WHEN PRAYER SHOWS UP: A REPORT ON THE SOCIAL RELATIONS OF PRAYER IN HEALTHCARE

Project Leads:
Dr. Sheryl Reimer-Kirkham, Professor School of Nursing, Trinity Western University, Langley, Canada
Dr. Sonya Sharma, Senior Lecturer in Sociology, Kingston University, Kingston-Upon-Thames, England

Site Investigators:
Revd. Dr. Christina Beardsley, formerly Head of Multi-faith Chaplaincy, Chelsea & Westminster NHS Trust, London, England
Dr. Barry Quinn, Macmillan Director of Nursing for Cancer and Palliative Care/Senior Lecturer at Barts Health NHS Trust, London, England
Dr. Christopher De Bono, Vice-President, Mission, People and Ethics, Providence Health Care, Vancouver, Canada

Research Team:
(listed alphabetically by last name)
Dr. Lori G. Beaman, Professor and Canada Research Chair in Religious Diversity and Social Change, University of Ottawa, Ottawa, Canada
Dr. Paul Bramadat, Professor of History and Director of the Centre for Studies of Religion and Society, University of Victoria, Victoria, Canada
Dr. Sylvie Collins-Mayo, Associate Professor in the Sociology of Religion, Kingston University, Kingston-Upon-Thames, England
Dr. Andrew Todd, Senior Lecturer and Director of the Professional Doctorate, Cambridge Theological Foundation, Cambridge, England

Research Coordinator:
Brenda Corcoran Smith, RN, MSN, School of Nursing, Trinity Western University, Langley, Canada

Post-doctoral Research Fellow and Research Associate:
Dr. Rachel Brown, Religious Studies Teaching Fellow, Centre for Studies of Religion and Society, University of Victoria, Victoria, Canada
Dr. Melania Calestani, Lecturer in Research Methods, School of Allied Health, Midwifery and Social Care, Kingston University and St. George’s, University of London, London, England

Research Assistants:
Sandra Graham, RN, MSN, School of Nursing, Trinity Western University, Langley, Canada
Kyla Janzen, RN, MSN, School of Nursing, Trinity Western University, Langley, Canada
Anne Redmond, RN, MSN, School of Nursing, Trinity Western University, Langley, Canada
Kelly Schutt, RN, MSN Student, School of Nursing, Trinity Western University, Langley, Canada

Transcription:
Jan Farquhar, Transcription, Abbotsford, Canada
Julene Reimer, Transcription, Winnipeg, Canada

Graphic Design:
Helma Sawatzky, Graphic Design, Surrey, Canada

Design & Layout:
Naomi Shields, Victoria, Canada

Cover Image Credit:
John Towner, Unsplash
Figure 1: Research Team September 2017

From left to right: Christopher De Bono, Brenda Corcoran Smith, Sonya Sharma, Barry Quinn, Melania Calestani, Christina Beardsley, Rachel Brown, Andrew Todd, Sheryl Reimer-Kirkham, Lori Beaman, Paul Bramadat. Missing: Sylvia Collins-Mayo

Funder:

This research was supported by the Social Sciences and Humanities Research Council of Canada. #435-2015-1729 (2015-2018)

Acknowledgements:

We acknowledge the participants who made this study possible, and the Practice Advisory Groups in London and Vancouver.

Trinity Western University is located on the traditional ancestral unceded territory of the Sto:lo people.


See: www.prayerastransgression.com

How to cite this report:

EXECUTIVE SUMMARY

The project explored the ways that prayer shows up—whether embraced, tolerated, or resisted—in healthcare, and how institutional and social contexts shape how prayer is understood and enacted. The research team, led by Dr. Sheryl Reimer-Kirkham (Trinity Western University, Canada) and Dr. Sonya Sharma (Kingston University, England), conducted fieldwork in 21 healthcare sites in London, England and Vancouver, Canada. We observed and interviewed 109 people including chaplains, healthcare professionals, administrators, former patients and families.

This Report is intended to inform the practices and policies of healthcare professionals, chaplains (also referred to as spiritual care practitioners), spiritual care practitioners, administrators, policy-makers, educators, and other stakeholders.
Ten key findings of this study:

1. Prayer shows up in healthcare contexts even amidst settings such as hospitals that are typified by high acuity, technology and managerialism. These high-paced environments can in turn result in prayer becoming invisible or less of a priority.

