TRINITY WESTERN UNIVERSITY

SPIRIT:

The Negotiation of Religious and Spiritual Plurality in Healthcare

Final Report

Funded by Social Sciences and Humanities Research Council: 2006 – 2009
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BACKGROUND

Diverse Societies

As societies are becoming increasingly diverse, so are healthcare contexts. In Canada, more than 200 language groups are represented (Statistics Canada, 2006). Immigrants currently represent 39.6% of the total population of Greater Vancouver, with 26% of all households in Greater Vancouver speaking a language other than English or French (Statistics Canada, 2006). Age and class are other diverse demographic descriptors.

Religious Plurality

A complex social landscape results:

- Global migration has brought increased numbers who adhere to non-Christian religions;
- There is decline in attendance at "mainline" churches but some rise in evangelical and charismatic church attendance;
- More Canadians than ever report "no religion" but continue to believe in God, often describing themselves as "spiritual but not religious";
- Personal quests for meaning are on the rise;
- The larger geographic region in which this study was located is sometimes referred to as Cascadia (B.C., Washington, and Oregon) has fewer institutionally religious people but most consider themselves deeply spiritual[1]. The Health Authority encompasses an area sometimes referred to as one of Canada's 'Bible belts'. Both characterizations—of being spiritual but not religious, and of deep religious affiliation—are represented in the study sample.

Healthcare Services

These social trends have significant implications for the delivery of healthcare services:

- Although many of Canada's healthcare services have their roots in religious movements (e.g., Catholic, Salvation Army), the administration of most hospitals shifted to provincial governments (and their designated health authorities), implying secular healthcare services;
- Healthcare professions are caught in between the fast-paced, high-technology world of medical treatment and their professional mandates to provide "holistic" care, sometimes with reference to "spiritual care";
- Faith communities continue to provide comfort and support to people during times of illness;
- Religious and spiritual values and beliefs influence ethical decision-making;
- Religion and spirituality are forces for social inclusion and exclusion. When enacted for social inclusion, religion and spirituality can foster connection in the provider-recipient clinical encounter. However, when religion and/or spirituality are mobilized to exclude, social pathways that lead to health and social disparities are entrenched.

Questions arise about how religious and spiritual plurality are accounted for in healthcare. This report presents the findings of a 3-year study that explored these questions. This work is particularly relevant in light of Canada's increasingly pluralistic population. The study advances our knowledge regarding how difference is negotiated in healthcare settings, and how religion and spirituality might contribute to social cohesion and/or division. Policy and practice recommendations are being developed in conjunction with practitioners and spiritual leaders regarding how to best create space for the expression of religious and spiritual plurality in healthcare and other social services.

PURPOSE AND OBJECTIVES OF STUDY

What?

The ***purpose*** of this project was to analyze the negotiation of spiritual and religious plurality in healthcare services, and the social, gendered, cultural, historical, economic, and political contexts that shape these social dynamics. The ***objectives*** were to:

(1) describe how spiritual and religious plurality is negotiated in healthcare provider/recipient encounters;
(2) examine how healthcare contexts shape the negotiation of spiritual and religious plurality;
(3) critically examine how societal contexts shape the negotiation of religious and spiritual plurality in healthcare;
(4) facilitate knowledge translation into practice, health policy, and professional education.

[1] Todd, D. (2008). *Cascadia: The elusive utopia. Exploring the spirit of the Pacific Northwest*. Vancouver, B.C.: Ronsdale Press.

METHODS

How?

Ethnographic methods of ***interviews*** and participant ***observation*** with patients, healthcare providers, spiritual care providers, and healthcare administrators. Relevant documents such as policy statements, patient resources, and educational materials were reviewed. A ***practice advisory group*** met to discuss emerging project findings and ***Think Tanks*** were held on a bi-annual basis to explore theoretical perspectives relevant to the project. The last phase of the project involved various ***knowledge translation*** activities (e.g., workshops and presentations). Ethical approval was obtained from the Health Authority and Trinity Western University.

INCLUSION CRITERIA:

Freely consenting healthcare providers (HCP) with a commitment to spiritual care-giving, spiritual care providers (paid or volunteer)(SCP), and patients ages 18 or over were included in the study.

SAMPLE

Where?

Data collection occurred in Metro Vancouver on palliative, hospice, medical and renal in-patient care units at two tertiary level hospitals and seven community hospitals. Some participants (e.g., hospice volunteers, healthcare professionals such as social workers, and physicians) had responsibilities that spanned institutional and community contexts.

Who?

Project participants include 16 patients/families, 20 healthcare providers, 21 spiritual care providers, and 12 administrators (n = 69). These participants come from various backgrounds (religious/spiritual affiliation, ethnicity, age).

INTERVIEW QUESTIONS:

Participants	Sample questions asked in the interview:
Patients	• What values and beliefs are important to you as you enter the healthcare system? • Are there specific things you would like a healthcare provider to do for you to support your spiritual/religious practices? • Do you have an example or story of when you felt well cared for by someone from a different background than you? What did they do to make you feel this way?
Healthcare Professionals	• How do spiritual and religious matters enter into healthcare provision? • How do you provide caregiving in intercultural, interfaith, or interspiritual situations? • Are there beliefs or traditions of your own that influence how you provide care? • What policies and resources are in place to support spiritual caregiving?
Spiritual Care Providers	• Tell me of an experience with a patient/family that stands out for you, perhaps where you felt you were really able to really connect. • What strategies or approaches do you use when patients/families are not from your spiritual/religious tradition? • How do you communicate patient spiritual/religious concerns or interventions with healthcare providers? Are there words or phrases that communicate these kinds of ideas?
Administrators	• How is diversity evident in your organization? • What are your views on spiritual caregiving in relation to healthcare provision? • How do practice environments influence intercultural, interfaith, or interspiritual caregiving? • What policies or resources support religious or spiritual caregiving in your organization?

