides a general foundation for qualitative secondary analysis and is followed by the current study design. The sections that follow describe: sorting and sampling, data analysis, scientific quality and ethical considerations.

Qualitative Secondary Analysis

Qualitative data is typically abounding with details that were overlooked as they did not serve the purpose of the primary study; this data offers a rich source of accessible information for researchers to revisit using secondary analysis (Corti, 2007; Corti, 2011; Corti & Bishop, 2005; Fielding, 2004; Thorne, 1998). Qualitative Secondary Analysis (QSA) has been defined as, “the use of an existing data set to find answers to a research question that differs from the question asked in the primary study” (Hinds, Vogel, & Clarke-Steffen, 1997, p. 408).

The QSA method has been described as “invisible enterprise” for which there is a “notable silence” amongst the qualitative research community” (Gladstone, Volpe, & Boydell, 2007, p. 431). While this method is historically rooted in the social sciences, avid discourse has begun as many openly debate the merits of this research method (Corti, 2007; Corti, 2011; Fielding, 2004; Gladstone et al., 2007; Heaton, 2004; Hinds et al., 1997; Long-Suthehall, Sque, & Addington-Hall, 2011; Mauthner & Parry, 2009; Silva, 2006; van den Berg, 2005). Although its virtues are debated, social researchers continue to utilize this method to fulfill the purpose of qualitative research: to examine the lived experience and meanings individuals attribute their social experiences (Corti, 2011; Corti & Bishop, 2005; Thorne, Reimer-Kirkham, & MacDonald-

Emes, 1997). The objectives of qualitative research can be met through collateral sources of data pertaining to the integration of spirituality into nursing practice (Corti, 2011; Thorne et al., 1997).

QSA may be employed for a variety of reasons, some of which have been summarized by Corti (2007) and Corti and Bishop (2005): description, comparison, reanalysis, research design and methodological advancement, verification, teaching and learning. Other purported uses of QSA are the exploration of contemporary historical attributes and synthesis of data sets to address a new question (thus distinct from data synthesis) (Long-Sutehall et al., 2011).

Heaton (2004) categorized secondary analysis into five non-exclusive categories:

- 1) Supra analysis – study exceeds the focus of the original study
- 2) Supplementary – extends primary study increasing the depth
- 3) Re-analysis – to verify findings
- 4) Amplified – combine multiple data sets
- 5) Assorted analysis- mixed method that combines primary and secondary research and may include naturalistic qualitative data analysis (p. 38)

This qualitative secondary analysis was founded on Heaton's classifications: multiple data sets were examined in light of a new research questions.

Fourteen years have passed since Thorne illuminated the lack of a “methodological foundation” for QSA (Thorne, 1998, p. 548) and the continued lack of guidelines continues to be debated (Corti, 2007; Corti & Bishop, 2005; Fielding, 2004; Heaton, 2008; Long-Sutehall et al., 2011). From a pragmatic perspective, Bishop (2007) reflected the process of secondary analysis was similar to primary analysis.

QSA critics raise ontological and epistemological objections to this method. These are beyond the scope of this thesis; however, the use of QSA requires the researcher to be cognizant of the weaknesses of the method. A summary of epistemological/practical issues was provided by Corti and Thompson (cited in Corti, 2007): these are “ethical and consent considerations; representation; coverage and context of the research and fieldwork; unfamiliarity with methods; lack of infrastructure for data-sharing; misinterpretation of the data, threat to intellectual property rights” (p. 45). Additional issues are: problem of fit between secondary research question and primary data set (Gladstone et al., 2007; Heaton, 1998; Heaton, 2004; Hinds et al., 1997; Long-Sutehall et al., 2011; Thorne, 1998), position/credentials of the secondary analyst (Heaton, 1998; Hinds et al., 1997) and exaggeration of researcher bias (Thorne, 1998).

Fielding reminded us of a universal truth: “...all qualitative research has to deal with gaps...” (as cited in Bishop, 2007, 11.4). The gaps found in QSA are unique as it straddles the divide between qualitative and quantitative analysis (Heaton, 2004) nonetheless, researchers have developed methods to enhance credibility. Long-Sutehall et al. (2011) summarized many of the approaches which build integrity into the research process: outline the original study, data collection and analysis, “the purpose should be transparent detailing the methodological and ethical considerations and explaining any decisions regarding missing data so interpretative process is transparent” (p. 337).

Study Design

Original study. In keeping with the tenets of QSA, it is necessary to outline the primary study. The original data set which I reviewed consists of approximately 60 semi-structured interview transcripts conducted to meet the objectives of an on-line graduate level qualitative nursing research course at Trinity Western University, a Canadian Christian University. The

topic for the interviews was the influence of practice environments on the integration of spirituality and religion into professional nursing practice. The interviewers were graduate students (and hence novice researchers) who utilized convenience samples to find participants.

The purpose of the original assignment was:

to immerse in and critically reflect upon the processes of qualitative research.

The portfolio or “mini project” will be comprised of group and individual components.

By working with two research partners, the experience of a research team and learning

community will be facilitated. The individual components facilitate reflexivity and

efficiency for more independence in completing the project (given the time and place

constraints of a ten week online course). Your submitted portfolio will include: (a)

research log, (b) reflexive journal, weekly entries, (c) field notes, (d) interview guide, (e)

transcribed interview, (f) coded transcripts and field notes, (g) code book, and (h)

thematic analysis (N530 syllabus).

Qualitative secondary analysis. The goal of this secondary analysis was to gain a greater understanding of the factors that influence the integration of spiritual care into everyday nursing practice. The objectives of qualitative research were met as I employed collateral sources of data pertaining to the integration of spirituality into nursing practice (Corti, 2011; Thorne et al., 1997).

Data Collection

Data collection in secondary analysis occurs formally through access to archived data or informally with the transfer of data amongst researchers (Gladstone et al., 2007; Heaton, 2004).

This study was based on data in the form of interview transcripts obtained from two professors in the Trinity Western University School of Nursing.

Part of the data collection process in QSA requires the researcher to evaluate the data set to determine if it is feasible to utilize it for secondary purposes (van den Berg, 2005). Heaton (2004) provided a summary of an assessment criteria created by Hinds et al. (1997) which suggested data be evaluated for accessibility, quality and suitability.

This QSA was influenced by the quality of the original data which: was conducted by novice interviewers, used different interview guides, and did not allow transcription accuracy to be determined due to lack of access to the original interview recordings (Heaton, 2004). Other limitations included: lack of access to the original researcher (Gladstone et al., 2007; van den Berg, 2005), lack of information about the context of the interview including the relationship between the interviewer and participant (van den Berg, 2005), the anonymization process (Bishop, 2005; Carusi & Jirotko, 2009; Parry & Mauthner, 2004) and how interpretable the data were (Hinds et al., 1997).

The format of this study prohibited evaluation of the data prior to ethical approval. Nevertheless, accessibility, quality and suitability were determined by the gatekeepers, Dr. Reimer-Kirkham and Dr. Astle. These experienced researchers deemed the data sets acceptable for the purpose of my project.

Sorting vs. Sampling

Complete data sets are rarely used in QSA. Primary researchers use methods of data sampling but secondary researchers utilize a “sorting” technique to reshape the data set to compliment the purpose of the analysis (Heaton, 2004; Thorne et al., 1997). The 60 anonymized interviews were sorted to determine suitability for analysis. Sorting criteria included examining the degree to which the interviews fit with the secondary research question (Gladstone et al., 2007; Heaton, 1998; Heaton, 2004; Hinds et al., 1997; Long-Sutehall et al., 2011; Thorne, 1998)

and choosing interviews where nurses provided a rich narrative of the topic of interest (Gallo & Knafl as cited in Long-Sutehall et al., 2011), especially their personal experience/spiritual insights. Fourteen of the transcripts which shared common elements were chosen for analysis (Thorne et al., 1997). The matrix method was used to sort and organize data (Garrard, 2011). A matrix chart was constructed for the sorting process to identify criteria on one axis and interview number on the other axis.

Inclusion criteria. Inclusion criteria for this study were two fold. First, the participant or nurse had to meet the criteria of current employment as a registered nurse or licensed practical nurse and have provided consent for future use of their interview transcript. Second, the nurses' transcripts were required to meet the following criteria: the workplace setting was identified, religious and spiritual identifiers were provided to give an understanding of the participant's view of the sacred (i.e. spiritual but not religious), integration of spirituality into the practice setting was discussed and environmental influences on spiritual care were addressed.

Exclusion criteria. Transcripts from interviews with nurses who were not currently employed were excluded from this study in order to obtain a current snapshot of nursing practice. Additional criteria for exclusion were: transcripts that did not provide necessary identifiers (i.e. practice setting), transcripts that did not provide a rich description or transcripts which did not address the research questions.

Sorting process. Once the inclusion and exclusion criteria were applied to the interview transcripts, nineteen were found to be suitable for this study. The transcripts were sorted by practice area (acute/community) and religious identifiers in order to provide balanced perspectives. Ultimately, fourteen interview transcripts were chosen: eight from acute care and six from community settings. The acute settings represented were: intensive care, orthopedics,

emergency, geriatric emergency, labor and delivery/postpartum, medical/surgical, float, and perioperative. Community settings represented were: pediatric home care, geriatrics, corrections (mental health), public health, midwifery and home care. A variety of spiritual perspectives were sought and interviews were weighted to allow for diverse spiritual views: five participants identified as Christians, two as Catholic, one as Muslim, five as spiritual but not religious, and one as not spiritual or religious. The demographic information of participants is provided in the table below:

Table 1.0*Participant Demographics.*

Participant Number	Workplace Setting	Self-Identifier
1	Public Health	SBNR
2	Home Care	Christian
3	Perioperative	Christian
4	Midwifery	SBNR
5	Medical/Surgical	Christian
6	Float	Muslim
7	Emergency (Geriatrics)	Catholic
8	Labor and Delivery/Postpartum	Christian
9	Emergency	NSNR
10	Orthopedics	SBNR
11	Corrections (Mental Health)	SBNR
12	Geriatrics	SBNR
13	Intensive Care	Christian
14	Pediatric Home Health	Catholic

Note: SBNR = Spiritual but not religious, NSNR = Not spiritual not religious

Data Analysis

Interpretative Description provided the framework for analysis (Thorne, 2008) and allowed for an inductive approach that accommodated the “epistemic pluralism” of QSA (Mauthner & Parry, 2009). Interpretative description enabled the themes that emerged from the data to be evaluated in light of nursing practice (Thorne et al., 2004).

“Interpretative description is always a meaning-making activity, directed at a particular kind of audience (such as clinicians) toward the purpose of rendering a new, enriched, or expanded

way of making sense of some problem or issue” (Thorne, 2008, p.175). The analysis was loosely structured around Morse’s analytic process; comprehension, synthesis, theorizing and recontextualizing (as cited in Thorne, 2008).

The process began with sorting the transcripts, as described above. Sufficient time was taken to become acquainted with the material before analysis (Corti & Bishop, 2005; Thorne, 2008). Originally, I had planned to identify broad themes which would give way to more specific coding. However, in order to become acquainted with the data, coding of each transcript began with verbatim and descriptive coding (Saldana, 2009). An extensive descriptive codebook was developed but was abandoned as the project progressed as it was too specific. Recoding of the transcripts began with the general categories: role of the nurse, spiritual and religious perceptions of the nurse, description of spiritual care and influencing factors. This level of coding gave way to axial and selective coding which allowed further exploration and comparison of concepts. The transcripts were compared to identify common groupings. Finally, themes were compiled and structured into an account of nurses’ perceptions of spirituality as transcripts were read, reread, coded in a variety of ways, from notations in the margins and through analytic memos (Thorne et al., 2004). Thorne et al. (2004) spoke to the necessity of “external guidance to support the kind of disciplined reflexivity” (p. 10) required in interpretative description. Supervision of this analysis process was provided by Dr. Reimer-Kirkham and Dr. Astle.

Scientific Quality

QSA cannot be measured by traditional qualitative quality standards (Gladstone et al., 2007; Heaton, 2004; Hinds et al., 1997; Parry & Mauthner, 2005). Yet, it requires safeguards to protect scientific integrity. Long-Sutehall et al. (2011) suggested credibility of findings are enhanced with: outlining original study, data collection and analysis, transparent purpose,

detailing methodological and ethical considerations, and explaining any decisions regarding missing data so interpretative process is transparent (p. 337).

Thorne (cited in Heaton, 1998) cautions neophyte researchers from undertaking a QSA due to its complexity. Nevertheless, the nature of my qualitative study was conducive to a secondary analysis and I worked under the tutelage of proficient qualitative researchers who fulfilled the “thoughtful clinician test” (Thorne et al., 2004, p. 17). I kept a reflexive journal throughout the research process in order to objectify my bias (Polit & Beck, 2012; Thorne, 2008) and produce an audit trail (Long-Sutehall et al., 2011; Thorne et al., 1997). Credibility of this study was also enhanced by using complete original unmarked transcripts, the supervision of the research provided by the gatekeepers, and provision of contextual information regarding recruitment and information regarding setting (Gladstone et al., 2007). Sufficient time was taken to become immersed in the research material (Corti & Bishop, 2005; Thorne, 2008) to minimize intellectual errors (Thorne, 1998; Thorne, 2008).

My interest in this project stems from my personal account of the challenges of incorporating my spirituality into practice and the joys and trials of spiritual care. My biases must be explicated at the outset of this thesis. First, as a graduate student I conducted/analyzed an interview for the purpose of N530 and therefore had preexisting knowledge of the original study and assumptions about spirituality in nursing practice. Second, the data was inevitably viewed through a Judeo Christian lens, given my own Christian commitment. Third, the sociopolitical climate that shaped my worldview was based on the core value of freedom (individual, populism and autonomy) (Wesley, 2011). Finally, my personal experience with the healthcare system in two western provinces over the last two decades has been less than stellar. Stories of my family members are eloquently summarized by the views of Byrne (2012), “While

often satisfied with the clinical outcome of medical [nursing] treatment there is a great deal of anger, resentment and grief at the lack of caring and compassion demonstrated by the HCPs providing the “cure” (p. 1).

Dr. Reimer-Kirkham and Dr. Astle also brought a Judeo Christian worldview and a vested interest in this project; they were the professors for the graduate nursing research course, N530, and thus the gatekeepers to the data. Reflexivity enhanced the analytic process by providing opportunity for personal reflection and thus, created a space to explore the meaning of the narrative intended by the original speakers. A reflexive journal allowed for ideas and biases to be documented and thoughtfully considered during throughout the study (Gilgun, 2010).

Ethical Considerations

The greatest ethical considerations in qualitative secondary analysis are “informed consent, confidentiality, nonmaleficence, and fidelity” (Thorne, 1998, p.550); in addition, issues of authorship/ownership must be addressed (Corti, 2011; Parry & Mauthner, 2004). Consent for re-use must be sought at the time of the original study as many review boards give participants the opportunity to mark data for future use (Corti, 2011; Heaton, 1998; Long Sutehall et al., 2011). My QSA explored data in which participants in the original studies were informed at the time of the interview that the information they provided could be re-used (See Appendix C). It was determined its reuse did not cross ethical boundaries (Carusi & Jirotko, 2009; Heaton, 1998; Thorne, 1998) as participants gave permission for re-use of their transcripts in the original consent form.