2. Prayer is somehow special or set apart, and transcends or goes beyond a moment or circumstances. Although prayer takes various forms, prayer is distinctive from other spiritual and non-spiritual practices. Prayer is communing with God or a Higher Power, but prayer also transcends present circumstances through a sense of the mystical, an experience of deep understanding, or profound relational connection.

3. Generic approaches to spirituality, with their intent to be inclusive, can miss the specificity of people’s spiritual and religious preferences. Similarly, multi-faith approaches can lead to assumptions about religious identities and leave unattended those who are spiritual but not religious or the non-religious. Both approaches can miss the array of differences present in today’s diverse societies.

4. Prayer moves across a continuum between formal religious traditions to non-religious practices. By whom and when prayer occurs can be difficult to anticipate.

5. Prayer is present through material objects in healthcare settings, from crosses, Humanist pamphlets, and Indigenous artifacts to a nurse’s apron substituted for an Islamic head covering. Symbols of majoritarian religions are in some situations given preference, especially when communicating the heritage or administration of an institution.

6. Prayer spurs from the presence of the arts and nature in healthcare settings.

7. Prayer finds its way more easily into seemingly secular spaces of healthcare through organizational mission statements that make way for equity, diversity and inclusion.

8. Prayer takes various forms in clinical settings such as Critical Care, Mental Health, Long-term Care, Street Clinics and Palliative Care.

9. Prayer is personal, reflecting the current needs of many who confront health and illness. Prayer is also political, addressing issues such as employment, education, housing and citizenship.

10. Prayer contributes towards deep equality, bringing people together amid crises and differences. A commitment to deep equality also creates space for the absence of prayer, where it may not be meaningful, relevant, or practised.
What was this study about?

This study set out to examine how prayer is expressed in healthcare settings, as a window to deeper insights on the negotiation of religion in the public sphere. Increasing religious and ethnic plurality, following decades of secularizing trends, is resulting in new attention being given to how religion and non-religion are expressed and negotiated in public spaces. Healthcare settings are notoriously complex places where life and death co-exist, and where suffering is an everyday occurrence giving rise to existential questions. At the same time, healthcare contexts reflect the full range of society’s diversity in its patients and staff.

Prayer shows up in a variety of forms, circumstances, and places. As a spiritual practice, it operates as counterpoint to the technologies, temporalities, and sensibilities of biomedicine. We examined the ways prayer highlights trends of secularization and sacralization in healthcare settings; how healthcare protocols complicate practices of prayer, such as how, when, where and if it occurs; and the ambivalences about prayer arising from staff and patients’ varied views on religion and spirituality, associated ethical concerns, and clinical and workload demands.

Moreover, we were aware and anticipated that prayer might not always be welcome. Thus, we framed the project with the questioning concept of “transgression”. We came to a definition of transgression through feminist and social theorists who view transgression as the ability to go beyond limits and conventions, to deny and affirm differences, to move against and beyond boundaries (e.g., hooks 1994; Taussig 1998). We were interested in how prayer (with religious and non-religious meanings) might disrupt the order of things, including the seemingly rational and secular nature of healthcare. Here is what we learnt, in brief form, about prayer as transgression:

- Prayer showing up served to transgress any assumption of a religion-free (entirely secular) public space.
- Prayer transgressed social difference. In some cases, perceptions of difference were diminished by prayer; in other cases, difference was amplified.
- Prayer transgressed the mundane and urgent concerns that mark healthcare settings, to open spaces in which to experience, relate, and think differently.
How did we do the research?

We began our 3-year ethnographic study in the autumn of 2015. The study’s objectives were to:

1. Examine how prayer transcends and/or heightens difference by connecting and/or distancing individuals.
2. Analyze how prayer transgresses institutional routines in the everyday, by examining how patients, staff and volunteers navigate regulated hospital schedules to meet needs for prayer.
3. Explore situations in which prayer might enact institutionalized power or a governmentality of religion.
4. Examine how acts of prayer transgress the secularity of public spaces, to gain insight into the expression of religion in public institutions.
5. Theorize new ways of understanding everyday acts and the ‘power’ of prayer to harden, blur, or bridge unlikely boundaries.