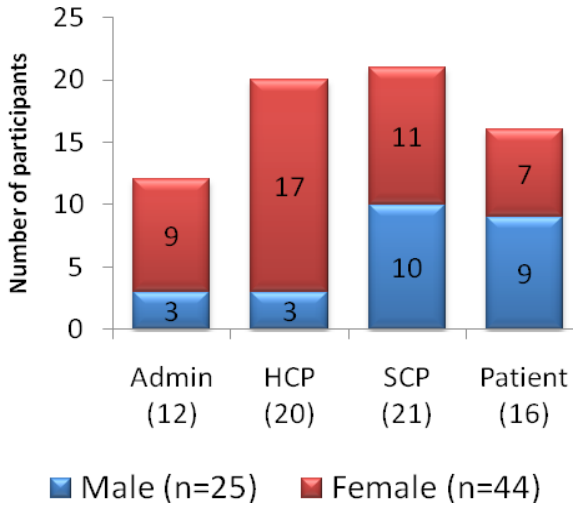

Figure 1: Participants by Role and Gender

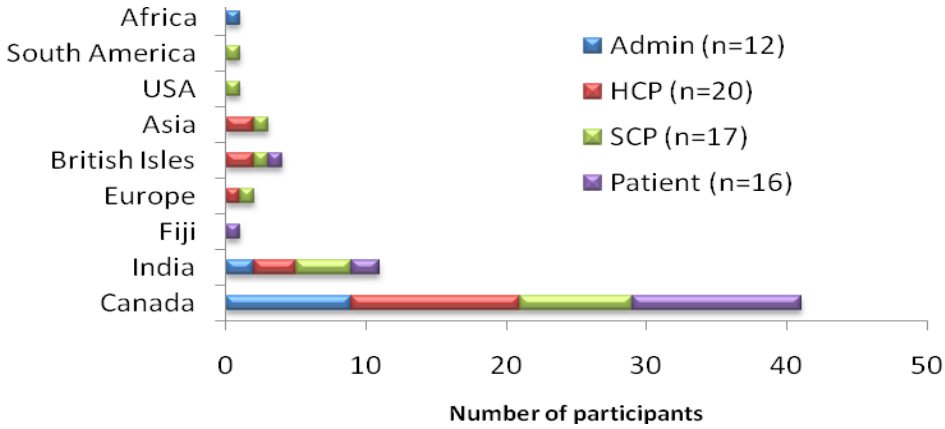

Figure 2: Participants by Country of Birth

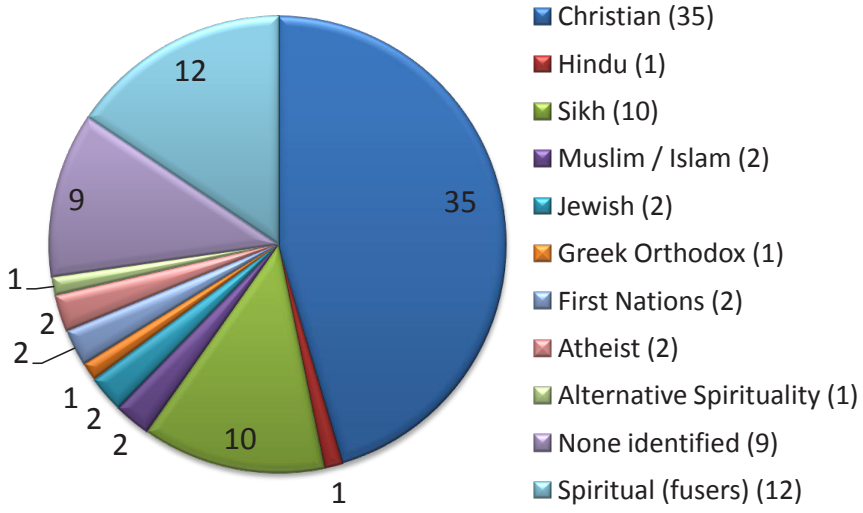

Figure 3: Participants by Religion

PRESENTATION OF FINDINGS

THEME #1.
The Sacred in Clinical Encounters

Findings from the project portrayed healthcare providers, spiritual care providers, and patients holding to a variety of values and beliefs about religion and spirituality. Our interest in this project was in how patients and caregivers interacted and negotiated these different stances. Some encounters (exchanges) were marked by profound connection, others by indifference, and yet others by marginalizing practices.

Connecting in Clinical Encounters

This theme was reflected in relational exchanges where two humans connected profoundly, sometimes on the level of the spiritual.[2] Acknowledging and/or tending to the sacred dimension (religion/spirituality) in a relational exchange was seen by many spiritual care providers and healthcare professionals as contributing to healing. Strategies as simple as engaging in small talk or referring to patients by their name humanized clinical encounters.