Authorship and ownership of data is also called into question in a secondary analysis. Intellectual property rights and copyright issues must be examined prior to embarking on a study (Corti, 2011; Parry & Mauthner, 2004). A member of the research ethics board at TWU was

contacted to determine if consent was required from the student researchers prior to accessing the data compiled for N530. It was determined that consent was implied as it was included on the consent form the interviewers (graduate students) provided to their participants (Badke, W., Personal correspondence, March, 2012). However, it was suggested that, as a courtesy, an information letter be forwarded to students outlining the purpose and method of the QSA (Appendix D).

Confidentiality was maintained with the anonymity of transcripts; they were scrubbed by Dr. Reimer-Kirkham and Dr. Astle who ensured meaningful data was preserved (Bishop, 2005). This process removed some of the contextual data which may have altered (Long- Sutehall et al, 2011) and thus may have compromised the veracity of findings to some extent (Parry & Mauthner, 2004). A second layer of confidentiality was introduced through the sorting technique as only 14 interviews were selected for analysis. Data was stored on a password protected computer.

The participants were not harmed during this qualitative secondary analysis and findings were grounded in context and interpreted in light of the exploratory nature of this study. Close attention was paid to fidelity as Dr. Reimer-Kirkham and Dr. Astle were familiar with the data set. Formal ethical approval for this study was provided by the Trinity Western Research Ethics Board, July 17, 2012.

Chapter Summary

This chapter imparted a balanced overview of qualitative secondary analysis and acknowledged the methods in place to enhance scientific quality. The distinct data collection and sorting methods were described and a brief review of interpretative description provided.

Ethical safeguards were reviewed and biases acknowledged. Findings created from this methodology are presented in the subsequent chapter.

Chapter Four: Findings

Introduction

Interpretive description provides grounding for the conceptual linkages that become apparent when one attempts to locate the particular within the general, the state within the process, and the subjectivity of experience within the commonly understood and objectively recognized conventions that contemporary health care contexts represent as the temporal and symbolic location for health and illness. (Thorne et al., 2004, p. 4).

This study utilized interpretative description in an attempt to make sense of the narratives of fourteen Canadian nurses. Moving from the raw data to coherent themes is fraught with complexities for the hesitant neophyte attempting to apply this method of analytic induction (Thorne et al., 2004).

This chapter provides an account of the findings from this secondary analysis, reflecting the unique experiences of the nurses as they provided spiritual care within the professional and organizational framework of the Canadian healthcare system. Five themes were identified and will be discussed as they occur in nested relationships within the healthcare context: the nurse as custodian of spiritual care, nursing acts of spiritual care, professional and organizational silence, distinctive environments, and the Canadian milieu.

Theme #1: The Nurse as Custodian of Spiritual Care

The nurse brings their worldview and lived experience to interactions with the patients and the findings suggest a nurse must have an inclination for the sacred for spiritual care to take place. Moreover, the type of spiritual care provided seemed to hinge upon the nurse's understanding of the sacred and how they chose to integrate these values into practice. Three subthemes were identified as: view of the sacred, choice, and bewilderment and ethical tension.

View of the sacred.

The purpose of this study centred on the influences on spirituality and spiritual care, not the hermeneutic distinctions of spirituality and religion in nursing. Therefore, the term sacred is used as a descriptor in acknowledgement of the complexities of labelling heterogeneous spiritualities and/or religious affiliations of the nurse (Taylor, 2012). Within this emerging understanding of the data resides an awe or reverence for something that exists beyond the physical and emotional realm. Thirteen of the fourteen nurses professed a belief in the sacred, with exposure to the sacred often beginning in childhood. The narratives of these nurses affirmed the influence of pluralism and syncretism within the West. While many nurses ascribed to various religious beliefs, eight of the nurses affixed labels to their sacred experiences: five as Christian, two Catholic and one as a Muslim. The remaining nurses had a syncretic belief system. An example of the syncretism found in the transcripts is exemplified in the narrative of a participant who integrated various beliefs from childhood and combined them with life experiences to arrive at an individual understanding of spirituality:

I went to the Catholic school when I grew up. I learned the basic right and wrong there. This is what shaped my personal value. I am now practicing meditation. It is a Buddhist practice where I practice self-awareness (Participant 1).

Other participants chose to personalize organized religion in order to construct a spiritual framework. This is seen in the following statement: “My liberal view; which is mostly Christian...because Christ is the teacher I understand the best but, that is how I view Him is as a teacher” (Participant 4).

Despite differing views of the sacred, the participants demonstrated commonalities when integrating faith perspectives into the practice setting. Common themes that emerged were

personal support, a values framework and guiding life principles. One group of participants spoke to the reassurance their faith perspectives provided in their individual practices: “It gives me a sense of peace to know that it’s not just me, that there is some bigger power out there that is, you know, helping me through my journey in life.” (Participant 11). A few mentioned the support and guidance their beliefs provided. One participant stated:

I always reflect after the end of my shift. I always reflect...on what happened today, what I could have done better and some of these thoughts they are docked in a prayer. I pray to God and I hope, I hope He could lead me to do the right things and when it’s a tough call I pray about it or I pray over the child...It’s just something that I do (Participant 14).

A second group of participants integrated their view of the sacred into practice in the form of personal values. One participant stated:

I really do believe in Karma and I do believe...you will get in life what you get out of it...whether its spirituality or not, but having that positive attitude on the wards and being respectful of every individual...everybody’s beliefs and recognizing that everybody has a different way of doing things at times and just...basic tolerance and respect (Participant 12).

Another participant upheld their values: “I’m not necessarily a religious person, but I do believe in a higher power and being a good person, and be caring and care about people that are in my life.” (Participant 10). This perspective was also echoed by a participant who self-identified as “not spiritual not religious” who said: “when you care for people you try to provide care by respecting the beliefs that they have and the wants that they have...” (Participant 9).

Underpinning these participants’ nursing practice are moral and ethical principles.

A third group, of participants were found to integrate beliefs by virtue of their personhood (Barnum, 2011) as they stated it was impossible to separate their beliefs from their being. This is seen in the following narrative: “That’s my way of life...that’s my spirituality my soul my spirit, it’s within me. And so that’s not something I can separate from me. It’s a part of me.” (Participant 3). Several other participants supported this integrative view and its impact on their professional lives, as reflected by this nurse:

Because it’s part of me and who I am, it’s going to come out in how I practice nursing and it’s going to come specifically in how I manage patients or clients and how I manage myself...I think that is the biggest impact that spirituality has on me is just that I can allow people to be themselves and looking at my own experiences and taking those experiences and what I have learned and trying to incorporate that into what I can teach others (Participant 11).

Through the narratives it became evident that a nurse with a strong commitment and understanding of the sacred was alert to the needs of others. A few participants had an instinctive and insightful ability to identify spiritual issues. An example of this ability is provided in the following statement: “I definitely see it when I’m working like, I can definitely sense the spiritual needs of the patients.” (Participant 5). Other nurses displayed an understanding of the importance of nonverbal indicators when providing care:

Having an open mind as a clinical practitioner is something that is very important in your job. Being able to judge more than verbal communication, more than physical communication, the way people interact with you, develop a nursing plan, related to your specific client at the time, no matter what is going on, if they, no matter their physical, mental, emotional status at the time, if you have to...your assessment skills have to

broaden, keep your ears open, your eyes open and you know pay attention to body language as well as what you hear people say (Participant 6).

These nurses were not only alert and attentive to the potential spiritual needs of their patients, but the nurses' spirituality enhanced their understanding and became an opportunity to demonstrate personal values and beliefs. One participant stated:

Because of my own journey I think that I am a better person, a better nurse and can give people the benefit of the doubt, and learn their own spirituality, how they feel, how it directly affects their care, how it directly affects the people around them and what is going on. My own spirituality I hope shines through with my care with clients (Participant 6).

Another participant acknowledged the importance of the spiritual health of the nurse when caring for the vulnerable:

I think it's very important to...as a nurse be focused on your relationship with God so that, that can shine through to them and I think that's, that's really important... if you ...are dealing with people who are unwell and sick (Participant 5).

Nevertheless, not all participants who described valuing the sacred were apparently alerted to needs of patients and families. This is evident in the following statement:

...I haven't, I guess, had a lot of...specific experiences with spirituality and religion in my nursing. And perhaps that might be because I worked critical care so many years and a lot of people really weren't...all that able to talk to me (Participant 7).

These findings suggest that the nurses' view and value of the sacred will impact engagement in spiritual care.

Choice: To attend or not to attend.

While mandated by the nursing profession, the findings suggested that oftentimes the invisible practice of attending to the patient's spirit is reliant upon the nurse or healthcare provider. A nurse who identified as a Christian acknowledged:

...on the flip side of peacefulness if somebody is really sick, sometimes if they are not peaceful because they, they're angry. `` [They question] if God loves me so much, why is this happening?" ...I see they are angry, angry at family members, at people. Same questions every day, I wonder if they have a way to cope? (Participant 13).

This participant recognized spiritual distress. However, when the interviewer reflected, `` So, it's a decision to engage or not to engage. `` The participant responded, ``It comes down to your wellness.'' This ICU nurse may not attend to spiritual needs due to the emotional and psychological demands that are required with engagement. A nurse in the perioperative setting indicated intentionality in the provision of spiritual care:

I had the opportunity just in the last month to help three people that really...needed it...really...seriously...in a crisis...so just being able to do that was good...I made the time...I was escorting a patient's wife out to the ICU...she was distraught, absolutely distraught and to be able just ...just take a few more minutes to pray with her...well that was great...just to help settle her...It was not going to help settle her too much but just to know that somebody's caring...someone cares about what happens...things like that they really need to be done...I think that's important... (Participant 3).

Most nurses affirmed the need for holistic care and acknowledged the inclusion of the spiritual care in the role of "nurse". Nurses with a strong sense of the sacred integrated this into

practice, freely provided clinical examples of spiritual care noting how they chose to attend to needs, as illustrated in this quote:

Usually you can pick it up quickly...whether that person is upset or worried or let's say crying something...maybe they are not? Maybe they are just petrified...which is when you can...apply your own spirituality...share it...calmness... compassion... (Participant 3).

In addition to this, these nurses were also more likely to discuss spiritual care early in the interviews and required little prompting from the interviewer. This readiness suggests their value of the sacred, personal knowledge, and experience, and underlined their eagerness and willingness to initiate spiritual care. This attitude is seen in the following quote:

Spirituality can be chatting with the patient: getting to know the patient more, the values, what their purpose in life, their faith, which might even be their number one. They might not even believe in those medications, but that faith...is the number one for them. If you tackle that first every other thing will work out smoothly (Participant 8).

Another participant demonstrated how spiritual assessment was a natural component of care:

[It begins] on patients' bed sides, lots of times, we can see what they are reading. You can judge a little bit some they pray before their hospital tray (*Giggles*). I don't know if they are totally worth praying for! So there is just that kind of surface stuff. You can see just what they are reading...but a lot of times, it just comes up in chatting. Especially grandmas and grandpas...they are pretty blunt (Participant 13).

In contrast, nurses who had colloquial views of the sacred had greater difficulty discussing spirituality with the interviewer, providing examples of spiritual care, and often required further prodding to answer interview questions. Hence, it appears that these nurses do not prioritize spiritual care in the same way as they lacked awareness, which was depicted through statements

which referred to patients' autonomy. These nurses appeared to operate under the auspice that the patient must identify their own need and request a spiritual care intervention. There is a hint of trepidation as these nurses appear to relinquish their responsibility to initiate care as they wait for the patient to invite them to attend to the spirit. Irrespective of the differences, all participants stated they would provide some type of spiritual care "if the patient requested". One nurse revealed personal discomfort in discussion of spirituality as they divulged:

I have to admit I probably don't outright think about it unless they'd start discussing it with me or bring it up repeatedly. I'm very careful about the topic. Myself, I don't bring it up unless the patient brings it up to me (Participant 7).

Similarly, another participant suggested that spiritual care was not important or expected from the patients perspective: "If I don't talk about religion/spirituality that is definitely acceptable and expected. Unless it's brought up by the client, then I will talk about it" (Participant 1). With a multiplicity of definitions, values/beliefs and graded value of the sacred, many nurses appeared bewildered as they seek to enact spiritual care from an individualistic perspective.

Bewilderment and ethical tension.

Underlying these narratives is the marked tone of confusion. Nurses could be heard whispering in the interviews, "Am I [doing] ok?" (Participant 8). Others have difficulty interpreting the questions leaving the interviewer to rephrase a number of times. A nurse questioned, "I don't know if, if I am on the right trail here...Am I OK? *Laughter*" (Participant 5). While the profession professes the value of spiritual care, conceptual confusion remains as some nurses are requiring validation if they are in fact describing/providing spiritual care.

This uncertainty was also evident when some nurses provided accounts of meaningful descriptions of spiritual connectedness with patients, outside of their current setting, some even

from decades ago. The importance or value placed on the experiences appeared to be based on shared desire for connectedness between the nurse and patient. This augmented a sharing of rituals and a deep spiritual connection.

Spiritual care created a point of tension for some nurses as they were unsure how to integrate personal values and beliefs into clinical practice. This difficulty was pronounced when nurses wanted to offer hope to patients but were concerned it would be viewed as proselytizing. One participant demonstrated how these ethical tensions are expressed in how nurses enact their spirituality:

It's such a hard thing, because as a Christian, it's very, it can be difficult at times, because someone shares with you, they're struggling with life, real life issues, like deep life spiritual issues, and let's say they feel very hopeless or, like I as a Christian...you can't cross that line of sharing too much of your own personal spirituality. Because...I don't know, like what is going to happen, am I going to be? Like keep those things to yourself, you don't share those things. You know, in some ways I feel like you have to keep things very, just like a broad spirituality. You talk about [it but]; it can't be very, like how I feel (Participant 2).

An unembellished connection is seen in the narrative of another nurse which describes an attempt to divorce personal and professional values and beliefs:

You don't just come in and start discussing your own spirituality or your own beliefs maybe trying to convert the patient to your own...belief. So as a as a caregiver really, you are limited. Because whatever you believe in is for you and when you come to work it's like, like I said before it's the patient that matters...(Participant 8).

In contrast, one participant spoke to the necessity of withdrawing from spiritual care for self-preservation: “I really find I’ve really separated myself...my world view and...the afterlife ...if you take that on, and think about that for every person that dies, it’s...it’s not healthy I don’t think.” (Participant 13). Perhaps the most pronounced ethical tension surrounds the inability to fully enact care and compassion due to contextual constraints. Most participants identified some aspect of the acute work environment as instrumental in their decision to provide spiritual care. This is heard as one participant described the negotiation that is involved in care of the sacred:

It’s difficult doing [meeting spiritual needs/wishes] in some situations. Like, when you know you have to compromise things and the other patient's care. You want them to be well, and you want them to get better, and continue with their life, sometimes it’s difficult...(Participant 10).

Whereas another participant spoke to the pace of the acute work environment: “The hospital is always busy, you know, so we often miss out on that piece [spiritual care]” (Participant 1).