We interviewed 109 participants (50 in Vancouver, 44 in London, and 15 in a pilot study), consisting of five participant groups:

- Chaplains (also referred to as spiritual health practitioners or spiritual care providers).
- Spiritual care volunteers.
- Administrators at various organizational levels.
- Healthcare professionals (e.g., nurses, social workers, doctors, physiotherapists).
- Former patients or family members.

Pseudonyms are used to protect the anonymity of our participants. For a more detailed description of the participants, please see Appendix I.

Across 21 research sites, located in Vancouver, Canada and London, England, we conducted interviews; photographed sacred spaces (formal and informal); examined artifacts, artworks, and surrounding nature; collected and analyzed participant prayer journals; and reviewed relevant organizational policies.

The chaplains (our primary sample) participated in a series of three interviews over a 12-week period. The initial interview provided an entry point for establishing participant-researcher rapport while gathering data related to the role of the chaplain and the definition, form, and content of prayer. During the second interview, a walking interview, participants were invited to lead researchers to the spaces that were significant to their work and in which prayer happened. In the third interview, we attempted to elicit how chaplains accommodate and resist institutional healthcare conventions, relations of power, and social differences, and sought chaplain recommendations related to practice, policies, and resources for spirituality in healthcare environments. Chaplains were also asked to keep a research journal recording a minimum of three experiences over the course of a six-week period that described how they enacted prayer and the relationships and contexts in which prayer occurred.

With administrators, healthcare professionals and citizens, we conducted in-depth, semi-structured interviews lasting approximately one hour. These interviews contributed to the broad depiction and understanding of prayer in healthcare settings. The qualitative approach to analysis of our data is described at the end of our report.

Please see Appendix II for more detail.
What happens when prayer shows up?

Prayer shows up in hospitals, long-term care facilities, and community-based clinics in a variety of ways. Mostly, prayer occurs quietly on the edges of day-to-day healthcare provision, with patients, families, and chaplains huddling in corners or bowing behind curtains. Some requests for prayer from patients, however, interrupt the clinical machinery of a hospital, such as when a patient asked for prayer from the chaplain while the operating room waited. More visible and ongoing requirements for prayer—a space for Muslim prayers, a space for Indigenous ceremony—have obligated many healthcare settings to approach prayer and other contemplative practices in new ways. Where a Christian chapel traditionally covered off needs for prayer, today’s healthcare contexts are creating inclusive spaces for a diversity of spiritual practices and religious services. The increasing numbers of those unaffiliated with a religious tradition present additional requirements on to healthcare settings, such as quiet, beautiful spaces for contemplation, or windows to capture light and expansive vistas.

The increasingly diverse religious and non-religious citizenry in London and Vancouver was represented on chaplaincy teams to varying degrees (more so in London than in Vancouver).

In both Vancouver and London, those we spoke with about prayer did so with an element of caution – even the topic of the study surprised people. The overarching message was that prayer was not to be taken lightly or offered inappropriately:

- As integral to religious traditions and involving the sacred, prayer was to be respected because people tended to hold it dearly.
- As a marker of religious difference or affiliation, there was an extent to which prayer could be divisive.
- As part of a history of abuse of power, it was not to be foisted on anyone – it was to be person-centred.

In the next sections of the Report, we provide more detail, answering the questions of: What forms did prayer take? What did people pray about? Who prays? Why did people pray? When did people pray? Where did people pray? What did this study tell us about religion and society?
FINDINGS

WHAT FORMS DID PRAYER TAKE?

There was variation and leeway in the forms prayer took in healthcare settings. The forms we discuss below operate on a continuum (e.g., both/and); they are not conceptualized as dichotomous (e.g., either/or).

Religious, non-religious, and in-between

- Religious prayers were understood as located within a religious tradition, whether Buddhist, Catholic, Muslim, First Nations, or Sikh and so on.
- Non-religious prayers were less likely to be restricted by religious forms and were directed to “the beyond,” “the universe,” or more immanently embedded in the day-to-day between people.
- Prayer could be experienced as being in the presence of art or nature.
- Prayer could also be viewed as “in-between”. Such “praying between the lines” could encompass many things, forms, relationships and histories, blurring religious and non-religious traditions and rituals.