- Sometimes these connections occurred through shared identity and involved offering spiritual support (as in cases of whispered greeting: ***"are you a Christian?")***.
- In situations when participants did not share the same religious or spiritual background, many caregivers transcended difference by seeking points of connection. A Sikh nurse, for example, referred to as older white woman as ***"auntie"*** to connote respect and connection, as she would with an elderly Sikh woman. Often these connections focused on shared humanity as reflected in a comment such as: ***"I see we're all in this life cycle together."***
- Eliciting patients' meaning systems rather than assuming to know what patients believed was a way of facilitating connection to transcend difference (e.g.,asking a patient in palliative care ***"what is important to you today?"***).
- Relational exchanges were also experienced as embodied,[3] where something as simple as providing physical care could be seen as tending to the spiritual. One caregiver described the bath and massage provided to a dying patient as a ***"spiritual encounter."*** It was not uncommon for study participants to acknowledge the challenge brought by cultural diversity and there were many examples of how individuals and organizations worked to foster inclusivity.

> *"The mystery, I think, is the same but we all wear different glasses to see it but we all rejoice in the mystery."*
> **(spiritual care provider)**

Marginalizing Practices in Clinical Encounters

In contrast to the efforts to create inclusive, relational connections, there were other examples, some blatant, where patients were marginalized on account of their religious affiliation, particularly where ethnicity and language also entered in as sources of 'difference.'[4] A Southeast Asian patient said:

> ***"They just assume … what you're like, what you're not like (…) I thought the nurse had an attitude and so I just asked her one day, 'Did I offend you in any way? Am I the wrong color?' …I noticed whatever race you are, especially a lot of our people because a lot of them do use the system, I'm not denying that, but a lot of them are just labeled and assumed that they're going to be bad people and abuse the system and when they don't speak the language, doesn't matter what nationality you are, it makes it really hard.…I find it kind of inhuman myself." (patient)***

Another Sikh caregiver explained:

> ***"I've had [Sikh] people left, you know, ignored for days because they didn't speak the language. So that's the biggest issue, is the language challenge. And people have told me to my face 'why don't these people learn English?' and 'if they don't know English they should not be allowed to come to Canada." (spiritual care practioner)***

The attitudes of individual healthcare providers are undoubtedly important in shaping whether encounters are relational or marginalizing. The study findings showed that many factors contributed to (or detracted from) meaningful connections; for example: personally held values and beliefs about "the sacred," social identity such as religious affiliation or ethnicity, professional roles; healthcare services, and the broader Canadian society. There was remarkable variability (diversity) within each of these levels, evidencing the complex social relations in the realm of religious and spiritual plurality in healthcare.

Interpretations of the Sacred

Interpretations of the "sacred" varied for participants in the study, and directly influenced provider-recipient encounters.

- For some, the sacred meant participating in ***organized religion*** (faith communities that were formalized to varying degrees). Religious affiliation was often interpreted as involving a deity as reflected in one participant's comment ***"…it's an encounter with God."*** Religion was often tied to cultural identity (e.g., Sikhism, Islam, Evangelical, Christianity) and emphasized community structure. There was considerable variation within any one religious tradition as to extent of affiliation (e.g., if they were a baptized or non-baptized Sikh, or a practising or non-practising Catholic).
- For others the sacred meant ***privately-held beliefs*** *and practices* that were deeply meaningful and nurtured a sense of self as a spiritual being. These participants defined spirituality with terms such as ***"connectedness," "relationship," "the essence of a person,"*** or ***"whatever the individual finds meaningful."*** For many, the sacred involved connection to nature.Sometimes these more private and individual interpretations were still rooted in religious traditions. Others referred to themselves as ***"spiritual but not religious."***

> ***"Spiritual can be anything that has a name for the patient so…for this one patient…crystals had a form of healing for her or the family it seemed. You could be listening to calming, soothing sounds like the water, a forest or birds chirping in the background, things like that." (healthcare professional)***

- Fusing[5] or ***mixing of beliefs and traditions*** was also demonstrated by some participants. For example, acculturation resulted in a personalized blending of Sikh and non-Sikh ways. A healthcare professional explained:

> ***"…in our family, we're not fanatically religious, you know, I've got the short hair and have a little drink here and there … so we're what you'd call the modern Sikhs (chuckling). Pick the best of what you want and then move on…Cause then you change it because you interact with other cultures as well. And you pick up little bits of culture and beliefs that suit your own personality."***

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[2] Pesut, B., & Reimer-Kirkham, S. (in press). The negotiation of religious and spiritual plurality in healthcare: Situated encounters. *International Journal of Nursing Studies.*

[3] Sharma, S., Reimer-Kirkham, S., & Cochrane, M. (2009). Practising the awareness of embodiment in qualitative health research: Methodological reflections. *Qualitative Health Research*. 19(11) 1642–1650.

[4] Reimer-Kirkham, S. (2009). Lived religion: Implications for healthcare ethics. *Nursing Ethics* 16(4), 406-17.

[5] Vincett G. (2008). The fusers: new forms of spiritualized Christianity. In K. Aune, S. Sharma, and G. Vincett (eds.) *Women and religion in the West: Challenging secularization,* (pp. 133-145). Aldershot: Ashgate.

- For yet others, the sacred ***did not hold particular importance*** in their lives. They might have loose affiliation to a religious tradition, but not personally hold religious or spiritual beliefs and practices.

Giving the Sacred a Language

In light of these varied interpretations and affiliations, finding a shared language for the sacred was challenging. The nature of the sacred—as ineffable, mysterious, and personal while also social and political—contributed to the difficulty of describing and talking about the sacred.