The findings from this first theme suggest that while the nurse attempts to be objective in their role, personal values and beliefs impact practice. Who the nurse is and personal views of the sacred govern how the spiritual needs of patients will be cared for. Nevertheless, the ambiguity surrounding the concept of spirituality created confusion and ethical tension and thus impacted the mode of spiritual care delivery.

Theme #2: Nursing acts of spiritual care: Spiritual Caregiving vs. Spiritual Care

The interviews provided multiple definitions for spiritual care, thus revealing a lack of consensus for best practice. Definitions of spiritual care can be understood as interpretative, relying on personal understanding thus leading to varying degrees of spiritual intervention.

While all participants spoke about spiritual care, the form of care offered was varied. Definitions

occurred within a range: from simple relational acts to supporting religious practices. For example, many participants stated spiritual care began with conversation: “If they’re dealing with issues or just need to talk things through or just need someone to listen to them, I do feel that is part of my job” (Participant 2). At the other end of the spiritual care spectrum, some nurses supported religious practices. For example, a new mother was provided with her placenta for a religious ceremony. Consequently, to make sense of the heterogeneous data, descriptive findings were sorted into two categories: spiritual care as distinct and spiritual caregiving as holistic (Pesut & Sawatsky, 2006). Nurses’ descriptions of spiritual care overlapped in these two categories.

Spiritual caregiving.

Many participants described spiritual care as that which involved the therapeutic use of self. These acts were holistic and were not confined to a particular space or time as demonstrated by the following descriptions of spiritual caregiving by many of the participants which included: understanding, open-mindedness, being present, talking listening, discussing, displaying empathy and sympathy, use of touch, respect, sensitivity, willingness, validation, demonstration of kindness, compassion, reassurance, sharing, calmness, tolerance and being non-judgemental. The narratives of these participants appeared to be relational and required a willingness by the nurse to engage on a “deeper” level; thus depicting the art of nursing (Chinn & Kramer, 2008) and could be described as an “I-Thou” encounter. This relational approach to spiritual caregiving is demonstrated by the following interaction:

I was working in a telemetry unit and she was one of our regular cardiac patients that was in and out, sort of an end stage cardiac failure. She had been having a relatively bad spell and all day she’d been having chest pain on and off... she was basically telling me she

felt that her time was short...And she was frightened. She asked me if I was Catholic and I told her I was. She asked me if I would say the rosary with her, it would make her feel better. And at that point, I felt that it was important to take that time and do that with her. For me it was...I wasn't... celebrating the Catholic religion and saying the rosary with her. I was maybe celebrating her spirituality and, and mine, together, when we said it. I was doing it for her and for myself. It really had nothing to do with being Catholic at that point (Participant 7).

The participant's position, as nurse, provided the opportunity to engage the spirit of the patient, however it required the nurse extend himself/herself to move beyond the prescribed professional role. The individuals described in this encounter, stripped away pretences and expectations to create an authentic, meaningful and symbiotic interaction. In summary, the narratives of this study suggest spiritual caregiving required a commitment to service, to care for another in "thought, word and deed."

Spiritual care.

For others, spiritual care was defined as discrete acts that occurred at a particular moment in time. These discrete acts were facilitating practices and were based on respect as they created space for integration of patient's religious beliefs into nursing care. This category of care could be understood as embodied in the "I-It" relationship. The nurse is providing care *to* or *for* the patient (Koenig, 2009), maintaining professional distance. The actions occurred within two distinct categories: nursing acts that occur within interpersonal nurse/patient relationships and acts that occur within inter-professional relationships.

Nurse/patient relationship.

Nursing acts of spiritual care that occur within the nurse/patient relationship were acts of service which realized the individuality of the patient. One participant described a desire to incorporate patients' beliefs into patient centred care:

If somebody has a certain religion or belief in the way that they want to be cared for, you're going to do whatever is possible to care for them. If it is part of their spirituality [or] religion then you will try to respect and meet their needs in that way (Participant 9).

Another described spiritual care as a desire to grant wishes: "Just being there for them and try to grant them their wishes, I think that will be what every nurse or health care provider can do for the client." This participant also described integration of religiously prescribed dietary habits: "You know people ask for specific food to be delivered to them or a specific food to be eliminated from their diet, like pork and stuff if you have you know a specific religion" (Participant 10).

A number of participants referred to creating space for patient rituals. Space was created for prayers. One participant described actions taken to support a patient:

I remember getting special permission; it's a very small point, but...special permission to open an emergency door several times a day for a young women and, and her husband, who would come to visit her. So, that they could pray facing East... (Participant 7).

Space was also created for spiritual/religious practices that the patient believed to take precedence over physical care:

Some patients after having the baby...we want to initiate breastfeeding and the mom will say no, "can we wait we have to say prayers?" Like some religion they want to say the prayers first to enter the baby's ear before the baby eats anything or they want to put

honey into on the baby's tongue before they feed the baby...That's why like, in my nursing care the spirituality and religion is very important because we know with our practice...we have guidelines...we have our procedure we have to do this at certain times but some people with their religion, and spirituality you know we have to really be flexible in order to accommodate them too (Participant 8).

Finally, one participant viewed spiritual care as an act of encouragement. Patients were encouraged to turn to their spirituality for support:

I wanna know what is it that they believe in...so hopefully I can support them just by them talking about it. I am supporting them [by]...reminding them that that is what they believe in hopefully just by talking about it...so they realize ...“that is one of the things I [they] can hold on to for support” (Participant 14).

Interprofessional relationships.

The second group of spiritual care actions surrounded interprofessional interactions. Participants described collaboration, coordination and referral of patients. In some cases nurses collaborated with family to provide care: “I was just thinking about one area of work that I did with a high Sikh population, and definitely you work together, you know, with their religious, they have certain dietary restrictions, even how they care for their ill...” (Participant 2). Generally, interdisciplinary collaboration did not appear to be the norm. However, one participant spoke to successful interdisciplinary collaboration which resulted in patient centered care:

So, it was about her and the holistic care that would involve her, so eventually from there we went to the doctors because we needed to order a day pass, and then consulted with them. There were the few doctors that were looking after her so they had consulted them

eventually you know, come to the conclusion. Yes, it's eventually her and her decision is more important than us making it for her (Participant 10).

A number of other participants focused on linking patients with representatives from their faith traditions: "The patient] will request a pastor from a different church or whatever church they're from..." (Participant 5).

These findings would suggest that whilst there is diversity in the beliefs and actions of the nurses, there is a common theme of care and compassion across the continuum of nurses' sacred experiences. Spiritual care is heterogeneous. Acts of spiritual care supported the patient in their spiritual journey whereas, spiritual caregiving occurred as part of the interpersonal connection in the nurse patient relationship. It is anticipated that nurses with a strong personal sense of the sacred engage in more spiritual caregiving.

Theme #3: Professional and Organizational Silence

The narratives in this study implied spiritual care was primarily an individual endeavour. Apart from limitations imposed by a professional nursing relationship, the profession or professional organizations were not found to have a large impact on spiritual care. What is more, the healthcare organization or institution was not found to address the implementation of spirituality in practice. Thus, the two subthemes of the nursing profession and the healthcare organization asserted the relevance of spiritual care beyond an interpersonal relationship.

Nursing profession.

Each nurse possessed a strong sense of respect for nurse/patient boundaries. The central theme of the nursing profession that arose from the narratives was the "division" created by these boundaries. In addition to this, the profession generally appeared to silently accept the

biomedical model while ignoring the educational needs of nurses required to perform spiritual care.

Professional boundaries as a barrier to care.

One group of nurses found the boundaries created a barrier to care and an ethical dilemma. This participant outlined the dilemma:

You are not in a position to also show your own religion or spirituality you know. So sometimes you kind of put your own values and spirituality and everything aside and when you come to work you have to face your work and (inhale& smile). It's all about your patient and their religion and what they believe in...(Participant 8).

The above reflection explicates a personal and private struggle as the nurse attempted to find authenticity in their encounters. The nurse's spirituality may be compartmentalized as they perform their professional tasks. The participant continues on:

It [supporting patients' spirituality] affects the patient positively but not positively to the caregiver because...you have to be supportive of that patient even if you like it's against your own values or religion. Yeah, there's conflict...it's sometimes difficult but I kind of take it I take it that like my patient is number one it's all about my patient and I've made up my mind and decided to be in this profession (Participant 8).

All the narratives had an undertone of consideration for the patient's beliefs. Many overtly expressed confusion on how to be sensitive to the patient's needs with the interplay of the personal and professional roles:

I guess it's more like determining the difference between who I am and my spiritual thoughts, and how that relates to being a professional nurse, and where does that all fit

in...you have to be professional, and I want to be sensitive to other people's needs, and I don't want to overstep those professional boundaries (Participant 2).

Finally, some nurses acknowledged the lack of congruency in their personal and professional values and beliefs and chose to segregate these roles. A few participants consciously made this choice as demonstrated in the following statement:

The barrier in that is that a part of my life...I keep...unbelievably private. And yet, I'm in their very intimate life...and it's easier if you can have some self-disclosure, right.

Because I'm asking them about their life, and their family, and their children. And they want the same information from me. Because they're inviting me into a very personal part of their lives (Participant 4).

Hiding behind the profession.

A second group appeared to hide behind the professional boundaries or role, not willing to emerge and engage in spiritual issues but focused on supporting religious observances. A commonality among this second group was their lack of comfort with the sacred, which is observed as hesitancy in the interviews. It is from this vantage point that one participant described spiritual care as a discrete act outside of the normal scope of practice:

I have known nurses that became very involved with their patient's spirituality or religion. I'm not sure exactly which one. Especially if they were of the similar religion, some would have even made a point of trying very hard to get a practitioner of the faith to come in and see them. Kind of went that extra mile. I can't say that I've ever been...quite that proactive, but maybe the situation, hasn't come up either? (Participant 7).

Many narratives indicated professional nursing organizations did not emphasize spiritual care. A number of participants were asked about the national nursing organizations professional

stance on spirituality; most were unaware of any formal position. This lack of awareness denotes a break down in the dissemination of professional knowledge, and is summarized in the statement of one nurse as she exclaimed she had never heard of the descriptive “spiritual”.

Another participant stated:

It’s certainly not a topic (spirituality) that we spend a lot of time discussing. I don’t read about it a lot in our professional magazines. Ah...I don’t know. It’s not a, it’s not certainly like infection control or legislations; changes in nursing. Like it’s just not one of those topics that’s out front (Participant 7).

Biomedical model.

The profession was viewed by the most participants as silent and appeared to have acquiesced to a healthcare system driven by a medical model. One example of this predominance of the biomedical model is visible in the following excerpt:

I think we sometimes put their care into...meeting the basic needs of food and shelter and clothing, and you know, medical needs like that but I think that sometimes it’s not necessarily looked at on a spiritual aspect...as a profession, Yes. I feel that sometimes it’s neglected (Participant 5).

Several other participants spoke to the overriding importance of the physiological needs of patients’ in acute settings. This emphasis is seen in following excerpt: “(Spirituality), it’s not something that is ever at the forefront of conversation. We’re always meeting the basic needs: are you feeling unwell, are you sick, are you nauseated...” (Participant 5). Another participant reminisced how the role of the nurse evolved as the medical model was embraced:

Nursing seems nowadays seems to have become more about the skills and how good the nurse is at performing them... I mean your assessments and the diagnosis and stuff like

that. I think stuff sometimes, like spirituality and taking care of patient's needs, get put off to the side because we are so focussed on finding out what is wrong with the patient. Looking at the symptoms and stuff like that...more the medical things rather than, I don't know the traditional nursing stuff (Participant 9).

Absence of education.

A second prominent professional issue, cited by most participants, was the lack of preparation for nurses demonstrating how to integrate spiritual care into practice. Lack of education at an undergraduate level was seen an impediment as one participant outlined how religious education during training expanded worldviews:

I think it starts with the nursing schools and making sure that it's [spiritual/religious care training] in there. Like when I took my training religion was a huge part of the person's existence and their being...on their hierarchy of their needs...so that before you even get to the workplace, they have some understanding and knowledge and acceptance and realization of how important this is (Participant 12).

The demise of spiritual/religious education in nursing practice environments was also brought to the forefront. Many of the nurses in this study described a lack of education and support when dealing with spiritual issues. This is seen in the following participant's excerpt: "Even in acute settings, it's not talked about. I mean there is a quiet room for religion or spiritual purpose, but no really other support such as training for nurses to deal with these issues" (Participant 1). The educational deficit identified by most participants was coupled with a desire for spiritual/religious education to equip nurses to care for those with different worldviews. Nurses in this study expressed a desire for increased awareness and understanding of the patient needs within the multicultural and pluralistic context:

I think there's also being aware of other sorts of religious practices as well. You know like cultural and spiritual practices that aren't necessarily what I would practice or what I believe. Like even just being aware of those sometimes makes it a challenge, being uneducated for sure makes it a challenge to meet those needs when you are not even aware (Participant 5).

The healthcare institution.

One participant described the Canadian healthcare system as being respectful and patient-centred thus providing a context for integration of spirituality:

Our health care system is built on respect for patients and their health. The health care basically is- it goes around the patients, she/he is at the center of the care, he/he is the one directing the care, and eventually respect for their wishes is the ultimate you know, ultimate thing. So maybe there are people with different opinions in health care to, but in the end the Canadian health care system revolves around the patient, not around the health care provider (Participant 10).

This archetype was not found at an institutional level. Many are disillusioned with how spirituality has been dismissed:

I guess that's (spirituality) often ignored. I mean I felt that in the organization, in theory they say they integrate religion or spirituality, but they do not in practice...the policy or business goal has said that we value diversity, but I guess it is not emphasized in term of religion/spirituality. I know racial diversity is definitely more of a priority in the organization (Participant 1).

The dichotomy between health care and the organizational model was emphasized. One participant stated:

This [spirituality] is called the fluff...we'll get to it, but the basic stuff needs to get done first...and in a climate right now where health care used to be a service...health care used to be a service and now it's a business, and when you're in business it becomes dollars and cents...(Participant 12).

In another narrative, the ambivalence of the institution was visible:

I think the administration of our hospital, we definitely have some things in place...we have the pastors and we have the contacts for the different churches...if the patients should choose to use them. So, I think it's good that way. I mean I haven't had a lot of encounter as far as conflict with that, either good or bad but, there is some stuff in place (Participant 5).

Nevertheless, a few institutions described were seen to be evolving and appreciating the role of the sacred in patient care:

I can see...the support is improving and people are being like open. And even the management that is open...no matter your background that everybody needs to get the support they really need, no matter their religion or their spirituality (Participant 8).

Communities of care.

One participant's description of their workplace stood in stark contrast to the others, providing an example of an organization which could be described as a community. Resources were used to create space for providing spiritual care. This was reflected in the hospital's mission statement:

... [hospital] mission statement...I was very happy to see it this year...updated. It is wonderful to feel that when you walk into a place they are not afraid to say the word Jesus and His influence on people and to be able to go into the OR and see the statement

that this person [the patient] has every [human] right. That this person is autonomous...this is how you respect this person...it's just lovely. It's wonderful. That's what makes this hospital very special. It is very rare that I hear anything bad about this hospital because people see it as...not so much as a haven but, as a family (Participant 3).