Within this range, prayers were theistic (in a relational stance with God/Higher Power/deity) and non-theistic (such as communication with nature or a deeper self-expression). In either case, prayers were distinct, special, and “set apart” from ordinary communication or thought.
Informal prayers on the other hand were unstructured and spontaneous. Examples included:

- “Listening to someone’s story” (Chen, healthcare professional, Vancouver).
- “Prayer puffs” as a means of “sending a little prayer your way,” to anxious waiting family members (Jane, chaplain, Vancouver).
- Expressions of dance and listening to music, for example, to opera singer Andrea Bocelli’s song “Prayer.”

Self and others

Prayer was relational, whether said amongst two or more persons or between a person and another energy life-force, divine being or deceased loved ones. Prayers could become an avenue to greater transparency, sincerity, and vulnerability, as “a space where I don’t need to pretend anymore” (Taryn, chaplain, Vancouver).

Participants described this relational aspect:

- “Connecting with the sacred.”
- “It’s about communication and listening and hearing what God says.”
- “Prayer is the internal experience and people will pay attention to their internal experience or not.”
- “Prayer is how we connect with a superior being, deity, or just our own deeper self.”
Collective and individual

Collective and individual prayers were equally common. Collective prayers were usually said in large and small groups, such as at a religious service. Prayers (or non-religious reflections) were offered at the beginning of a Board meeting in Vancouver, at a weekly Christian Fellowship in a London hospital chapel, and in the viewing room near the morgue that consisted of chanting in the presence of family and their deceased loved one to release the expression of grief and emotions.

Individual prayers were those of a chaplain said silently entering the hospital at the start of the day, or a Muslim doctor slipping into the Multi-Faith Space in London to say prayers. Individual prayers were also non-verbal, such as “prayer is breathing.”

Material and immaterial

Religious artifacts facilitated prayer in healthcare, representing material forms of prayer. Participants discussed physical objects such as prayer beads, prayer mats, headscarves and turbans. Zara, a healthcare professional in London, talked about the importance of prayer bags: “It helps you to connect spiritually because you feel like there is somebody religious, caring, kind and [who is] thinking of you.” Crosses hung in many rooms at one research site, but staff knew that these could be viewed negatively, and therefore removed them if requested by patients or families.

For others, the immateriality of prayer meant no prompts were required to take them beyond their immediate or physical situation. Curtis said, “prayer transcends reality by its very nature, it is connecting with that which is beyond” (chaplain,

WHAT DID PEOPLE PRAY ABOUT?

The content of prayers said in hospital, long-term care, and clinic settings revealed much. Prayer involved coming to terms with or making meaning of one’s circumstances (Giordan and Woodhead 2015). An Indigenous elder said it this way: “Pray about it and you will get an answer. Pray about it and you will find an answer.” The slight shift between the first and the second sentence suggests insight might come from external or internal sources.

The prayer books and cards in hospital sacred spaces (chapels) were well used. These written prayers were usually intercessory (praying on behalf of patients or staff), and could involve affirmations of faith and expressions of praise.

Some anonymous examples from the prayer books:

• “Once again I am writing a note of encouragement. If you lose someone, I know it is sad, but focus on fond memories and the promise of everlasting life in paradise.”
• “Dear Lord, have mercy on my sister in palliative care.”
• “Thank-you, God, for helping my mom and the surgeon get through her surgery!”
• “Sisters lost yet never ever forgotten (with a drawing of a cross and flowers).”
• “Bless my sons with good marks in their education.”
WHO PRAYED?

A surprising cross-section of people pray in healthcare - they may be religious or non-religious, sick or well. The identities of those who prayed varied by ethnic background, sexual orientation, age, education, and any other demographic variable. Yet, we are cautious not to claim that everyone prayed. There were some for whom prayer was foreign. Some described other non-religious rituals apart from prayer. Yet others did not find spiritual practices, whether religious or non-religious in nature, meaningful.

Chaplain practices

Not surprisingly, those in spiritual care (i.e., chaplaincy) roles were most likely to report that they prayed with patients, often many times a day in both formal and informal settings. One chaplain wrote in their research journal: “something that chaplains, almost uniquely, can provide: prayer”. While other staff might from time to time also pray with patients, it was chaplains who offered prayer most often in their role. Chaplains also emphasized being in an internal stance of prayer, for example, in a meditative attitude.

Chaplains could be both centrally and marginally placed within healthcare settings and often were navigating and negotiating their presence and position with and among patients, families and staff. They were skilled in dealing with the unexpected and challenging decisions, accompanying those through difficult processes of health and illness. They were able to pray within and outside of their religious traditions.