- **The sacred as ineffable, mysterious, and personal:** Stories and metaphors were often used describe spirituality and spiritual caregiving interactions. Some spoke of epiphanies, decisive moments where they had new insights or saw things in a different way.

> *"I looked after a patient who died at home, he was a very devout Christian and the moment he died he had his family members surrounding the bed and they were holding hands together and singing hymns and I believe his soul was transported into heaven that day. I stepped outside of that, it was a cool night, about 2 o'clock in the morning and not a cloud in the sky and the moon and the stars were all out and I knew at that moment this is what I want to do for the rest of my life. That's why I'm a palliative care physician." (healthcare professional)*

- **The sacred as social and political:** Efforts were made to use ***inclusive language***. This was best reflected in the shift in healthcare services from Christian terms such as "chaplain," "pastoral care," and "chapel" to more inclusive terms such as "spiritual care practitioner" and "sacred space." Some participants adapted these terms to be understood by the patients (e.g., a spiritual care provider introduced himself as chaplain when speaking to an elderly Protestant patient).

However, despite these efforts to be inclusive, some tensions remained. Religion and religious-talk was problematic for some, as reflected in comments such as *"we don't bring religion to work but we do bring spirituality to work"* and *"religion was a bad word to say."*

> *"I'm still working on gathering material that uses language that is more embracing of other people and other faiths in a way that doesn't come across too, too Christian or too religious but at the same time is profound and spiritual and, and has something to offer. I've found out language is everything in dealing with people from other cultures and faiths and so just kind of getting rid of our typical Christian jargon (laughing.)" (spiritual care provider)*

The language used about 'the sacred' was important in communicating respect and belonging. Care was taken not to exclude people with the language used. However, even language intended to be inclusive could be perceived as exclusionary for those who adhered to particular religious traditions. The language of "spirituality" as a general reference to the sacred did not resonate for some of the Sikh participants who were more likely to use the language of "religion" and "faith." A Sikh spiritual leader explained that in her tradition, spirituality would be understood as a state of devout, heightened religiosity:

> *"…somebody who's a religious person, they identify with specific rituals and often go somewhere to a temple or holy place or church. Whereas somebody may be deeply spiritual and they may not do any of those things but something brings them into a place where they feel connected, energized, find meaning and purpose in their life, and so those [religion and spirituality] need to be distinguished I think."*

The Enactment of Religious and Spiritual Identities

Clinical encounters are dynamic interactions between healthcare providers and patients. Caregivers' religious/spiritual affiliations influenced how they approached the sacred in professional practice.[6] Some participants were aware of the influence of the self on spiritual caregiving, others were less aware.

- **Knowing oneself:** To a considerable degree, one's social identity and all of the sociocultural, historical, and gendered social world wrapped up in that identity, influenced how religion and spirituality were addressed in patient care services. Participants varied in the extent to which they were self-aware about this influence. Illustrating this influence: A Sikh nurse was more likely to encourage a family visiting as a way of tending to the spiritual (and less likely to see herself as providing spiritual care by her presence), whereas a British-trained nurse was more likely to sit quietly at a bedside of a hospice patient with the question *"what is your hope for today?"* (rather than asking direct questions about religion). Both nurses are providing care through the lens of their social locations.

- **Being Aware of Professional Boundaries:** Many caregivers expressed caution regarding professional boundaries, to the extent that concern for professional boundaries and/or political correctness could inhibit tending to the spiritual. There was also difference between professions as to how they viewed their role in relation to spirituality and religion.

  - **Palliative Care Physicians** (n = 3). Physicians in the study tended to view their role as that of symptom management (in the context of palliative care) to make room for the patients' spiritual work. They were less likely to articulate concern about boundaries.

> *"I clarify the medical questions they may have. I provide them with a rough guide for prognostication and I am able to provide them with fairly quick symptom control for their physical symptoms and by putting that nicely into a little box then I can begin to allow them to do the spiritual work that they need to do." (healthcare professional)*

  - **Nurses** (n =13). Observational sessions provided examples of some nurses enacting a position of "caring spiritually" where their stance was one of integrating attention to the spiritual in all they did, rather than seeing "spiritual care" as discrete interventions. For those nurses who incorporated particular practices as spiritual care for their patients (e.g., prayer, healing touch), they often did so discretely, with some concern that they might be crossing a boundary to do so. Other nurses focused on providing supportive psychosocial care and "body care" (immediate physical care), which,

[6] See Pesut & Reimer-Kirkham (in press) for an expanded discussion on clinical encounters.

while not explained by them as spiritual caregiving, might by others be deemed as such.[7] Some nurses said that spirituality and religion rarely entered into their professional practice.

- **Social Workers** (n =3). Social workers expressed few boundaries in relation to spirituality. For the most part, they saw tending to the spiritual as within their role, in the context of psychosocial support and clinical counselling. Roles between social workers and spiritual care providers were sometimes blurred.
- **Spiritual Care Providers** (n =21). Spiritual care providers were the "experts" in relation to the work of tending to the spirit, taking on roles such as spiritual director, counsellor, support, and facilitator/ broker of religious practices. Many saw their roles as extending to supporting staff. A unique contribution to the team was that of "theologizing" (as referred to by one administrator in the study) where they guided patients/families to make meaning of suffering and other life events within a patient's particular meaning system.