It is noteworthy, that two other participants described a feeling of kindness in their hospitals. They did not provide their mission statements but, described them as "Catholic" institutions. These environments had a warmth and compassion that that could be felt across these institutions. This feeling was in contrast to previous places where these participants had been employed as demonstrated in this participant's statement:

This hospital that I work for currently is a Catholic hospital although, the last remnants of that are fading. There are no longer any nuns in the building...But, I truly (emphasized) find that there's a general feeling in the building, and with the people that work here, that I've never really felt elsewhere, and I've worked at 3 other hospitals. And, I'm not sure that lasting sense of people have their moments and they grumble and they do whatever, in general, I just feel, a sort of a warmness here, that I, I can't say that I felt other work places and, a willingness to help people. Just a general kindness and our patients certainly kind of amplify this. I don't know how many of the patients up in recovery especially, tell me oh, I just, I never want to have surgery at CITY. I want to come here. People are nicer; they're happier; they're friendlier. They, they just make me feel good (Participant 7).

The findings from this study suggest there is a lack of support from the professional and organizational level for nurses to fulfil the mandate for spiritual care. It appears nurses have a desire to be educated in the provision of spiritual care. Additionally, an organizational model

that supports spiritual values is necessary and as the institutional mandate appeared to impact the nurses themselves and the environment in which nursing care is provided.

Theme #4: Distinctive environments

Along with professional and organizational contexts, a further theme of environment at the meso level is central to the provision of spiritual care: the context can enhance or inhibit engagement between the nurse and patient. Unravelling the concept of environment produced three subthemes: nature of nurses' work, team collaboration and the physical environment.

Nature of nurses' work.

According to the participants' narratives, the practice area and workload impacted the delivery of spiritual care. Barriers to care were more visible in acute setting as nurses struggled to meet the demands of their roles.

Area of practice: appropriate specialties.

Even though spiritual care is implemented by the practitioner, some participants found the sacred more applicable in specific practice settings. Notably, spiritual interventions were seen to be contingent upon the population being cared for. For example, elderly populations facing end of life were identified as conducive to care of the sacred:

When you're caring for someone who is elderly and frail and death is imminent then it, it's something that you are forced to look at whereas with the younger population that's in with you know, broken leg or whatever it's not something that's, we are not forced to look at it (Participant 5).

Additionally, a patient's level of acuity was seen to impact the type of spiritual care provided: "The hospital is very accommodating when it comes to life and death. But you don't get that special environment when you are not critically ill" (Participant 1).

Furthermore, many nurses reflected on past experiences in palliative care or postulated the palliative environment would foster spirituality. This influence is seen in the following participant statement:

When I worked in a hospital, on a palliative care unit, there were definitely more opportunities to talk with people on deeper levels about spirituality because they're facing end of life issues...I mean, in palliative care, spiritual matters were more...looked after I guess, there were social workers that were very caring and meeting the families spirituality with their emotional needs (Participant 2).

In summary, the participants evaluated workplace settings to determine the fit of spiritual care. Participants identified specialty areas where spiritual issues would be paramount and should be addressed: perioperative care, intensive care, geriatrics, palliative care and mental health.

Workload.

For many participants, the organizational infrastructure created barriers to spiritual care as nurses were challenged to balance care of the body, mind and spirit. It appeared that acute settings produced the greatest challenges. Participants in acute settings were more likely to cite institutional or workplace barriers to spiritual care than their counterparts in community practices. Most participants in the acute care cited barriers to spiritual care; namely that nurses' heavy workload, limited time and interaction with patients prevented the establishment of the trusting relationship necessary for spiritual conversations. This is depicted in the following statement: "Spiritual care requires added time with you patient, as I think that most of us have not perfected being able to do that while...we provide pericare" (Participant 6). The perceived role disparity between nurses and other professions was seen as one participant lamented: "... in a busy acute care as a nurse it is very hard to spend a lot of time (pause) unless you are a social

worker or play therapist” (Participant 14). The pace of work environment and length of hospital stay were also seen to sway amount and type of spiritual care. A nurse in labour and delivery addressed the issue:

There is that problem [short hospital stay] because they come in you don't have much time to them and also, we nurses most of the time we come in with our pre-planned actions, procedures, protocols, we just come in and impose it on the patient because this is the protocol, this is the procedure, forgetting that all our patients are unique and they have their, their needs are quite diversified and unique that we should treat them as individuals we forget that we are all most of the time busy to carry (sat up straight, wide smile) out our preconceived or pre-planned agendas, you know? (Participant 8).

The reduced length of time in hospital placed emphasis on nursing tasks. Procedures and protocols were seen to dictate care and thus may overrule person centred care. The participant continued on:

Most times I can see we come in, like we think we (smile) we (chuckle) we know it all and...whenever we see a patient 'this is it, this is what the patient needs' and then we tackle it not going in really to find out what...yeah, like spiritual needs, religious needs that will influence how they will perceive the care they receive. Yeah, so lack of enough time with the patient I think it's also influences that way (Participant 8).

In contrast to the acute setting, only one of the six community nurses identified workload as a barrier to spiritual care: “It is definitely difficult, because the organization is always on the budget and short staffed. There is always limited time, and it is very hard to have one to one connection with the clients” (Participant 1). This exception may be explained by: the public health setting, the population served and the type of care the nurse provided. It appears

establishing rapport and relationships in public health are not valued by healthcare organizations and may be due to the population focus of this speciality area.

The remaining five community nurses were less likely to identify time as a barrier to care. These nurses were employed in in midwifery, corrections, long term care or home care. A mental health nurse employed in corrections addresses the benefit of time with patients:

I have an opportunity to sit and talk with people for a long period of time, so I can you know set up an interview say once or twice a week and I can sit with them for say an hour and we can explore certain things...and... see where that goes and just by talking and making connections, you know we talk a lot in nursing about therapeutic relationships and I think that I have the benefit of developing that and would more easily be able to explore someone's spirituality. I am fortunate here as opposed to someone who is doing bedside nursing who would perhaps only have a few minutes with patients and spends time focusing on very specific tasks, where I can explore whatever the patient wants to explore. So I have the opportunity for I guess...to display empathy and sympathy and have teaching moments working here is a good opportunity to discuss spirituality (Participant 11).

Spiritual care appears to evolve within the context of the relationship between nurse and patient. A community nurse found opportunity for spiritual care as relationships developed with clients:

When you are in long term care, you're getting, you come to asses a family, and long term care is more of a longer term relationship, like you don't, like you ask those, you do that, and a lot of times people tell you, you know, I'm Sikh, I'm a vegetarian, or, and

that's all you get for now, but as you get to know the families you get to know more of their spiritual needs (Participant 2).

A pediatric home health nurse confirmed the personal and professional benefits of establishing a relationship:

Because I am able to, I have more time to reflect, more time to speak with the clients, help them to open up and encourage them to hmmm I guess look to their faith, look to their values that is important to them and support them in whatever they are dealing with and in the sense that I am able to do that, I find it very, very rewarding (Participant 14).

Additional advantages of addressing spirituality in a community environment were found to be: privacy, patient was at ease in their own home, and adequate time to establish a relationship with the patient and family.

Overall, it became evident that nurses who perceived spiritual care as a discrete act were more likely to identify the workplace as prohibitive of spiritual care. The inability to provide "acts of spiritual care" seemed to leave nurses frustrated. One emergency room nurse confessed:

[Not meeting requests] it makes me feel like I didn't do a good job. Like, you couldn't provide for the patient what you wanted to or what they wanted from you, you know?

You make a mental note of it and make sure you remember the previous experiences and try to work hard to meet the next person's requests (Participant 9).

Nurses who viewed the sacred from a holistic and integrated lens looked past environmental constraints. These nurses who defined themselves by their beliefs and identified spiritual caregiving as integral to their being, found some way to integrate spirituality in acute practice settings. Spiritual caregiving was an expression of their spirituality which included providing compassionate care. This tie is heard in the narrative of a perioperative nurse:

I think that for a lot of nurses...there is a lot of compassion...there is a lot of wanting to help...it just comes out. And people see that and especially nurses...especially when they have a few minutes of their time...to talk and share things and patients just pick it up ...because they are in need. I just think it is part and parcel of being a nurse...how you are brought up and your own spirituality (Participant 3).

A medical/surgical nurse described how she was alert to the spiritual needs of a dying patient and made the time to connect with him:

We had this patient who was dying and...I knew he was a Christian. And I'd just...I had such a burden for him and for his wife and for his family. And I just remember going into the room and I asked him, "Can I pray for you?" He said: "Absolutely!" So we prayed with him and his wife... (Participant 5).

Practice settings were seen to impact discrete acts of spiritual care but had less influence over nurses who engaged in spiritual caregiving.

Team collaboration.

In general, nurses in practice settings that they perceived to have limited resources were cautious about approaching the sacred. They were less likely to discuss spirituality from a personal or professional perspective in the workplace. One participant articulated the lack of visibility of spiritual care in the workplace:

I, I don't actually feel that spirituality and religion come up that often, in our practice. I don't recall the last time that we ever talked about it with anyone at work. Um, so, no I don't generally feel that their [colleagues], their feelings or their ideas really, affect me that greatly (Participant 7).

Yet, another participant noted the lack of availability of resources in the acute setting:

“...Whereas in the hospital I don’t even remember who the chaplains were...” (Participant 11).

While the interdisciplinary healthcare team may not discuss the sacred and resources were not readily available, some nurses found encouragement from colleagues with similar views of the sacred. In some cases, participants interacted with colleagues socially:

A couple of friends that I work with, it’s like we are friends outside of work. So we do vent to each other quite a bit...especially, since [when] we know the patient is Christian as well...We definitely vent to each other...Bounce things off each other...Otherwise I would have to be in a different unit (Participant 13).

In other cases, participants highlighted the influence of collegiality in the workplace:

I think (environment) it has a huge influence...I think because we as humans are very, we’re very impacted by how our peers view us and...I think sometimes that...that can definitely be a struggle...I think as nurses...I think it [colleagues] can be a support and [colleagues] it can also be negative. It really, it really just depends on the staff (Participant 5).

A distinction was seen in settings where members of the healthcare team were committed to supporting sacred values, beliefs, and practices. Nurses described resources for the patient and staff as they provided spiritual care: chaplains, social workers and other nurses. A participant outlined resources available in a community setting:

I would think generally the workplace does you know, work towards meeting peoples religious and spiritual needs...I don’t think it is where it should be totally, but I definitely think they work towards that, or working to meet people’s needs that way...there’s definitely the social workers and the nurses around you who have expertise and like, you

could always ask, you know, how to handle this matter and be sensitive to their spiritual needs, so in that way it definitely felt, I definitely feel supported...I've worked with other nurses, even just my managers with situation. We have team meetings, and if you have situations that are more complicated and if religion or spirituality is part of that. And we have had patients that um it affects their care; they refuse care or refuse parts of care that have been prescribed for them. So, that can be very difficult, right? (Participant 2).

Likewise, a nurse in a correction setting verified the significant assistance from chaplains:

"...we also have a large chaplaincy program and we have really great facilitators of that program so that is an added resources that we have" (Participant 11).

Furthermore, a nurse on an orthopaedic unit described a team relationship between the nursing staff, the patient care coordinator and physicians who were committed to the provision of patient centred care and supporting religious practices (Participant 10). An exemplary collaborative environment was illustrated in a setting that encouraged multidisciplinary discussion and a unified goal of care:

At coffee it all comes out (conversations about spiritual care with colleagues)... we are one of the few hospitals that actually have doctors and nurses in the same place...they prefer it that way...it's quite interesting....sometimes it's...turn that sports channel off (we laugh). I think there are quite a few in the OR that care about what happens...it's good...it's good (Participant 3).

Physical environment.

In the Canadian sociocultural context, spirituality/religion is a private matter. However, in healthcare, spiritual issues may arise in the public realm as individuals deal with their physical frailty. First, the narratives highlighted that a lack of privacy within the institutional setting may

prevent nurses from assessing and patients from discussing spiritual concerns. A perioperative nurse demonstrated the need for intimacy: “When you are in the patient holding and there is an opportunity to...you just draw the drapes or something and speak to them quietly and reassure them...makes a huge difference” (Participant 3). Similarly, a nurse spoke of an experience on a telemetry which depicted the graded levels of privacy related to time of day:

And so we pulled the curtain and I just sat beside her and held her hand and...it was later in the evening, privacy wasn't such an issue, certainly during the day, privacy is quite an issue, I think...In a busy, noisy hospital environment, there's always somebody popping in. You know, to see people, even behind a curtain (Participant 7).

A distinction was seen in the community setting; issues of privacy were not found in the narratives of community nurses. On the contrary, the physical setting was seen to add to the rapport necessary for spiritual discussions. A narrative from a community nurse expressed this:

I think that in the community setting it's bit easier you are in the home and so they are very open you are in their home so they are very open to healing whichever way they want and you know one of the of the ways of healing for lot of them in my experience is praying (Participant 14).

Second, the physical environment determined the posture the nurse would take during the provision of care. Regardless of specialty area, many nurses made reference to “sitting” with the patient when entering into discussions of the sacred. The posture of ‘sitting’ appeared to be foundational to intimacy; symbolizing the presence and humanity of the care provider. One example of this is imparted in the following statement: “It's very important to like meet those aspects of a person as well like just to sit with them to let them know and to know that you're listening...” (Participant 5). A second instance emphasized sitting at length for a connection

between the nurse/patient to be established: “I have an opportunity to sit and talk with people for a long period of time...and I can sit with them for say an hour and we can explore certain things...” (Participant 11). Reference was also made to how chaplains “would come and sit at the bedside of the patient” (Participant 12). Frustration was heard as nurses in many acute settings are often unable to display presence by sitting at the bedside: “Some days because of the heavy patient load, there is not possible way to even sit and ask them about their family let alone spirituality” (Participant 6).

The findings from this theme suggest nurse find spiritual care applicable in specific settings and populations; predominately end of life or those with high acuity. The busyness of the acute setting was seen to detract from spiritual care opportunities. However, nurses who had a strong integrative view of the sacred incorporated spiritual care into the workplace despite the environmental constraints. Workplace culture was seen to impact awareness and frequency of acts of spiritual care; workplaces that were favourable enhanced nurses’ spirituality and their delivery of spiritual care. Finally, the physical environment restricts privacy and the development of an interpersonal relationship which is foundational for spiritual care.

Theme #5: Canadian Milieu

The narratives of the participants in this study reflect the unique values embraced by the broader Canadian sociopolitical context. Canada is evolving from its European roots and is synthesizing a new sociopolitical stance based on tolerance, multiculturalism and pluralism (Beyer, 2008; Fowler, 2012). It is estimated 85 percent of the Canadian population ascribe to some belief in the sacred (Bibby, 2011); this context provides a unique perspective to pluralism in healthcare, multiculturalism and the irreligious state.

Pluralism in healthcare.