Prayers inside and outside of faith traditions

==> Inside. Chaplains prayed with those from their faith tradition: Paul, a Catholic chaplain, for example, explained how he had spoken to an elderly Catholic patient about the “Irish faith family traditions” that they both knew, which led them to saying the rosary together. An advantage of chaplains working within their own faith was that they had knowledge of the prayers most likely to be familiar to patients, even if the patient had lapsed in practise. They also had the knowledge and dexterity to modify traditional prayer practices to meet patients’ needs where appropriate. Ali, a Muslim chaplain described how he would teach a bed-bound Muslim who could not get to a mosque or assume the normal prayer positions, how these conventions could be adapted to current circumstances: “You can stay in your bed, if you can’t move your head, fine. If you can’t move your head, just say it with your eye. You can pray with your eye.”

==> Outside. When participants did not match or share a faith tradition, or did not feel comfortable doing so, they employed other strategies to maintain or cross boundaries while respecting difference. As Jane asserted, “When I pray with people, they pray with me, we are crossing boundaries. It’s not like anything else because prayer crosses so much. It crosses people’s lives. It crosses faith traditions, religions.” Bao, a spiritual care volunteer said, “We don’t care whether it’s Catholic or Christian or Sikh or whatever. If they call us, we’re going to go.”
Healthcare professionals’ perspectives

Healthcare professionals expressed an array of viewpoints on prayer in the healthcare setting. Many welcomed it, but only if it was deemed appropriate. Some prayed individually for patients and families and many were aware of the hard histories associated with prayer as a religious practice.

- “I pray on my own for a patient and when I’m with patients, silently in my mind I will pray, and I’ll do that on my own if someone’s really struggling and I don’t know how to help them.” (Ameena, healthcare professional, Vancouver)
- “Prayers can be damaging for people when they come from a critical parental voice which reinforces shame or feeling bad about yourself, guilt, all of those things.” (Ersi, healthcare professional, London)
- “The Sisters prayed for her last Friday, and you know what, I think it made him feel much better.” (Sharon, administrator, Vancouver)
- “Prayer is part of spiritual care, but only when it is appropriate.” (John, administrator, London)

Patient-led and person-centred

Interestingly, whether patients engaged with prayer did not follow predictable lines. Chaplains and healthcare staff mused that who might appreciate prayer could be unexpected: it could be someone of any social standing, any sexual orientation, or any faith or non-faith affiliation. Equally, some who one might expect to pray did not. Therefore, it was important that prayers were patient-led. Chaplains and spiritual care volunteers discussed this approach in their work and were very aware of not wanting to impose practices or beliefs, but rather took direction from patients and families. “You take your cues from the situation, the environment, the people within that space. There is an element of permission to pray, you ask, ‘what does prayer mean to you?’” (Taryn, chaplain, Vancouver). The process of prayer came about by seeking permission and determining whether there was a desire by the patient for prayer. By far the majority of descriptions in our study were those of prayer offered in careful, person-centred ways to patients and families, but a close reading of the data revealed times when patients and families could be left to their own devices for prayer or simply ignored, or conversely, openness to prayer could be assumed.

WHY DID PEOPLE PRAY?

Prayer in healthcare settings was typically in response to something—whether crisis, sickness, or death. Underlying (or motivating) these responses were the beliefs and values of organizations and individuals.

Organizational values

The values of an organization, expressed in mission statements and resource allocation, could shape how prayer was understood in healthcare contexts. Mission statements could be religious in nature or secular and values-based, but in either case could communicate permission to pray. Values such as respect and dignity were interpreted as requiring a responsiveness to a patient’s preferences, including requests for prayer. A caution in faith-affiliated organizations is the imposition of prayer on staff and patients. For this reason, one faith-affiliated organization had taken great care to remove all religious
symbols and icons so as not to offend. Likewise, where prayers broadcast over an “intercomm” system had been the practice at several sites, it continued in only one site.

Resource allocation involved, for example, chaplaincy positions and space (“real estate”) dedicated to sacred spaces such as chapels, prayer rooms, and gardens. One site was exemplary in its provision of spaces, but was in constant negotiation in the number of chaplaincy positions (with the threat of cutting these resources). At another site, the number of paid chaplaincy positions was well above the national norm, but the sacred spaces were small and in out-of-the-way places.