While working collaboratively, each profession needs to do what it does best: whether symptom management, coordinating care including "bodycare," or counselling, all of which are part of caring spiritually (tending to the spirit).

- **Nurturing a sacred self:** Many caregivers (spiritual care providers as well as some healthcare providers) spoke about how they cared for themselves, whether by setting boundaries of time, spending time outdoors, being with other people, or by meditation and prayer, reflected in comments such as:

  "I, I love nature so stepping outside my door, at home, makes me feel part, connected to the bigger universe and I go aaahhh, phew, I'm just a little cog in a wheel." (healthcare professional)

  "I regenerate by whistling in the halls (laughing). And, and at coffee time we connect, we have discussions with staff. Our regeneration has a lot to do with me knowing I'm part of a team." (healthcare professional)

  "I have my own faith that works for me, your own faith and your own spiritual underpinning are important and you nurture those." (spiritual care provider)

  "I think time boundaries are really important. I start my morning off, every morning, I have some routines that I go through and the last one is here actually where I go up and I sit and pray through those requests in the chapel here before I get started." (spiritual care provider).

- **Being known by the patient:** Participants told of situations in which their identity was being "read" by patients to see whether they shared their religious background, and this might determine whether the patient would accept their care. Creating connections was dependent thus upon caregivers responding to patients' expectations and preferences. Most patients were not expecting spiritual care per se from healthcare providers, but rather emphasized respect, kindness, and timely care. Their expectations of spiritual are providers were more specific, and they appreciated spiritual care providers ***"walking with"*** them during hospitalization and difficult situations.

- **Enacting religious and spiritual selves:** Professional references were made to spiritual care[8] although healthcare professionals interpreted how they gave spiritual care differently:

  Some ***concretized*** what they did so that spiritual care consisted of discrete activities such as referrals to spiritual care coordinators, facilitating religious practices, or praying with a patient/family.

  "R: You were telling me about when you do your assessment you like to be able to touch the patient.
  P: for me it's almost, it's like a calming or soothing, um, and I also feel part of it's like a healing touch too. When I put my hand on their forehead I can feel it makes a difference. It seems to calm the person down….When you touch you feel heat. I feel positive afterwards, a sense of calmness, a well being, like I've done some good." (healthcare professional)

  Others held a more ***integrated view*** of spiritual care where it encompassed all they did as care providers.

  "I bring spirituality into every situation I'm in. Not by forcing patients to hear my take on, on what they should believe in …but, in every situation, whether I'm in the busy Emergency department or in a quiet private room of a dying patient, I enter that room with a spirit of humility and humbleness because more than anything I want to create an arena where God works …" (healthcare professional)

  Some who ***struggled to articulate matters*** of the spirit and spiritual caregiving during interviews were observed to make connections and elicit meaning systems of patients in ways indicative of spiritual caregiving.

  "I'm not the church, but I am the connection, I will sit here and listen to how things are with you. Any nurse should be able to offer that piece." (healthcare professional)

THEME #2. Recognizing the Influence of the Healthcare Context on Religion and Spirituality

The influence of the healthcare context (hospitals in this study) shaped how religion and spirituality were negotiated. Some of this influence was direct—as in the services and resources provided through the spiritual care department. Other sources of influence were less obvious, because the influences were more likely to be taken for granted—as in the diverse cultural mix represented by patients and workforce, the organizational culture, and the curative agendas of healthcare. The hospital is a social repository of difference as patients and healthcare providers from all walks of life are brought together in intimate and intense circumstances.

"I think there's just enormous diversity in organizations starting with the patients we see and it's not just religious diversity, it's linguistic, it's cultural it's everything." (administrator)

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[7] Pesut, B. & Sawatzky, R. (2006). To describe or prescribe: Assumptions underlying a prescriptive nursing process approach to spiritual care. *Nursing Inquiry, 13*(2), 127-134.

[8] Pesut, B. & Sawatzky, R. (2006). To describe or prescribe: Assumptions underlying a prescriptive nursing process approach to spiritual care. *Nursing Inquiry, 13*(2), 127-134.
Sawatzky, R., & Pesut, B. (2005). Attributes of spiritual care in nursing practice. *Journal of Holistic Nursing, 23*(1), 19-33.

Spiritual Care Services

Spiritual care services provided a range of services and were described as "bridges" amongst staff, patients, faiths, and cultures.[9] The spiritual care services department was disbanded as the project was coming to an end (November 2009).

- **Role with patients:** Broadly, the role of spiritual care providers (paid and volunteer) with patients was that of facilitating healing, doing this through presence with the patient family, compassion, advocacy, and theologizing the experience to assist in making meaning of suffering, illness, and death. They connected people to spiritual resources, whether formal or informal, and facilitated making meaning of illness and death experiences.

  "So the professional practice leader took the initiative to go to the spiritual care coordinator and say, 'I need more about the theological beliefs of Jehovah's Witnesses so that I can make this visible to the staff' …" (field notes)

- **Role with staff and hospital community:** The presence of spiritual care providers reminded staff about the spiritual dimension. It was not uncommon to spiritual care providers to serve as "spiritual leader" for staff (often those who do not belong to a faith community or have a spiritual director/leader). This role expanded to conflict resolution, crisis intervention (e.g., being called in to Emergency when there were multiple fatalities), or supporting staff with the effects of repeated loss and/or chronic stress (e.g., at several hospitals the spiritual care providers hosted 'Tea for the Soul' where staff were invited to attend to talk about difficult situations they had faced or patients who had died).