Western society's movement away from organized religion is reflected in the narratives of these nurses as just one discussed their "religious" beliefs but all emphasized their spirituality. Even beliefs that were historically defined as religious were reinterpreted in the current context. This is evident in the following statement: "I don't consider myself religious; because I believe that I am Christian...It's just a way of life..." (Participant 3).

The nurses in this study had an awareness of the diversity that existed within spiritual/religious beliefs. This is exemplified when a nurse stated:

It is a hard time also to provide spirituality to individuals because it is individual. It is not cookie cutter care. Everyone has their own type of spirituality and you may not be able to access or even understand it. There is such a vastness of spirituality that sometimes we do not understand all the different types or even know about it... (Participant 6).

These nurses approached the sacred with prudence and reverence while endorsing the postmodern idea of spirituality. This is seen in the following narrative:

I do try to explore spirituality with the people that I work with but it's on a very generic basis...looking at just having someone explore their feelings...if we are talking about loneliness or if were talking about feeling powerless, knowing that there could be a bigger spirit there could be helpful. I think it is important to use the spirit or high power as opposed to using God or Jesus or something like that but definitely I would at least explore it with them. If they feel like they would like to journey onto that then I would definitely assist them but I don't push it on anybody (Participant 11).

Nurses' narratives demonstrated their endeavor to be nonjudgmental: "We are not here to judge them. We are here to care for them." (Participant 11). Care was also extended to colleagues through the extension of respect:

Well, if you work with someone, for example, and they don't believe in Halloween or they are Jehovah's Witness, you try to respect that. Well, when the holidays come up, for example, you always put that at the back of your mind. You know, their beliefs so they don't feel bad about it and by doing this I hope I am protecting their beliefs... (Participant 9).

Yet, an undertone of "the other" was reflected in some of the narratives. The Western ideal of health care with standardized, evidence based care does not easily embrace diversity. One participant underscored this:

There is much culture and diversity and beliefs too. So I have seen other nurses saying oh my god, what is she thinking? Doesn't she- or what the mother is thinking? Or what the family member is thinking? Don't they know that, for example, this is not good for her? She's not supposed to do that, or you know other re-steps she has to take to do this and that. Of course there are people that you know do oppose and do voice the opposition against them, but at the same time there are people that embrace it, and they say "no its about them not us and what we believe" (Participant 10).

Discord was outlined in the narratives of nurses who appeared monotheistic and did not support postmodern concepts of multiple realities. An Islamic participant spoke to intolerance within society:

...the fact of the matter is that we do live in a society that generally shies away from things that are generally different from the norm. I think however that somebody's

religion and spirituality are somebody's own beliefs and are not to be condemned to any of it...Islam is a religion that is in the media that does not exactly have a stellar reputation. We are a media driven society (Participant 6).

A Christian nurse spoke to intolerance amongst employees in the workplace:

I think it [spiritual care], it can be sometime frowned upon as if you're...pushing your views on somebody that...or unlike other employees and staff. I don't know that it's always widely accepted because there is so many views on spirituality and religion...it is very difficult to say I gonna believe this even though other people don't (Participant 5).

In contrast, one participant specified that intolerance may also come from patients. One example of this explicated the disregard of the syncretistic views of the nurse:

[She] she said "Oh, that sounds very Christian, but I know that you're not Christian"... And I thought...I let it go, but it was very surprising to me that she would say that I'm not Christian but I'm not Christian, by her standards (Participant 4).

Sanctioning multiculturalism.

Canada is a built upon multicultural values and respect of cultural diversity (Kelly, 2011).

The nurses in this study recognized the diversity within their communities and were found to enmesh cultural diversity with spiritual/religious diversity. This is exhibited in the following quotation:

Canada being a very multicultural nation, I think...nurses that are perhaps in bigger centres nurses of the future are gonna to run into spirituality and religion in a different form than I've ever run into it [in a smaller homogenous centre]. With people that they're maybe not as familiar with and they're gonna have to, face it in a different way because they don't maybe understand... (Participant 7).

Nurses faced concerns regarding cultural and spiritual diversity as they are not always aware how to provide “meaningful care”:

I think the fact that there is so many different religious and spiritual backgrounds makes it really hard to...share with them spiritually I feel somewhat divided by doctrine and not knowing kind of where they're from or how their or what their spiritual background...makes it difficult (Participant 5).

The participants' experiences mirrored the complexities of diversity within a multicultural society. Participants voiced examples of spiritual/religious/cultural difference that occurred in the work environment. One such example was:

In that region of the world [Southeast Asia] there's Hinduism and there's Sikhs and so I have had to actually separate two staff...two health care workers 'cause one practices their Sikh religion and one (who) was (of) the Hindu (faith) practices their Hindu religion and they didn't tolerate each other at all...the Sikh person didn't feel the Hindu person should be allowed to work there...That makes stress amongst everybody (Participant 12).

Whereas, cultural differences were not problematic amongst colleagues in another setting:

Another one of our doctors is Muslim and he's actually very, very good about it, like, he brings in Christmas gifts and things for all the nurses because he knows we celebrate Christmas even though he doesn't...He's never judgmental but...but if we ask him questions, he's perfectly fine to answer (Participant 13).

Ultimately, the nurses in this study seemed to look beyond spiritual/religious differences and focused on “caring no matter what” (Participant 6). One example depicts how the worldview of the participant spoke to universal support and acceptance:

In my practice of nursing, that translate to me being...able to view the world or, and the people that I treat as...without judgement. Because it means that I basically believe that all people are good and have good intentions and...not that we're perfect...and whatever way you become a good person is the right way or the right path for you. And I feel no pressure to change you. I feel no pressure to judge you. I feel only pressure to help you get there, to be the best person that you can, which is the servant leadership...

(Participant 4).

Even those who rejected the pluralistic paradigm revealed a universal dedication to spiritual care:

Considering that we are in a very multicultural area we have that opportunity all the time...so it would depend on exactly what kind of support the person needed. Christian or not, I still give them the same care...I still offer them a hand, still comfort them, I would still them give compassion...as far as their own religious beliefs...I do not know how I could help them...but maybe next time someone there could. It doesn't matter...you still...the hand that needs holding...still gets held (Participant 3).

Irreligious state.

Canadian healthcare is state run, funding is predominantly provided by secular provincial and federal governments (Wesley, 2011). The voices of the nurses in this study exemplified the challenges of integrating spiritual care in publically funded institutions. Nurses in this study were heard "trying" to provide spiritual care within the constraints of a secular organization. This reflects the division of church and state and postmodern values of Canadian society. One group of participants appeared to address spiritual care with a cautionary note:

The barrier, it's just societal kinda taboos, to talk about, to really talk about religion, just like politics...in the workplace...especially among co-workers. Even...Un-unless it's

like someone you know, that you really know and if you are a friend who share the same beliefs but just...usually it leads to nowhere good (Participant 13).

The “polite” and tolerant cultural of Canadians was outlined in another excerpt:

So sometimes some of this time...that you...and effort that should be spent on spirituality and these types of things...it doesn't happen because it's...it's...too airy-fairy, it becomes fluffy...people don't know how to handle it...they don't want to offend anybody...they don't...it's just easier to push it under the carpet (Participant 12).

A second group of participants' expressed discomfort when crossing the public to private barrier in an attempt to engage patients: “How do you ask them about it... Hi. You just met me but, can you tell me about your spirituality?” (Participant 6). Finally, the disparity between the national value of freedom of religion and secular institution was heard. One participant identified a barrier to spiritual care as the “public sector”: “I don't know maybe, maybe just not feeling that there is that always that freedom to share spirituality in like the hospital, like the public sector, do you know what I mean?” (Participant 5). However, later in the interview the same nurse summarized the social values of Canadians:

...Canadians we're free to practice what we believe you now I don't think there is anything stopping us. Which I suppose is a benefit like there is nothing. We are in a free country where we are not banned from, you know praying with our patients, or you know addressing spiritual issues, so that's definitely a benefit like. (Participant 5).

This sentiment was an undertone for many narratives in which nurses described their value of the sacred and the struggled to incorporate into the healthcare setting.

Findings from this theme suggest pluralistic values are found within the healthcare system. The dynamic multicultural balance of society is mirrored within the healthcare

organization. The social boundaries of a secular state influenced spiritual care delivery. While intolerance exists within society, the participants acknowledged cultural diversity, yet maintained a desire to extend themselves across differences.

Chapter Summary

The findings from this study present a constructive view of the interdependence of the personhood of the nurse and the environment in the provision of spiritual care. The nurses' impetus for the provision of spiritual care determined if acts of care are seen as discrete or holistic, when and how spiritual care was provided. Professional and organizational environments can inspire or impede this care of the sacred. As a result, spiritual care was found to be contingent upon the institutions climate of care. The Canadian milieu is laced throughout the narratives as tolerance, acceptance and pluralism. Though the environment was found to be instrumental in influencing the delivery of spiritual care, all the factors appear to merge the level of the individual nurse who is the custodian of spiritual care: it is the nurse who will choose to extend themselves to care for the spirit of another.

Chapter Five: Discussions of Findings

Introduction

The findings of this secondary analysis demonstrated the application of spiritual care in nursing practice is as varied as definitions of spirituality itself. The purpose of this study was to gain insight into the spiritual care perspectives of a group of Canadian nurses. The findings of the previous chapter add to research which demonstrated spiritual care is dependent on intrinsic and extrinsic factors (McSherry, 2006). Although the intrinsic ability of the nurse is pivotal in the provision of spiritual care, extrinsic and contextual factors were found to inhibit or encourage the nursing act of spiritual care. The interrelationships between the themes of nurse, acts of spiritual care, the profession, as well as organization and societal influences will be discussed in the following sections.

The Nurse

The nurse is instrumental in the delivery of spiritual care. The personal spiritual values of the nurse and how these are translated to practice impacted how the professional boundaries are interpreted and authenticity of relationships. Situated within the Canadian postmodern society, it is important to recognize that all but one of the study participants valued the sacred. Why is this mentionable? Studies have revealed that to provide spiritual care one must first have a personal understanding of the sacred (Cavendish et al., 2004; Chan, 2009; Koenig, 2009; Sinclair, Raffin Bouchal, Chochinov, Hagen, & McClement, 2012). As individual views of spirituality are impacted by religious heritage, culture, generation and nationality (Gall, Malette, & Guirguis-Younger's, 2011), each nurse brought a unique perspective of spirituality and spiritual care to the study. This is consistent with previous research findings highlighting the plethora of definitions of spirituality: "no single perspective on religion [spirituality] dominates

postmodern culture, but rather multiple perspectives exist simultaneously” (Hood et al. cited in Zinnbauer et al. 1997; see also Fowler, 2012; Koenig, 2009).

Holism brings the conviction that body, mind and spirit are a cohesive unit and they cannot be separated (Taylor, 2007): in this way the values and beliefs of the nurse are impalpably present as the nurse performs her role. Therefore, definitions of spirituality and delivery of spiritual care are contingent upon who the nurse is and their impetus for nursing: it is based on the nurse’s unique identity (Sinclair et al., 2012).

How do nurses integrate their spirituality identity in the workplace? Pesut and Thorne (2007) suggest the nurse brings three rival identities to the workplace: the professional identity with the public’s trust, the identity as citizen within a pluralistic paradigm and personal identity of values and beliefs. Does the personal or professional identity dominate as nurses enter the workplace? How does the nurse identify themselves? As a Buddhist nurse or a nurse who is a Buddhist? Am I a Christian nurse or a nurse who is a Christian? While it may seem like a play on semantics, this self-identification offers a tentative explanation into how nurses are integrating and prioritizing spiritual care.

One group of nurses in this current study, found their identity in the sacred, integrating it seamlessly into their nursing role. McGuire (2008) utilized the term “embodied” to describe this of experience. This embodied dimension of the sacred has been found to cross social boundaries despite the separation of the church and state:

Improvisations and adaptations are integral to making space for God in everyday life. When religious people enter a situation or setting that in some way precludes religion, they leverage the features of their environment that are under their control to adjust the way space for God is constructed (Williams, 2010, p. 277).

Nurses that made space for the sacred personally and professionally, could be described first by their personal identity (inclusive of spiritual identity) and second, by their professional identity: a Christian nurse or an Islamic nurse.

The second group of nurses in this study was comprised of those who had difficulty discussing their spirituality and spiritual care. These participants would likely describe themselves by their professional roles and then, by their personal values and beliefs. An illustration of this would be, a nurse who is Catholic. These nurses may emphasize discrete acts of spiritual care as their faith is set apart from the professional identity. Such compartmentalization is in keeping with Fowler and Reimer-Kirkham (2012) who state: “Persons with less developed spiritual lives tend to compartmentalize their faith to a greater degree (p. 46).”

While the participants acknowledged the value of spiritual care, some found themselves in ethical dilemmas struggling to determine how to enact their own spirituality and provide spiritual care to patients. The distance between the nurses’ personal and professional identities brought some degree of inauthenticity to the relationship: there was identity conflict (Pesut & Thorne, 2007). Taylor and Fowler (2012) explained “The religious dimension of their [the nurse’s] personhood cannot be extracted and placed in the nurse’s locker while she or he works (p. 354).” Simington (2004) spoke to the importance of authenticity in spiritual care from an ethical approach:

...all nurses are taught therapeutic use of self. All are educated in the skill of listening and responding with empathy. When we do so we touch the soul of another. When we do not, we tighten the bounds that hold their agonized souls in captivity. We have an ethical responsibility to do the former (p. 479).

The findings from the current study concur as they suggest authenticity may be based on moral and ethical transparency in interpersonal and professional identities. This finding adds to research by Sinclair (2012) who described the importance of presence in care of the sacred as an expression of self, and not something that could be “brought in and left in a room like a technical competency”: it was seen as vulnerability (personal and professional), being fully present and the essence of being (Sinclair et al., 2012). Rankin and DeLashmutt (2006), (p. 284) summarized presence as:

The essence of presence is a healing relationship. It involves an interaction wherein a reciprocal experience relates to the whole of the person, goes beyond the technical, and attends to the complexity of the person’s needs (Chase, 2001; Doona et al., 1999; Duis-Nittsche, 2002; Smith, 2001). Presence facilitates the healing potential of the nurse-patient relationship and brings about a sense that the care provider is in communion with the recipient of care (Duis-Nittsche, 2002; Godkin, 2001; McKivergin, 2005; Rankin & DeLashmutt, 2005).

By being fully present, a nurse creates space for an intimate, healing relationship with patients based on a respect for humanity. The experience of having a nurse who is connected and present has the potential to significantly impact the lives of individuals.

With vague protocols in place, the nurses in this study approached spiritual issues with confusion and caution. This uncertainty supports others’ findings which call for a practical definition of spirituality and spiritual care to be integrated into practice so as to provide nurses with clear direction in the engagement of patient care (Barnum, 2011; Clarke, 2009). The connection between body/mind/spirit and health has been upheld by many nurses (Carr, 2008) including the small group of Canadian nurses in this study. The narratives demonstrated that

these nurses generally esteem the spiritual, support the ideology of holism in health and may require nothing more than to be united in purpose.