Individuals’ motivations

For the most part, participants were motivated to engage in prayer in accordance with what they believed about prayer (Reimer-Kirkham et al. 2017). The following intentions were present:

**Therapeutic:** Chaplains and staff often offered prayer to promote wellbeing (e.g., hope or comfort). Sometimes patients asked for healing prayer, as reflected in the comment, “Some will say, please will you pray for God to heal my leg, I’m having pain. Then you pray in that direction.” (Frida, spiritual care volunteer, London)

**Pastoral:** Those who offered prayer might be tuned to spiritual formation or growth: “I want them to know that God sees them as a precious individual. I want to reaffirm who they are, to us as a community but also to God.” (Bill, chaplain, Vancouver)

**Sociocultural:** Prayer could be offered to underscore identity and offer a familiar ritual: “Prayer is a lot more cultural than religious for a lot of people; and that’s a lot of our residents.” (Samuel, chaplain, Vancouver)

**WHEN DID PEOPLE PRAY?**

The dimension of time in relation to prayer was an important finding. Here we present two temporally-related themes: (i) that passages or transitions were often times when prayer was requested; and (ii) that prayer could transgress or change ordinary time. Prayer could interrupt clinical urgencies and even transcend time all together. Art and nature were often cited as important to prayer in this respect of disrupting ordinary time.

**Passages as a time for prayer**

Some of the participants were more likely to “time” prayer to end-of-life, as reflected in these two excerpts:

“Most of prayer is around death… prior to death, either at that time or shortly after death, either with the residents or with the family, or possibly with staff and then in the mini-memorial.” (Mila, chaplain, Vancouver)

“At end-of-life I think we accommodate religious and spiritual needs very much in healthcare.” (Zaria, healthcare professional, London)

One participant very intentionally did not limit prayer to end-of-life, but rather musing that any change or passage could make one more in need of prayer:
I wouldn’t necessarily restrict prayer to dying. I might broaden it out to any time there is a significant change in the direction of life. That can include those things like the birth of a child. It could also be the loss of a limb. It could be receiving a terminal diagnosis. It could also be the chemotherapy you’ve responded well to it and we’re hopeful that you will be cancer free moving forward. It is anytime that the trajectory departs significantly from that which is expected. (Curtis, chaplain, Vancouver)

Prayer amidst clinical temporalities

Prayer was found amidst the temporalities of clinical contexts. The urgency of providing treatment, the scheduled times of giving medicine, the routines of care given by healthcare professionals, the time and spaces needed to rest and repair the body. What happens when prayer enters in to alter these temporalities? We saw prayer show up through the arts and nature to transform clinical time, by interrupting the urgencies, slowing down the present, or erasing time all together.

Prayer and arts

Time taken to be with a higher power such as in a religious or non-religious space can be qualitatively different from other ordinary mundane times and spaces (Eliade 1959; Kirk 1990). Paul, a chaplain, reflected on the art found in a chapel of one London site.

At that hospital, there is something there for me, which represents my belief in the way I want to express it, for example, the painting, whether you have any faith or not… it’s a painting that is expressing something, while behind you there’s a whole hospital going on … At that hospital the calmness is created by some of the imaginary.

Art, for Paul, created a “calmness,” time away and apart from the “whole hospital that is going on” around him.
The arts (i.e., dance and movement classes, fine art, sculpture and music) could provide our participants a vehicle for which to engage with another being and to mark a sacred time and space amidst a high-paced ethos of clinical care. Elaine, an administrator, described prayer as “reflection” and expressed similar sentiments about the art found in the healthcare context she worked: “When you walk around the hospital, you see a lot of both staff and patients looking at the artwork and talking about it ... It lifts the spirit.”

Taking time to view the art could be thought of as the sacred merging into the ordinary activities of an appointment and the going to and from an office. “Sacred and profane” temporalities transgressed each other.