  "…the spiritual care coordinator was talking about his role to facilitate conversations amongst staff to create a space where you could talk about examples of conflict…" (field notes)

> *"The spiritual care department is the soul of the hospital"*
> **(spiritual care practitioner)**

- **Legitimating and justifying spiritual care services** was a central focus for spiritual care providers. They worked hard to make visible the type of services they provided, even as they described to the researchers how difficult it was to enumerate and concretize the ineffable (the sacred). A workload tool, for example, was created by spiritual care coordinators to account to administrators what their work entailed (e.g., number of visits). Yet, with their services in place, a culture was established that acknowledged the legitimacy, even to other healthcare providers, of providing spiritual care. As articulated by one healthcare provider:

  "I feel that freedom to discuss spiritual issues because if they're going to fund a chaplain to discuss those things, then it's not a taboo subject for me as part of the healthcare team." (healthcare professional)

- **Professionalization of spiritual caregiving:** Many health professions (e.g., nurses, physicians, social workers) are now integrating spirituality into their professional role. For example, spiritual care providers and social workers negotiated (sometimes with tension) interprofessional practice and role development.

Sacred Spaces in Institutional Settings

Sacred spaces were real material places, whether the hospital's designated ecumenical space or informal sacred spaces created elsewhere (e.g., patient's room). Sacred spaces could also be metaphysical or relational spaces that occurred for individuals or through interpersonal connection. These spaces evoked a feeling of a sacredness of space and time for participants (a sense of transcendence, immanence and/or connectedness in the everyday).

- **Sacred spaces designated within the institution:** Effort was made to have the designated sacred space (formerly referred to as 'chapels') reflect various faith traditions. As put by one spiritual care provider: *"I want to have things representative… I didn't want to make a room that was very Christian or any one thing. I wanted it to have some things that people would feel could relate to when they come in. And also for myself because I really, I, I, value the wisdom and teachings of other faith traditions."* Family members and patients accessed the Sacred Space for meditation, prayer, and quiet. A patient said: *"After about two weeks they told me that there's a room upstairs at the hospital that's like a religious room where you can go in a pray. It was very relaxing up there. I felt the room was like very peaceful."*

- **Sacred Spaces created informally:** Informal sacred spaces were also created outside of the designated Sacred Space; for example, when meaningful religious traditions were incorporated or spiritual symbols brought into a patient's room. An Aboriginal patient had a cedar bow on her bed: *"like you see that cedar bow on my bed, it brings a lot of healing power to me and a lot of energy."* Another patient blended home and hospital with meaningful sacred symbols:

  "I can think of one patient. She was quite young and quite spiritual….Her family brought things from home and decorated her room. So they'd have various pieces of fabric hanging or attached to the curtains around her bed that had significance to her. She had some crystals in the room and a crystal on her tummy." (healthcare professional)

  Facilitating religious practices such as cleanliness for a Sikh patient before prayers was part of creating sacred space within the hospital (and problematic when not accommodated), as reflected in this quote:

  "But for a Sikh person it's very, very important. An early morning bath or shower before you eat something. You shower, you cleanse your body and then you cleanse your mind, say your prayers and then you eat. And then, after toileting I will give the patient a wet towel. That's all they need is just to clean their hands but, you know, the nurses can't be bothered, don't have the time, don't even think about it." (spiritual care provider)

  Other religious rituals were also facilitated in informal sacred spaces. A healthcare provider explained: *"for the Muslims it would be respecting if they wanted to cover their body or cover their hair, um, have the curtains round, closed around them, um, yah. And then for the Catholics some of them like to have their prayer beads so they can hold on to those."* These examples illustrate how sacred spaces are facilitated by caregivers, and how patients live their religiosity and spirituality through bodily (physical) practices and rituals.

Organizational Culture, Leadership, and Spiritual Caregiving

Leadership at every level of the organization—from the patient care unit to the program to the hospital to the health authority—played an integral role in creating the space or climate where spiritual caregiving was valued and practiced, and where culturally safe care was provided.

[9] Pesut, B., Reimer-Kirkham, S., & Sawatzky, R. (in review). Hospitable hospitals in a diverse society: From chaplains to spiritual care providers. Submitted to *Journal of Religion and Health.*

*"…when there's more pressure on people, fewer people to do that work, it makes it harder to create the space to have those conversations so now it's like working in the emergency department all the time….. so much is determined by the leadership. **The tone and the space the leadership creates for having the conversations determines what happens."** (administrator)*

- **Frontline Leadership:** Professional practice leaders were crucial in role modelling spiritual caregiving, supporting staff, and providing resources for staff. For example, one professional practice leader consistently put the Spiritual Care Resources binder in a visible place on the unit so that people would be *"confronted with it and would need to think about it."*
- **Program Leaders/Hospital CEOs:** Spiritual care coordinators often made reference to how supportive the hospital administrators were of the spiritual care department. Members of the hospitals' leadership teams also acknowledged the centrality of their role with references to creating organizational culture as: *"caring organizations," "spiritual organizations,"* and *"ethical organizations."* One administrator commented:

  "An ethical organization to me is one that intentionally seeks to live with integrity. It's an organization that….recognizes that there will be different things that are important and these are in tension with each other. That in that context strives to make the best decisions possible, all things considered, always and in the process seeks to make sure that we demonstrate meaningful respect towards everyone that is in that organization. From the patients and their families, to front line staff, right through to everyone, recognizing that everyone's integrity is at stake."