Acts of Spiritual Care: Spiritual Caregiving vs. Spiritual Care

This second theme, the act of spiritual care, is congruent with other findings which agreed the difficulty in differentiating spiritual care from psychosocial care or “good nursing care” (Carr, 2008; Clarke, 2009). As a nurse enacts spiritual care, Milner-Williams (2006) identified that “nurses can provide spiritual nursing care and can provide nursing care spiritually” (p. 818). This is consistent with findings from this study that identified spiritual care to occur from a discrete or holistic perspective.

Discrete acts of spiritual care involve a specific type of intervention. Interventions occurred at an interpersonal level, for example, making space for the patient’s rituals. Interventions were also observed at an interprofessional or multidisciplinary level, for example the nurse advocating for patient centered care, or the inclusion of spiritual requests. These supplemental nursing acts fostered patient spirituality yet, would require additional time and skill by the nurse (Milner-Williams, 2006).

Nurses who ascribed to spiritual caregiving from a holistic perspective could be said to embrace the definition of spiritual care by Sawatzky & Pesut (2005): “Spiritual nursing care is an intuitive, interpersonal, altruistic, and integrative expression that rests on the nurse’s awareness of the transcendent dimension yet reflects the patient’s reality” (p. 30). Spiritual care was threaded throughout their nursing practice, regardless of circumstances or opportunity: it is relational as it involves the art of nursing (Chinn & Kramer, 2008). This category describes acts which involve the therapeutic use of self, centering on presence and the following nursing acts of spiritual caregiving. This type of spiritual care is built on the caring and compassionate impetus

of the nurse and the communication of these values in the manner the nurse provides care (Milner-Williams, 2006). The advantage of this embracing this perspective is “the manner in which one provides care does not require any extra time on the nurse’s part, which is of great benefit to the over-tasked nurse” (Milner-Williams, 2006, p. 818).

This philosophy of spiritual care is supported by a recent Canadian study (Sinclair et al., 2012) of palliative care professionals who described spiritual care “as a philosophy of care that informs and is embedded within physical and psychosocial care” (p.319). Spiritual care was found to occur through physical presence, touch, speech, sight and hearing. This study found spiritual well-being of patients was impacted by simple “bedside skills” when performed by a care provider whose value of the sacred was expressed as compassion. In addition, the findings suggested spiritual care through this framework could occur with or without the intent of the care provider and superseded the professionals’ humanistic, religious or spiritual philosophies.

The concept of “embedded” acts of spiritual care (Sinclair et al., 2012) is in keeping with a study of Irish hospice nurses (Bailey, Moran & Graham, 2009): “The nurses actively used (‘weaved’) the knowledge and skill of embracing spiritual care through their self-awareness, empathy and commitment to embracing holistic nursing care in end-of-life care” (p. 48). This research endorsed findings by Carr (2008), who explored perspectives of spiritual nursing care. It was concluded that spiritual care occurred by developing a caring relationship and fostering connections in addition to receptivity (being there), humanity (humanity meeting humanity), competency (holistic care), and exchanging positive healing energy. The findings from this current study were similar to those of Sinclair et al. (2012) and Carr (2008) but expanded these individualistic interpretations; demonstrating spiritual caregiving is also highly contextualized and socially constructed.

A recent study by Dhamani, Paul and Olsen (2011) delineated the importance of context in determining the mode of spiritual care delivery. Additionally, categories of spiritual care and themes, similar to those in the current report, were also identified in an analysis of Tanzanian nurses' spiritual care narratives. Spiritual care was described through "religious" and "non-religious" interventions. Religious based interventions were facilitating, conducting prayers and reading Holy Scriptures. Non-religious based interventions were grounded in moral and ethical behavior as nurses' demonstrated love, compassion, encouraged forgiveness, counselling and reassuring. When comparing the findings across cultures, these findings are analogous to the themes of the current study: spiritual care was based on an ethic of compassion and facilitating spiritual practices.

Drawing on this current study and the findings from Dhamani et al. (2011), it can be suggested that differentiation in the levels of nurse/patient engagement appear to be related to type of nursing interactions. The two types of nursing acts, discrete or holistic spiritual care coincide with the two types of relational interactions described by Buber, an existential philosopher: "I-It" and "I-Thou". A simplistic view of these relationships is as follows: "I-It" relationship is goal oriented; there is a lack of reciprocity where each maintains individual identity. "I-Thou" relationship is reciprocal, mutual, entails presence and focus on the whole: an encounter. These relationships are not thought to be mutually exclusive but are both necessary to our interaction with the environment (Properezi, 2011). Pesut and Thorne (2007) expand on the understanding of Buber's work:

This 'It' world represents the cumulative experiences that form the substance of our identities as professionals, citizens and persons. The 'I-You' world is a world of relation

characterized by immediacy and reciprocity. It is an encounter unmediated except through grace and it is ‘spoken’ with our whole being (p. 401).

Buber’s paradigm is useful to nurses as they are called to move back and forth between the two relationships in practice. The ‘I-It’ relationships are one sided and require care of a vulnerable person. However, within this context of intimate interaction, the care provider may step out of their professional role and address their vulnerability and the patient with a common humanity: “I-Thou” (Pesut & Thorne, 2007; Sinclair et al., 2012). The findings of this study support this philosophic model as nurses utilized an array of techniques to provide spiritual care. Distinct acts of spiritual care model the “I-It” relationship as the nurse is providing a service to the patient. Whereas spiritual caregiving is manifest in an “I-Thou” relationship; based on the nurses value of humanity and interpersonal care. Spiritual caregiving is encircled in solidarity and may allow the nurse to enter into an “I-Thou” relationship with patients. The importance of the individual encounter between the nurse and patient cannot be underestimated. However, this encounter must not be viewed apart from its meso (professional and organizational) and macro (societal) context.

Professional Organization

This study demonstrated that nurses are struggling to implement personal and professional elements of spirituality in many healthcare settings. Distinctive professional barriers to spiritual care cited in the literature include: the elusive definitions of spirituality, lack of education and competence and role ambiguity (Barnum, 2011; Carr, 2008; McSherry, 2006; Narayanasmy, 2006; Puchalski & Ferrell, 2010). Nurses may also be cautious about including the “‘non-scientific’ realm into a science-based nursing practice” (Simington, 2004, p. 472). The themes from this study are congruent with this earlier research.

A comprehensive view of the complexity surrounding the integration of spiritual care begins with the difficulty in defining the concept of “spiritual care” for the healthcare setting. While the nursing profession borrows knowledge from other disciplines (Rogers, 2005), it has been hesitant to assimilate definitions and methods from these disciplines into nursing practice. Set in the western materialistic paradigm, nursing has returned to thoughtfully examine the soul as it searches for ‘meaning and purpose’ (Pesut, 2012b, p. 4). Yet, the profession has been unable to agree on a consensual definition after 20 years of exploration (Carr, 2008). This leads to a critical question: are we “defining our profession or defining spirituality?” (Clarke, 2009).

Many researchers are touting the advantage of a pragmatic definition which uses religious language because the sacred undeniably impacts health (Fowler, 2012; Taylor, 2012). Other nursing scholars are calling for the return of values based ethical approach to nursing care (Doane, 2004; Storch, 2004). Despite Canada’s multicultural and pluralistic landscape, it has been noted by Fowler and Reimer-Kirkham (2012) that most faith traditions “often converge at the point of ethics” (p. 37) calling attention to the enduring relationship between morals/values and religion.

This study’s participants supported holistic care, which included spirituality, yet these values appeared to be “muffled in the noise” of the healthcare system. The overwhelming presence of the biomedical model could not be ignored as nurses described the barriers to spiritual care. The nurses spoke about a lack of education to address spiritual issues and that this may be attributed to the change in the model of care that occurred with professionalization: the patient was no longer seen to be comprised of body/mind/spirit but rather the profession accepted the biosychosocial view of the medical model (Carr, 2010). This changed the focus of nursing to the scientific, pushing the art of nursing aside (Simington, 2004). Medicine has been

described as having “traded mystery for mastery” (Remen, 2010, p. xiv) and to some extent the nursing profession has traded some “mystery” with its integration into the medical model. The lack of emphasis on the spirit within the nursing profession is evident in the findings: while many participants had personal knowledge of spirituality, they lacked awareness of spirituality within a professional context. This gap may be related to the limited dissemination of professional knowledge. Many of the nurses in this study did not appear to benefit from the Canadian Nurses Association (CNA) position statement on spiritual care even though it is easily accessible on the website. Possible explanations for this could be: the biopsychosocial model of care in a secular workplace, a lack of advertisement by the profession, a lack of interest by the nurse coupled with a position statement does not easily translate into practice. Ultimately, the profession champions spiritual care but few resources have been committed to upholding this value.

In addition to providing a vague definition of spiritual care, the profession has not answered the question, “To what end are nurses to provide spiritual care?” In the culture of evidence based practice, discussion of spiritual care outcomes were lacking in this study. This begs the question: what is the ultimate purpose of spiritual care? Pesut and Sawatzky (2006) argued against a prescriptive approach to spirituality in healthcare, citing the creation of ethical dilemmas. Barnum (2011) highlighted the incongruence between spirituality and the biomedical focus of healthcare: setting goals and measuring outcomes in the current context of logical positivism threatens the very nature of spiritual care: “the essence of spirituality...is vulnerable to being lost in the domain of objective concreteness” (Barnum, 2011, p.135). However, in the age of evidence based practice operating within a business model of care, how can nurses look toward a spiritual care goal? Can the profession monitor competency and quality of care without

a specified outcome? Shall it be left to the individual nurse? Taylor (2012) explored the goal of spiritual/religious conversations and concluded: “If the goal for nurse-patient discourse about religion is not to assess, then it is to support the patient in exploring how their religiosity and well-being intersect (p. 15).” This finding is compatible with Smeets et al. (2011) discussion of chaplaincy care outcomes which included: the immediate goal of conversation and the ultimate goal of health. Eventually, the profession must determine what nurses seek to accomplish with the provision of spiritual care.

Furthermore, the overwhelming presence of professional boundaries was identified as influencing spiritual care in this analysis. These participants were intimately aware of the responsibility that accompanied their position: the boundaries were required to protect the rights of the nurse and the patient (Puchalski & Ferrell, 2010; Smeets et al. 2011). Participants appeared to value boundaries/patient autonomy as they acknowledged the power relations within the nurse/patient interaction. However, from the narratives a theme of division emerged: the profession as barrier to spiritual care and hiding behind the profession in confusion.

Clarke (2009) speaks to the profession as barrier and critiques the profession’s unfounded concerns over spiritual care:

[it] has been fuelled by unconscious irrational anxieties about proselytization; anxieties that nurses will not be able to distinguish religion from spirituality; anxieties about nursing being associated with theology and anxieties about having shared knowledge. These anxieties have fuelled the drive toward existential and inclusive definitions of spirituality. Now it may be that it is this very model which is preventing the inclusion of spirituality in nursing (p. 1672).

Barnum (2011), in contrast, calls nurses to step out from the mask; abandon the instinct of self-preservation in order to engage with patients in a meaningful way. Puchalski and Ferrell (2010) also express concern about putting up ``walls`` for self-protection which creates a non-therapeutic outcome. This non-therapeutic outcome impacts patients' care.

Chinn and Kramer (2008) acknowledged, "All knowing is expressed in action, in ways of being and doing that convey powerful symbolic representatives of what is known" (p. 16). Are nurses and the profession demonstrating their valuing of the sacred? While nursing scholars have contributed to the multitude of research on spirituality, the findings from this study suggest that the nursing profession has not placed a high value on the sacred in the clinical setting. This lack of valuing was demonstrated by the limited resources that were committed to educating nurses on spiritual care. Due to the complexity of integrating spiritual care into practice, many plausible explanations exist for the disparity. Perhaps nursing is lost behind its professional mask. Perhaps in attempt to embrace individuality, self-expression the result has become "a preoccupation with self" (McSherry, 2006). Perhaps the value of humanity, compassion, care, concern and respect for others are no longer the foundation on which the profession stands. Perhaps we have embraced the materialistic culture and not voiced our dismay at the medicalization of nursing care. Perhaps relativistic philosophy has been allowed to pervade society and the profession and has moved us away from adherence to our own standards and value of holistic care.

A solution to the nursing professions implementation of spiritual care in practice may lie in defining spirituality from an ethical perspective (Fowler et al., 2012). This is by no means a panacea but may provide an opportunity for nurses to interpret a caring nursing practice as an expression of their spirituality through spiritual caregiving, removing the ethical tension while

providing spiritual care to patients. If the profession were to view spiritual care from a holistic and integrative perspective, one quickly arrives at the conclusion that value based care must be reinstated. Chinn and Kramer (2008) describe the importance of the ethical perspective: “Ethical knowing [as that which] guides and directs how nurses conduct their practice, what they select as important, where their loyalties are placed, and what priorities demand advocacy” (p. 6). Storch (2004) described nursing ethics as occurring in relationship, involving “moral commitments of nurses to those they serve” (p.3). Ethical nursing also involves moral agency, sensitivity and courage; creating a moral climate resulting in a moral community (Storch, 2004). Spiritual care from the holistic perspective is integrated into every action; it is lived. Doane (2004) proclaimed, “we need to move beyond the habit of thinking ethics is something we *follow* to seeing it as something we *are*” (p.443). Koenig (2007) describes spiritual care as that which permeates compassionate and competent care: “Almost everything a nurse does with, to, or for the patient can be carried out in a spiritual manner; however, some of what the nurse does must have an explicit spiritual component” (p. 146). From this perspective spiritual care could be imparted across the diverse settings of the healthcare spectrum.

The findings of this theme focused on the professional role and appropriate boundaries in the provision of spiritual care while providing individual perspectives on how to enact care in practice. The focus on boundaries leaves one not with a view of what spiritual care is but rather, what it is not: intrusive, disrespectful or proselytizing.

The Health Care Organization

The paradox of spiritual care is only fully known when examined in light of its organizational context. The healthcare organization is fraught with complexities as it handles economics, the empirics and humanities. Though spiritual care is mandated by the CNA, there is

limited consideration to how is “spiritual care” to be provided in a “secular healthcare context?” A bureaucracy regulates the science of healthcare but, is not able to provide protocols and procedures for the care of the soul (Smeets et al., 2011). Professional autonomy is necessary as spiritual care occurs as a relational interaction between two unique beings, therefore it cannot be controlled by bureaucracy (Smeets et al., 2011). Yet, the interplay between bureaucracy and autonomy may create dissonance for a nurse who values spiritual care and yet struggles to implement it in the workplace (Simington, 2004).

The perplexity surrounding spirituality and spiritual care created ethical issues as the nurses in this study appeared unsupported in their provision of spiritual care. Participants spoke briefly to the multidisciplinary role of spiritual care; however, most nurses in this study did not describe an intimate connection with chaplains and social workers. One explanation for this may be that whilst searching for professionalism, nurses have added to the competitive nature of healthcare at the expense of collaboration in an effort to define scope of practice (Clarke, 2009; Fowler, 2012). Another explanation for this may be the reduction of spiritual care services, namely chaplains, in the healthcare systems as the business and empirical models of healthcare prevail (Reimer-Kirkham et al., 2011). Barnum (2011) recognizes that nurses may be the only resource available for spiritual care as was evident in the narratives of some nurses in this study. Yet again, we are reminded that patient care is an interdisciplinary endeavor: “each discipline contributes a special perspective on human experience, which when taken together can lead to a general understanding of the healing process” (Ward cited in Bratton, n.d., slide 56).