Prayer and nature

Indoor and outdoor gardens, park benches, flowered terraces and views from windows that looked onto mountain views or trees and cityscapes provided healthcare users ways to connect and be with nature. Nature also had the capacity to slow down or shift daily clinical routines:

I brought you out to the smoking area in the garden. I see people out there and they’re on their own and stuff is going through their heads when they’re out there. They’re going through something when they’re out there. To my mind that’s almost like a place of prayer. (Jane, chaplain, Vancouver)

[Nature is important] especially for other faiths … Buddhists and Hindus. Some Sikh doctors or nurses may come here. Sometimes I come here when I’m tired and I need some quiet time. I sit down here. It’s often on my way to somewhere else. I go around the wards for one hour or one hour and half and then I stay here. (Luis, chaplain, London)

Separation between sacred and profane may not be so clearly demarcated. Time for God or prayer can be planned and set apart and also unplanned and all the time, when temporalities of prayer in relation to art and nature are non-linear and are time spent within time, blurring and transgressing temporalities of clinical routines.

WHERE DID PEOPLE PRAY?

In our research, geography mattered to prayer. It mattered to when, where and why prayer could happen and how it was constructed. Prayer and space are co-constituted resulting in formal, informal, in-between and unexpected spaces of prayer. Figure 2 depicts where prayer happened in our research sites, in formal and informal spaces of prayer.

Formal and informal spaces

Formally designated spaces for prayer and religious services in healthcare settings included chapel spaces, prayer rooms, meditation and quiet rooms, Indigenous spaces for spiritual rituals and multi-faith spaces. If healthcare settings did not have a designated space, they would find ways to make one such as a chapel space created in a corner of a dining room, transforming it from a mundane eating space to sacred space via an altar and sacred texts and stained-glass art.

Informal spaces included unofficial sites of prayer that were in non-designated areas and identified as particularly meaningful by our participants. These were seemingly ordinary spaces, outside of the “officially sacred” (Kong 2001).
A chaplain explained:

*I will pray in quiet rooms, I’ll pray at a patient’s bedside, I will pray on the garden terrace. I could be comfortable praying on a garden bench in a park with a patient, if I take a patient for a walk.* (Niall, chaplain, Vancouver)

Many received prayer at the bedside. Corridors, the smoking area and gardens spaces as mentioned above were informal spaces where prayer also occurred.

**In between and unexpected spaces**

Sometimes the mundane spaces of everyday life could be spaces of prayer that were in between and unexpected. For example, a Humanist chaplain showed us the entrance to the Chapel, which could be considered the boundary between the formally designated space of prayer and an ordinary one. With the Christian altar in the background, she gestured to a rack used to display some Humanist booklets. This was considered meaningful to her, a way to make the non-religious visible in the religious space.
Unexpected spaces included the elevator, where chaplaincy staff recalled being stopped by patients on their way to surgical theatre. They were frequently asked to pray for and with them, implying that the ordinary elevator space was transgressed by prayer. Likewise, they talked about specific rooms in some wards, outside surgical theatres or in the doctors’ lounge.

**WHAT DOES THIS STUDY TELL US ABOUT RELIGION AND SOCIETY?**

The public space of healthcare is one in which the social dynamics of diversity are worked out in the day-to-day. This study on prayer provides a window into these dynamics, especially around four trajectories.

1. **Secularization of healthcare institutions.** For centuries, religious institutions and communities have been involved in caring for the sick. As healthcare became institutionalized with government oversight and funding, the influence of religious communities has lessened. In sociological terms, secularization has resulted in what Jose Casanova (1994) refers to as the institutional differentiation of secularization, whereby functions that were once carried out together (i.e., spiritual and healthcare delivered simultaneously by the church) fall into separate spheres with their own norms and institutions. As a result, public institutions such as healthcare for the most part no longer need or are interested in maintaining a “sacred cosmos or maintaining a public religious worldview” (Casanova 1994, 37). Religion, then, continues its presence in healthcare, primarily through the religious identities that individuals and groups carry, rather than through institutions. However, even in the publicly funded healthcare systems in both Britain and Canada, remnants of institutionalized religious influence remain. For example, the state has agreed in some cases to permit faith sponsored healthcare to continue, through agreements which still reflect the core mission (which is religious). Some of the healthcare organizations in which we conducted this study were faith-affiliated, resulting in a hybrid space with increased visibility or presence of religion, though no longer in a monolithic or hegemonic way. Rather, the religiously and ethnically diverse societies created a demand to open up to pluralistic expressions of religion and prayer.