- **Health Authority:** During the course of this project, the Spiritual Care Department within the Health Authority was being established with considerable policy development and implementation. However, toward the end of the project, the Spiritual Care Department was deleted with 13 spiritual care coordinators laid off as part of a cost containment and restructuring phase. There was an ongoing tension between valuing the provision of spiritual care services and resource allocation decisions.

  "…if we're saying spiritual and we don't say religious, then we're eliminating a huge bunch of the population."

  "…we have to think as an organization, what is our role … it seems to me there's a distinction between a facilitator and the deliverer of [spiritual care] services." (administrator)

Priorities and Effects of the Healthcare Context on Religion and Spirituality

Findings from this study demonstrated how today's healthcare services, particularly in acute care settings such as hospitals, have priorities that do not easily align with spiritual caregiving.

- **Curative Focus:** The emphasis on curing illnesses and treating symptoms made it difficult for healthcare professionals to value tending to the spirit.

  "…as a bedside nurse you are focused on the black and white stuff." (healthcare provider).

  "…It [referring to hiring spiritual care coordinators] is a hard sell because they're not doing tasks which the medical model really supports." (administrator)

- **Managerial and Fiscal Concerns:** In today's climate of outcomes-oriented and cost effective healthcare, spiritual caregiving fits uneasily. Spiritual care coordinators and some healthcare providers spoke about needing to provide evidence of cost-effective services.

  "…the results of spiritual care aren't as evident. When you come up against that as you do in a health authority or any setting, you try and put the soft side of what spiritual care can do for them verses the pill that you can do a clinical trial with it's a very tough sell." (administrator)

The combination of a curative focus and the emphases on efficiencies resulted in heavy workloads for healthcare providers and very sick patients (acuity) that often exacerbated the challenge of integration religion and spirituality, as noted by patients, caregivers, and administrators:

"Nurses are running around, you know, they're running around and they can't think of everything. To be able to see what each patient needs you have to sit with that patient for a long time. They don't have time to do that." (patient)

"… healthcare is such an intense place …there's so much pressure on the system we don't have the space for just listening." (administrator)

Spiritual care services were revealed in this study as a vital dimension of how religion and spirituality were integrated into the day-to-day provision of healthcare services. 'Sacred spaces,' whether designated or informal, were created as havens in busy, intense hospitals. Healthcare providers and spiritual care providers alike found it challenging to tend to the sacred in a healthcare context with competing demands and values.

THEME #3. Accounting for Societal Context: Plurality in the Realm of Religion and Spirituality

The project with data collection from 9 different hospitals provides a snap shot of the mix of religious affiliation, sacralisation, secularism and religious illiteracy typical of Canadian society.

- Various interpretations were held about ***secular*** healthcare organizations. Some participants indicated that secular referred to the ***public domain*** (in contrast to private or religious domains). The underlying assumption in this case is that religion and spirituality are generally kept out of the public domain, and yet, given the political nature of both religion and spirituality, it is not realistic to assume they do not take any form In the public realm. Creating a strong dichotomy between public and private runs counter to how many newcomers to Canada and adherents of non-Christian faith traditions view lived religion.

  "I have a sense that because the environment is, is a secular hospital, it is a public place and I often feel that a lot of the nurses and doctors are afraid to provide certain, uh, spiritual care or encouragement because they are afraid that something may happen but I know many of them are spiritual people."

  "I would interpret secular to mean in the public realm as opposed to the religious realm …is how I view secular … you sort of see secular as state verses private."

  "When I was interviewed for the position, the administrator said to me, "we are a secular organization and so … you know, as a Christian, make sure that you don't have any of it leaking over from your faith into what you do." (spiritual care provider)

- In contrast to the theme of a religion-free (but possibly spiritual) secular space was that of creating a truly ***pluralistic public*** *space* in healthcare

that was welcoming to all faiths, recognizing that, as one participant put it, ***"an organization such as a health authority must be accessible and appear accessible to every faith, every, every culture."*** Several of the participants were articulate about the importance of integrating both spirituality and religion, in light of the continued affiliation of many patients with organized religion, including the "lived religion" of many newcomers to Canada. For example, for many of the Sikh participants, religion, rather than spirituality was foregrounded. Sikh tended not to understand spirituality in the generic sense as existing outside of formalized religion, but rather understood spirituality as a state of devout, heightened religiosity.[10]

> ***"It's not us pushing our stuff or ignoring their stuff. That's what I'm afraid of. So if we, if we go to the whole spiritual route which to me says, okay, we'll just deal with an understanding of the most modern ways of expressing spirituality, then we're eliminating these people that are a little bit 'ooh, what's this thing mean' … if we're saying spiritual and we don't say religious, then we're eliminating a huge bunch of the population."***

- The realities of a diverse society in this study also demonstrated ***the ambivalences of religion*** as a source of social cohesion and/or violence. In some situations, profound connections (relational sacred spaces) were created between people with alike and different values and beliefs as religion and spirituality became avenues for connection. In other situations, persistent boundaries around who is deemed "Canadian" were reflected in comments such as ***"if they don't know English they should not be allowed to come to Canada"*** and by marginalizing practices such as ignoring religious prohibitions. When religion and/or spirituality are mobilized to exclude, social pathways that lead to health and social disparities are entrenched.