Most organizations in this study did not appear to prioritize or value spiritual care in practice. This may be in part due to corporatism, efficiency and health care bureaucracy (Carr, 2010). If spiritual assessment and care was encouraged by the nurses’ institutions, it was mostly

completed in a superficial manner: customs, rituals and dietary restrictions. However, a brilliant description of a “community” of spiritual care was provided by one participant. The institution’s value of spirituality was explicit in its mission statement and resources were committed to enacting this in the environment. One physician advocated for the integration of spirituality into a specific setting, and the institution responded by creating a physical space for reflection on the floor, and a space which encouraged multidisciplinary relationships and discussions. This resulted in a close knit community who were valued, respected and united in a common goal: to care. The setting described in the narrative aligns with some of the attributes necessary to construct a “culture of spiritual care”: a mission statement inclusive of spiritual care, promotion of respect and love in all levels of relationship, leaders who are accountable for creating a culture of spiritual care, provision of space for reflection and marking of resources for spiritual care (Taylor, 2006). Reimer-Kirkham, Pesut, Sawatzky, Cochrane and Redmond (2012) research “revealed that leadership at every level of the organization played an integral role in creating the climate where tending to the sacred was valued” (p. 5).

This concept of a community or climate of spiritual care is gaining importance beyond the borders of healthcare. Many secular organizations have recognized the importance of the authenticity and the sacred in public arenas:

It is hard for many of us to separate our work from the rest of our being. We spend too much of our time at work or in work-related social and leisure activities for us to expect to continue trying to compartmentalize our lives into separate work, family, religious and social domains. As one result, the pressure many of us feel to recognize and respond to the sacred in us must find an outlet in the secular workplace. If personal or social transformation is to take place, it will most likely take place at work. For, after all, life is

about spirit and we humans carry only one spirit that must manifest itself in both life and livelihood (Fairholm cited in Bygrave & MacMillian, 2008, p. 98).

A variety of methods have been developed to facilitate spirituality in the workplace which is beyond the scope of this thesis. It should be acknowledged, however, that these methods focus on the individual, group, organization or leadership to integrate spirituality into practice (Pawar, 2009).

Workplace spirituality has a variety of definitions some of which were discussed in a previous section. The workplace has become introspective; some organizations are forming humanistic cultures which value “body, mind and soul of employees” which is accomplished by development of an organizational framework with spiritual values, a humane focus and long term sustainability (Bygrave & McMillian, 2008). This creates an environment where the employee is able to find “meaning, community, and transcendence” (Pawar, 2009, p. 375), and increases job satisfaction while moderating job overload (Altaf & Awan, 2011). It is worth returning to the definition and benefits of workplace spirituality described by Altaf & Awan (2011):

Workplace spirituality is the spiritual wellbeing of an individual in working conditions.

This can include different factors which influence the satisfaction of an individual toward his or her life or job. If these factors are limited, then they may result in dissatisfaction of the individual due to the workplace and the organization at large and, in some cases, dissatisfaction due to life itself. Workplace spirituality means that employees are satisfied with all categories of spiritual well-being as set by Hungelmann (1985). This means that they find fulfillment of both the vertical and horizontal dimensions of the spirituality. The most interesting thing is that providing a spiritual environment and following the work place spirituality activities can result into not only a satisfied

employee but also results in high productivity, morale, and increasing competition (p. 94).

Altaf and Awan (2011) identified the benefit of workplace spirituality to the employees' spiritual wellbeing and then to the organization. These benefits were realized in the findings of this study as one participant described a community of care which was invested in the health of the care provider and the patient. This investment appeared to contribute to job satisfaction, morale and commitment to the organization. A few other participants spoke to their positive workplace culture emphasizing the benefits of working in a faith based (Catholic) environment.

Looking beyond the borders of healthcare, two prominent businesses have adopted organizational models of spirituality and owe their successful engagement of employees to the integration of the sacred in the workplace. The first company is the American company, Southwest Airlines which was seen to have a "strong sense of spiritual-based values guiding its organizational goals and practices" (Milliman et. al., in Saks, 2011, p. 333). After watching its achievement the Canadian airline, WestJet was patterned after it. The success of these companies can be attributed in part to "the importance of spirituality at both organizations in the form of transcendence, community, and spiritual values and the high levels of employee engagement over time (i.e. maintenance) and across tasks, roles, and situations (i.e. generalization)" (Saks, 2011, p. 335). Saks (2011) isolated five vital similarities between Southwest and WestJet:

- (1) employees believe they are part of a larger purpose and cause that involves providing high-quality service to customers at low costs;
- (2) employees are part of a community and have a strong connection with each other, the organization, and customers;
- (3) they are based on and driven by spiritual values that shape the organization's culture;
- (4) employees exhibit high levels of engagement;
- and (5) both organizations have

consistently been included on lists of the best companies to work for and have exhibited high levels of profitability and performance (p. 335).

A common complaint about Canadian healthcare organizations is the use of the business model. WestJet, however, is an example of how a corporation can integrate spirituality and spiritual values in the pluralistic Canadian context and flourish. This begs the question; could healthcare meet its economic and humanistic goals if a similar model was adapted?

These spiritual organizational models tout committed, effective leadership with humanistic values as the key to success in the workplace (Saks, 2011). Nursing scholars have also demonstrated that leadership is fundamental when integrating the sacred into healthcare (Reimer-Kirkham et al., 2004; Reimer-Kirkham et al., 2012; Storch, 2004). Morrison (2009) stated that many healthcare providers work within a “spiritless organization” and noted: “most people who are served by healthcare organizations do not want their care to be provided in a robotic, spirit-bereft manner. They seek providers who are compassionate, understanding and empathetically centered on their needs (p. 330)”. Wilford (cited in Morrison, 2009) highlighted that “Organizations with spiritual leadership behave different from leaders in other organization. They employ leadership strategies and practices that create cultures based on moral/ethical values” (p. 330-331).

The impact of spiritual leadership at an organizational level was evident in findings of this study as some nurses spoke to caring and compassionate workplaces. This denoted the expression of spirituality through universal values and practices with spiritual roots (Lambert, 2009). Findings also demonstrated that workplaces may be “spiritually bereft” and lack the leadership necessary to incorporate spiritual or ethical values.

The brief look that the sacred in the business arena has demonstrated positive benefits to the employee and organization. One can assume the benefits would be translatable to healthcare organizations. If healthcare organizations implemented a spiritual model in the workplace it could give nurses the freedom to be authentic, provide an opportunity for exemplary nursing care, allow nurses to see their work as meaningful/valuable as they positively impacted the stories of their patients and impact morale. Creating culture which recognized the vulnerability of nurses and value the contributions of its members may enable nurses to manage the competing demand in their lives as they care for their own body, minds and spirits. Koren et al. (2009) speaks to the humanity of the care provider: “In turn, if the spiritual well-being of nurses is intact, they will be able to provide higher quality patient [spiritual] care” (p. 124).

Discrete Environments

Much of the previous research on spirituality has been conducted in a limited number of settings: palliative, maternal-child, oncology, and psychiatry. There is a gap in the research which compares influences on spiritual care across specialty areas and settings. While researchers acknowledge spiritual care is often context specific (Koenig, 2007), there is little discussion on how to integrate spiritual care across the healthcare continuum. Findings in this small study suggest nurses categorized settings according to their suitability for spiritual care: spiritual care was seen as most applicable in environments with high morbidity and mortality. The multiple settings in this study highlight spiritual care takes many forms. Smeets et al. (2011) likewise acknowledge this contextual influence, recognizing the varied nature of chaplaincy work and specialization within the field.

Overall, this study demonstrated a marked difference in the acute and community workplace cultures. Even though acute settings varied, the barriers to spiritual care in acute

settings identified by participants were: lack of time, workload, limited interaction and pace of the work environment. These factors are remarkably similar to those found to inhibit good nursing care (Purdy et al., 2010) which may suggest the two may be one in the same or at least share overlapping ground. Good nursing care is a result of what is “known and valued” (Chinn & Kramer, 2008). Swinton and Pattison (2010) suggested competing priorities in nursing care may drown out “good care” and spiritual care in a system which mandates care priorities. This observation is in keeping with the findings of this study whereby those who defined integration of the sacred as a “discrete” act were more likely to cite these extrinsic barriers to care. Nurses who defined themselves by their beliefs saw nursing acts as spiritual caregiving which supports the concept of embodied spirituality (McGuire, 2008); a form that was less constrained by extrinsic barriers such as workload and perceived lack of time.

Reflection on the environment in which spiritual care is delivered returns the focus to the healthcare organization. Though research on healthcare organizations influence on spiritual care is limited, Carr (2010) explained how nursing environments have been impacted by the Canadian healthcare system (p. 1380):

Restructuring [of the Canadian healthcare system] was founded on the bureaucratic ethic of efficiency, which is at odds with notions of spiritual and holistic nursing care. This is because efficiency succeeds in compressing nurses’ time to the point where tasks, not the person, become the focus. In today’s ‘efficient’ system, nurses rarely have enough time to do their assigned work comfortably in the fashion they were taught. Instead, they must rush through everything from medication administration to bereavement care (Canadian Health Services Research Foundation, 2006; Carr, 2003; Torgerson, 2007). Such time

constraints can prevent nurses from focusing beyond tasks and attending to the spiritual needs of their patients (Burkhart & Hogan, 2008).

In summary, Carr (2010) identified organizational constraints on spiritual care: “lived space that was uncaring, lived time that was “too tight”, lived body experienced as an object for technical intervention and lived other experienced from a distance” (p. 1388).

Can the Canadian health care model make space and time for spiritual care? A recent report noted an innovative model that is transforming practice. Several health regions in Saskatchewan and Manitoba are attempting to address some of these barriers by piloting a healthcare model, Releasing Time to Care (RTC). This model is based on a manufacturing model from the automotive giant Toyota. The model was created to mimic the:

‘lean’ manufacturing process that Toyota developed to improve productivity by eliminating all tasks workers do that are not directly related to related to the building of vehicles. The NHS institute [National Health Services] applied this thinking to the work that takes place in health-care wards; to reduce activities that take time away from patient care...more time for patient care means greater nurse and patient satisfaction. (Fortier, 2012, p. 24).

This model adhered to the health care organizations goal of efficiency yet, creates space for the nurse to establish rapport and a therapeutic relationship, to sit with patients, to demonstrate presence and care for the spirit. Providing an ethical foundation for nurses with unit specific training could enhance confidence and all nursing care across the spectrum.

The definition of spiritual care plays a central role in how nurses determine suitability of spiritual care across the healthcare spectrum. Perceived barriers to spiritual care were interpreted based on the distinct meaning attached to spirituality and spiritual care. Nurses with a discrete

view of spiritual care were more likely to cite environmental barriers. However, barriers to the provision of spiritual care were consistent across the acute care setting and contrasted those in the community setting. The findings draw also attention to the premise that a positive workplace culture will become more important in the days ahead as the profession seeks to engage and retain three generations of nurses (Lavoie-Tremblay et al., 2010).

Canadian Milieu

Canada is often identified by its unique social values. The value of secularism, multiculturalism and tolerance define our nation (Sossin, 2009). The task of reconciling the role of spirituality in the public sphere is an ongoing debate (Sossin, 2009):

One can surmise that Canada is less clear about how to think about religious diversity, let alone how to structure it in public discourse and public policy. Religion, one might suspect, hovers somewhere between being a problem, a regular and important aspect of Canadian reality, and an irrelevance (Beyer, 2008, p. 20).

This statement provides context for the findings of this study: nurses, the profession and society are all contending with the role of spirituality in the public sphere. The discussion of findings of this theme include: the feminine vs. feminist perspective, pluralism and multiculturalism and post-secularism.

Feminine vs. feminist perspective.

Obstacles to spiritual care identified by participants centered on individual or organizational deficiencies. One must question if nurses have truly embraced the feminist ethic:

Feminism attempts to point out that personal problems and situations, such as the working conditions and scope of practice of nurses, have a political component; treating problems only on a personal level, as if they were the problems of the individual rather

than the context, allows the political dynamic to persist. Thus, what is immediately personal also must be regarded as political (Chinn, 1989, p. 73); change needs to address the context and the political situation and not be limited to the individual (Rogers, 2005, p. 169).

Embracing a feminist ethic would expand the understanding of the sacred and draw attention to the societal context in which nurses' practice. The influence of the sociopolitical environment must not be ignored as nurses seek to practice within a society that is pluralistic, multicultural and values socialized medicine.

Pluralism and multiculturalism.

Sossin (2009) described Canada as a country of contradictions: a secular society that embraces pluralism. In addition, it is "based on mutual recognition and the promotion of multiculturalism" (Sossin, 2009, p. 504). The theme of pluralism in healthcare was identified in the narratives of the nurses: in their own syncretism and in patient care. Nevertheless, while the narratives spoke to respect and tolerance of the other it is not known if pluralism was embraced. This reflects the cautious approach toward pluralism is echoed in Canadian society as a whole as outlined by Reimer (2008): it remains to be seen if Canadians can be moved beyond their "peaceful coexistence...tolerant avoidance, or a "live and let live" approach to diversity" and welcome pluralism in its entirety" (p. 123).

The findings of this study modeled the obstacles of multiculturalism in greater society. Embracing multiculturalism is an individualistic endeavor and must be attended to within the confines of specific contexts and interpersonal relationships. Ultimately, nurses' narratives in this study were covered in care and a desire to help all patients. Nurses accepted the mysteries of

the spirit and value its impact on health. The voices were tolerant and accepting of difference but, acknowledged ignorance of others views.

Post-secularism.

The limitations of modernization and secularization are being realized (McSherry, 2006). This coupled with the fact that the majority of Canadians have some value of the sacred (Bibby, 2011) would appear to support post-secularism. The post-secular philosophy hypothesizes a reflexive and meaningful return of religion to society. Post-secularism can be understood as an attempt to blur the lines that separate public and private, reintroducing religion back into all domains of society (Calhoun, 2011). However, the findings in this study did not support this ideal.

Participants in this study reinforced the societal taboo that surrounds spirituality/religion. The western paradigm that draws a clear distinction between public and private (Kelly, 2011) was emphasized; most nurses in this study appeared to make a strong “distinction between the sacred and the secular and between physical and spiritual realities” (Simington, 2004). This does align with the philosophy that the sacred has returned to the public sphere (Calhoun, 2011) but, the findings do suggest that nurses are willing to enter into discussions. The cry of nurses is to give them the knowledge to enact spiritual care and this is summarized by one participant's simple statement, “why don't we talk about it?” However, Dillon (2010) identified the challenge of true acceptance within the post-secular paradigm:

Independent of whether an individual is religious or not, tolerance of otherness does not come easily. Most of us are too embroiled in our own everyday reality and the immediacy of its “here and now” demands (Schutz 1970:69) to be able to fully recognize our reality as one of many possible realities. Most of us realize we do indeed have to

coexist with others and, depending on the particular everyday context of our lives, some or many of those others are not like us, whether the sources of otherness are religion, race, social class, sexuality, or some intersecting mix of these and the other differences permeating everyday experiences. But this coexistence, in any case, mostly requires our passive acceptance of pluralism rather than a reflexive engagement toward our own particular reality—to see it as one among many possible standpoints and thus one from which we can simultaneously disengage in order to appreciate the other—those who do not believe or live as we do (p.149).

This highlights the passive acceptance of pluralism and a disinterest in engaging in a reflective dialogue. It is not known how these participants address post-secularism. Nevertheless, this movement toward a post-secular paradigm suggest opportunities will be created for discussion of the role of the sacred in public arenas.

Canadian culture shares values of its American and European allies, it is both materialist and humanistic; which creates a space for spirituality in the workplace (Bygrave & McMillian, 2008). The findings in this study underlie the social values that pervade Canadian culture: value of the sacred, tolerance, pluralism which would support a spiritual organizational framework in our public healthcare system.

Chapter Summary

The esoteric task of integrating spirituality into the public sphere must be shared by the state, the organization, the profession, and the individual. Therefore, the perplexities faced by the individual nurse in the provision of spiritual care must be placed within the context of a society which lives with ambiguity. It is unlikely that society will entirely or quickly reconcile the place of the sacred in the public sphere. Therefore, the nursing profession must ascertain

how to meet the mandate for holistic care within these social margins. While nurses must cultivate the intrinsic qualities for spiritual care, they require a supportive workplace with effective leadership that is based on spiritual values in order to provide authentic spiritual care.

Chapter Six: Conclusions and Implications

Introduction

Once laden with promise, modernization and secularization have not remedied the societal ills of our time. Individuals have begun to seek answers outside of the confines of traditional religion developing a personalized spirituality. As Canadian society returns their attention to spirituality, nursing acts of spiritual caregiving gain importance. It is within this dynamic milieu that the conclusions and implications of this study must be examined.

Conclusions

Appreciating the multifactorial nature of spiritual care, the purpose of this study was to explore the influences on spirituality and spiritual care in nursing practice. This qualitative secondary analysis explored the narratives of fourteen nurses from a variety of practice settings in Canada. Eight nurses' perspectives were obtained from acute settings: intensive care, orthopedics, emergency, geriatric emergency, labor and delivery/postpartum, medical surgical and perioperative. These perspectives were compared and contrasted with narratives from six community settings: public health, home care, midwifery, corrections (mental health), geriatrics, and pediatric home care. The participants in this study self-identified their spiritual beliefs: five as Christians, two Catholic, one Muslim, five as spiritual but not religious, and one not spiritual or religious. From an interpretative descriptive framework, five nested themes were identified as influencing spiritual care in healthcare contexts: the nurse as custodian of spiritual care, nursing acts of spiritual care, professional and organizational silence, distinctive environments, and the Canadian milieu. In summary, who the nurse was impacted the type of spiritual care provided: discrete acts of spiritual care or holistic spiritual caregiving. Nurses with strong view of the sacred were more likely to provide spiritual care that was integrated throughout nursing practice

and were less likely to cite environmental barriers to care. Contrasts were seen in the acute and community environments, with workplace culture cited as a barrier to spiritual care in the acute setting. Ultimately, spiritual care was influenced by Canadian social values of tolerance, pluralism and multiculturalism.

Limitations of this Study

Qualitative researchers must be cognizant of the parameters of their investigations. The themes from this analysis must be examined within the limitations of this inquiry. Demographic information was unavailable to the researcher and thus prevented the assessment of findings in the context of age, gender, race and socioeconomic position. Canada has distinct cultural differences and each province has unique healthcare infrastructure which could not be accounted for, as regional data was not accessible. The sample was not representative and thus biases may exist as no attempt was made to ensure the sample population reflected the spiritual perspectives of the Canadian population. The themes may also be impacted by complete reliance on the narrative and symbolic interactionism; which infers the nurses in this study reflected, made meaning of their experiences and communicated this effectively (Flick, 2008). In addition to this, the interviews were conducted by multiple novice researchers with interview guides with common themes. As secondary analysis occurs from a distance, it is impacted by the researcher's ability to captivate the meaning of the narratives and as well as exercise the "intellectual inquiry" necessary for interpretative description (Thorne et al., 2004). The Judeo-Christian and Anglo-Saxon bias of the researcher and the first and second reader must be emphasized. Finally, the findings would be enriched if the themes were explored through the lens of emergent spirituality and holistic nursing literature, in order to bring more coherence to our nursing discourse.

Implications

The “tentative truths” this study has established, provide insight into the chaos faced by nurses as they attempt to provide spiritual care in practice. Findings from this study imply that nurses require support from the practice environment, the profession and the organization in order to provide holistic care. Implications from these findings can be made for nursing practice, nursing education, nursing leadership and health policy.

Implications for nursing practice.

Nurses are “mandated” to provide spiritual care and this in itself is often overwhelming. Grounding the sacred in the greater organizational, institutional and societal context may give individual nurses permission to accept the conflict that exists in practice environments. This study suggests that nurses in practice provide spiritual care relationally (spiritual caregiving) and by discrete acts (spiritual care). As the profession seeks to clarify how spiritual care is utilized, the greatest implication for practice is to institute an understanding of spiritual care as holistic and relational expressed through exemplary nursing care. Exemplary nursing care, inclusive of spiritual care, begins with a nurse who communicates the value of the patient through their actions. The demonstration of ones beliefs through actions is in keeping with a Judeo Christian perspective explicated by St. Francis of Assisi, “Preach the Gospel [or your beliefs] at all times and *when necessary* use words” (emphasis added). Viewed from this perspective of “living one’s beliefs,” nurses can express personal value of the sacred and appreciate the needs of a patient in *any* and *all* healthcare setting.

Implications for nursing education.

While it is important to educate nurses on the principles of spiritual care it should be noted that most have an impetus for caring service (Koenig 2007; Pesut, 2012b), and by

providing good nursing care they are caring for the sacred. As spiritual care centers on the nurse, opportunities should be provided throughout the educational process for reflexivity coupled with moral/ethical development and values clarification to enhance spiritual care abilities.

Approaching spirituality from a values based approach would create commonality among nursing students (Fowler & Reimer-Kirkham, 2012) and could easily be modeled and implemented from a variety of pedagogical approaches. Moreover, it would seem that nurses in settings which routinely attend to the sacred (i.e. palliative) should be provided site specific training and ongoing opportunities for spiritual care within the context of professional development.

A radical pedagogical approach that could be implemented would be to provide the student the opportunity to be immersed in the role of patient in an acute setting. Perhaps if the student was isolated and barely clothed in a hospital gown, the vulnerability of the spirit that accompanies illness would truly be known. Examples of spiritual caregiving could be juxtaposed with acts of care that were demeaning. Negative role modelling may have a memorable impact on the student and cause them to continually question, “do my actions create pain and distress, or do my actions assist in moving myself and others in a direction of healing and wholeness?” (Simington, 2004, p. 479).

Implications for nursing leadership.

The nursing profession is attempting to reconcile the difference in values that exist between its caregiving profession and the biomedical and corporate model of healthcare. The position statement put forth by the CNA demonstrated the commitment of the profession to holistic care. However, this study suggested few resources have been pledged to ensure this mandate is realized in clinical practice. A commitment to spiritual caregiving can only begin

with a leadership that values the spiritual dimension of patients and nurses alike. As others have suggested, nursing must cultivate spiritual leadership to develop moral communities of care.

The implications for this study support others which appeal for a leadership to develop consensual, perhaps even multidisciplinary, definition of spirituality and spiritual care. The definition must be pragmatic and account for all the constraints within the current Canadian health care climate for example, short hospital stays and limited time with patients. This thesis supports the scholars who petition for spiritual care to be defined from an ethical and holistic perspective. This interpretation would remove the ambiguity engulfing this dimension of health and outline to what end nurses are to provide care across the healthcare spectrum.

As nursing leaders explore the role of spirituality in clinical practice, discourse must invite a multidisciplinary approach that realizes the opportunity for continuity of care for patients: physically, emotionally and spirituality. In addition, attention must be paid to the context of care and how to account for the differences in the bureaucratic and professional mandates; how can nursing leadership influence the healthcare bureaucracy to address workplace constraints that influence the spirituality of patients and nurses? Nursing leadership with spiritual values is required to advocate for a workplace environment that creates moral communities of care. Perhaps nursing leadership should be called upon to ignite discussion on a societal level about the workplace constraints, such as workload and staffing issues that inhibit holistic nursing practice.

Implications for health policy.

“A person should be able to identify exactly how the organization is implementing its stated philosophy by observing members of the [healthcare] staff, reviewing budgeting priorities, and talking to consumers of healthcare” (Marquis & Huston, 2009, p. 153). Viewed

from this perspective, few organizations in the sample would be viewed to value spiritual care. The healthcare monopoly operates as a poorly run corporation. Discourse must continue on how to implement innovative changes from the corporate world to the Canadian healthcare system in order to increase efficiency and focus on developing an interpersonal relationship with the patient. Implications from this study suggest that spiritual organizational models may have a profound influence on the spirituality of the patient and the nurse, while increasing morale and efficiency and commitment to the organization. As healthcare is a publically funded enterprise, nurses are positioned to begin dialogue amongst stakeholders so as to explore methods of creating a system that continues to be based on the social values of Canadians, which is seen to include spirituality.

Suggestions for Future Research

While all areas of nursing are called to care for the sacred, little is known about integration of spiritual care in practice settings outside of the environments which routinely address the sacred. Further research is needed to determine how nurses, of all faith perspectives, view care of the sacred across the healthcare spectrum. What influences spiritual caregiving in specialty settings across institutions? What influences spiritual caregiving within specific organizations? What is the nurse's role within in a multidisciplinary environment? Moreover, how do specific organizational structures impact spiritual care? What is absent in these narratives is discussion surrounding the goals of spiritual care. To what end are nurses to provide care? What measures are in place to evaluate if best practice was used? How would nurses perspectives of the sacred change if spiritual care giving was defined as an extension of self? Finally, how do culturally and spiritually diverse Canadians want to be cared for?

Chapter Summary

While modernism, materialism and technology have infiltrated Western culture (McSherry, 2006), it cannot erase the needs of the soul. As society struggles to place the pluralistic and subjectivity of the sacred in the public sphere, for many healthcare has become a salient metaphor for salvation (McGuire, 2008). Nursing must re-orient itself in a spiritual ethic to address the unique needs of a society which places high individualistic and moral expectations on health (McGuire, 2008). Amidst the social/political deconstruction and cynicism of this era (Rohr cited in Pesut, 2012b), the profession is in a unique position to help reinstate belief in humanity (Pesut, 2012b). While the context of nursing care must be challenged, nurses must approach spiritual care with vulnerability and humility; extending their spirit to another.

While the sociopolitical and economic constraints facing the Canadian healthcare system are daunting, this thesis has provided a few examples which give insight into how nurses can create an ethical environment in which to enact spiritual care. As the profession looks to the future there are exciting possibilities.

A return to a values based ethical approach to nursing and spiritual care would allow nurses to attend to the core values of nursing. Phillip Melanchthon, a German theologian once said, “Keep the main thing, the main thing, the main thing” (Boda, M., 2012). The nursing profession must not be distracted by political and organizational influences. The unique focus must remain on, and advocate for, the “main thing,” that is, extending compassionate care that touches the soul.

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Appendix A: Summary of Literature Search

Search words utilized for the literature review consisted of : “nurse”, “spirituality”, “integration of spirituality”, “integration of spirituality into nursing practice”, “nursing and education”, “nursing practice”, “nurse’s spirituality”, “healthcare” or any combination thereof.

Search engines utilized were PubMed, Sage, CINAHL and Google Scholar.

Appendix B: Ethical Consent Form**NURSES' PERSPECTIVES ON THE INFLUENCE OF
PRACTICE ENVIRONMENTS ON THE INTEGRATION OF SPIRITUALITY AND
RELIGION INTO PROFESSIONAL PRACTICE**

A course-related learning activity
NURS 530: Nursing Inquiry I

Professor: Dr. Barb Astle
School of Nursing
Trinity Western University
(604)513-2121 ext. 3260

Purpose: The purpose of this project is to provide graduate nursing students experience in conducting an in-depth research interview and analyzing data. Students will elicit nurses' perspectives about the influence of practice environments on the integration of spirituality and religion into professional practice. You are being asked to participate because of your experience as a nurse. This research is part of course requirements for NURS 530 Nursing Inquiry I of the Master of Science in Nursing (MSN) program at Trinity Western University.

Procedures: If you agree to participate, you will be interviewed for 30 – 60 minutes about your perspectives on how practice environments influence how spirituality and religion are integrated into professional practice. The interview will be conducted by a MSN student and will be audio-recorded. You may ask to turn off the recording at any time. The interview will be held at a time and place convenient to you. The findings of the project are related directly to meeting the student's course requirements. You may ask for a copy of the transcript of your interview.

Potential Risks and Discomforts: No risks or discomforts are anticipated.

Potential Benefits to Participants and/or to Society: Nurses often benefit from talking with another nurse about their professional practice. In addition, your participation will contribute to student learning about the skills of interviewing and research.

Confidentiality: Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. All documents will be identified only by pseudonym and kept in a password protected online classroom accessible only to the student, two other students on the same learning team, and their professor. Data will be collected anonymously and names will not be linked with any information. Data will be stored anonymously by the professor (on her password protected computer) for potential future use.

Contact for information about the study: If you have any questions or desire further information with respect to this study, you may contact the professor, Dr. Barb Astle at 604-513-2121 ext. 3260 or Barbara.Astle@twu.ca

Contact for concerns about the rights of research subjects: If you have any concerns about your treatment or rights as a research subject, you may contact Ms. Sue Funk in the Office of Research, Trinity Western University at 604-513-2142 or sue.funk@twu.ca.

Consent: Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study and that your responses may be put in anonymous form and kept for further use after the completion of this study.

Participant Signature

Date

Printed Participant Name

Student Interviewer

Appendix C: Courtesy Letter

June 1, 2012

Re: N530 Interview data

My fellow students,

I am undertaking a qualitative secondary analysis for my capstone project. Secondary analysis is a responsible approach to maximizing large data sets that tend to be under-analyzed. The aim of my project is to explore how nurses integrate spirituality and spiritual care into practice. My research question is: What are the influences on spirituality and spiritual care in nursing practice environments?

Many will recall the Nursing 530 project in which each MSN student conducted an interview on the topic of spirituality/religion in practice. At the suggestion of Drs. Reimer-Kirkham and Astle, these interviews will become my data set. This secondary analysis has undergone ethical review; all safeguards are in place regarding ethics. Confidentiality will be protected as identifying data will be removed from the transcripts by professors Dr. Barb Astle and Dr. Sheryl Reimer-Kirkham prior to my reading them. 12-15 of the transcripts that offer the richest narratives will be selected for analysis; I will not know who conducted these interviews, nor who the interviewees are. To complete the study, I will be facilitating a focus group to compare the findings.

The projected completion date for this project is October 2012. Please refer back to the MSN website later this year to read the final thesis.

Kindly,

Kyla Janzen