LIMITATIONS OF THE RESEARCH

Several limitations of this project must be noted. First, only English-speaking individuals were included. Second, by relying on volunteer and snowballing methods of sampling, certain viewpoints may be overrepresented in the data. Third, the study took place in one healthcare authority with its own unique trajectory of providing formal spiritual care services.

IMPLICATIONS AND RECOMMENDATIONS: Lessons Learnt

Findings from this study give direction for healthcare services and future research.

1. Caregiver Identity and Self-Awareness

- Self-reflection and self-knowledge are important in how relationships are established between healthcare providers and patients, especially across difference.
- Social identity (including ethnicity, profession, gender, and religious/spiritual affiliation) can play a key role in how religion and spirituality are addressed, especially in regard to views on spiritual caregiving in healthcare contexts.

2. Caregiver-Patient Relationships

- Respectful healthcare encounters in which caregivers seek to ***establish connections***, based on shared common humanity, are foundational to tending to matters of the spirit.
- ***Eliciting meaning*** (finding out what is important to the patient/family) is a related strategy that fosters spiritual caregiving, particularly in contexts of difference. Questions such as 'what do you think will happen?' or 'what did that mean to you?' are simple, effective ways of eliciting a patient's meaning system.
- Because religious/spiritual identity and affiliation encompasses all of life for some Canadians, caregivers should listen for cues from patients/families when faith perspectives, values and beliefs might influence health related decisions (such as treatment or end-of-life decisions).

3. Healthcare Services

- We need to articulate professional roles and work collaboratively to highlight the expertise brought by each team member. Spiritual care providers and volunteers hold multiple roles in healthcare settings in their relationships with patients, families, and employees.
- Barriers to the incorporation of religion and spirituality into healthcare service provision continue to exist and include: lack of time, training, and comfort on the part of caregivers; concern about stepping outside one's area of expertise and professional role; discomfort with the subject and fear of imposing one's values and beliefs on patients; and misconceptions that public secular healthcare services should be completely free of any religious and spiritual dimensions. These barriers can be addressed with education and communication.
- Multi-faith, plural environments that welcome different expressions of religion and spirituality are important. Sacred spaces (as designated ecumenical spaces as well as informal spaces) bring comfort and healing, but can be charged with political undertones. Involving various faith communities in the creation and maintenance of relevant sacred spaces (with meaningful religious symbols) and community spaces (such as visiting areas) communicates a spirit of inclusivity.
- Religion and spirituality can be pathways to social inclusion or further marginalization. Marginalizing practices (such as when a patient's religious/spiritual values and beliefs are not respected or integrated into care) can reinforce existing social pathways leading to health disparities, and inaccessible and/or inappropriate healthcare services.
- Interpretation of what is meant by ***secular and public delivery of healthcare services*** requires careful consideration. We suggest that to be secular does not mean the removal of all traces of religion and spirituality imagery and reference from hospitals; rather a public healthcare services must be welcoming of all faith traditions.

4. Future Research

- The negotiation of plurality in the provisioin of healthcare services in non-hospital (non-institutional) based settings is needed to explore how shifting relations of power affect how plurality is accommodated (e.g., home settings, rural settings).
- Much of the current research in this field is characterised by implicit or explicit assumptions founded in the Judeo-Christian tradition. Along with the acknowledged but unresolved difficulties associated with defining spirituality and religion, this results in research that is biased or inapplicable to people who choose to express their spirituality in a non-Christian way. A challenge for researchers is to conduct studies (and generate measures) of religion and spirituality that cuts across a range of religious traditions without robbing those traditions of their distinctive and substantive characteristics.
- Research methods are required that capture the complexity of religion and spirituality as intertwining with other social categories such as class, gender, and race.[11]

[10] Reimer-Kirkham, S. (2009). Lived religion: Implications for healthcare ethics. *Nursing Ethics 16*(4), 406-17.

[11] Reimer-Kirkham, S., & Sharma, S. (forthcoming). Adding religion to gender, race, and class: Seeking new insights on intersectionality in healthcare contexts. In Dhamoon, R., & Havinsky, O. (Eds.). *Intersectionality-type health research in Canada.* Vancouver, B.C.: UBC Press.

Several manuscripts reporting the findings or this study in more detail have been published (or in press):

Pesut, B., & Reimer-Kirkham, S. (in press). The negotiation of religious and spiritual plurality in healthcare: Situated encounters. *International Journal of Nursing Studies*.

Pesut, B., Reimer-Kirkham, S., & Sawatzky, R. (in review). Hospitable hospitals in a diverse society: From chaplains to spiritual care providers. Submitted to *Journal of Religion and Health.*

Reimer-Kirkham, S. (2009). Lived religion: Implications for healthcare ethics. *Nursing Ethics* 16(4), 406-17.

Reimer-Kirkham, S., & Sharma, S. (forthcoming). Adding religion to gender, race, and class: Seeking new insights on intersectionality in healthcare contexts. In Dhamoon, R., & Havinsky, O. (Eds.). *Intersectionality-type health research in Canada*. Vancouver, B.C.: UBC Press.

Sharma, S., Reimer-Kirkham, S., & Cochrane, M. (2009). Practising the awareness of embodiment in qualitative health research: Methodological reflections. *Qualitative Health Research*. 19(11) 1642–1650.

We are grateful for the assistance of Fraser Health Authority at various points in the research process, particularly the Professional Practice and Integration division. Our gratitude is also extended to the many health care professionals, spiritual care providers, patients, and administrators who participated in the project.

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