2. **The globalization of religion.** Vancouver and London are both cities in which the presence of globalized religions is quickly evident. Diaspora in new lands typically maintain links to the communities from which they came through religious identities and networks. In Canada, immigration from Asia, the Middle East and Africa has created ever-growing Buddhist, Hindu, Muslim, and Sikh communities (Statistics Canada 2017). According to the 2011 census, England’s current religious profile shows 59% self-identifying as Christian, 25% as “nones”1, 5% as Muslim, 4% adhering to religions including (in order of frequency) Hinduism, Sikhism, Buddhism, and Judaism, and another 7% who do not indicate religion (i.e., missing data) (ONS 2012). This diversity has required healthcare settings to accommodate the prayer needs of staff and patients; providing space and time for Muslim prayers has become commonplace.

---

1 “Nones” encompasses a diverse group of those who do not identify as religious. With this grouping we cite sociologist Sarah Wilkins-Laframme who describes nones as “individuals who say they have no religion because they either do not identify with a religious group or tradition, or conventional Western religious labels do not apply well to them (which is especially the case for some Indigenous and Asian groups)” (2017, 2).
3. Decolonizing religion and healthcare. Another trend involves the decolonization of healthcare (and other public) institutions. In Canada, this movement has been accelerated by the 2015 Truth and Reconciliation Commission. The Commission’s Call to Action #22 states “We call upon those who can effect change within the Canadian healthcare system to recognize the value of Aboriginal healing practices in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients” (TRC: Calls to Action 2015, 3). Separate spaces demonstrated Indigenous rights within a hospital. Prayer ribbons, stones and cedar bows, sage for smudging, objects for traditional tea and the drum for healing circles could be found in these spaces.

4. The rise of non-religion. Amidst secularization and globalization of religion, Vancouver and London healthcare settings are also host to increasing numbers of the non-religious. In this regard, healthcare settings provide an excellent “laboratory” for how the non-religious engage with spirituality and contemplative practices, including prayer. The trajectory of healthcare chaplaincy from “pastoral care” to “spiritual care” and, more recently, “spiritual health” has been intentional in communicating inclusivity for all, not just those who are religious. The self-identification as “spiritual but not religious” came up frequently in our study, but not necessarily as a barrier to prayer.

In light of this, how did prayer fare?

First, asking about prayer revealed a full range of spiritual practices in healthcare contexts where existential questions may be provoked. This Report has provided numerous examples of religious and non-religious prayer, including prayer across and between lines of social difference.

Second, prayer “showed up” as a meaningful ritual and corporate practice in times of city-wide crisis. In London, a chaplain was called to be on standby to provide prayer at the hospital when it was put on alert during the March 2017 terrorist attack outside the Houses of Parliament. In Vancouver, a city-wide vigil and prayer was organized by the hospital to honour the lives lost to the opioid crisis. In these ways, prayer crossed beyond hospital walls.

Third, in the midst of clinical demands and organizational priorities, prayer was often sidelined. It needed to fit in and around urgent procedures, hi-tech equipment, and noisy waiting rooms. For some, it was viewed as outside the “core business” of healthcare, or simply unfamiliar. Amidst fiscal constraints, chaplaincy services were sometimes threatened; as one manager put it, “if made to choose, it would be another critical care nurse over a chaplain.”

Fourth, prayer could create some tensions to be negotiated and worked out “on the ground”, but this was not the dominant story we heard. We did hear of staff anticipating problems and acting discretely to avert problems (e.g., in removing crosses from patient rooms). This working it out in the day-to-day exemplifies deep equality (Beaman 2017).
RECOMMENDATIONS

As a multi-disciplinary group of university researchers (sociology, anthropology, theology, chaplaincy studies, religion, and nursing) and healthcare organizational leaders, we sought to explore the ways that prayer is manifest—whether embraced, tolerated, or resisted—in healthcare settings.

We found that prayer, although tolerated and supported within secular and faith-based public healthcare organizations, was complex and even tentative on the ground. It was for the most part delivered sensitively.

Emerging from our analysis of participant interviews and Practice Advisory Group meetings with chaplains, administrators and healthcare professionals, we offer the following recommendations.
Throughout our study, chaplains cited person-centeredness as core to their work. Such a stance accounts for diversity, fosters cultural safety, and requires self-awareness of one’s own social positioning and limitations in knowledge. The following recommendations aim to enhance this approach:

1. Create educational opportunities for chaplains and healthcare professionals for equity, diversity, and inclusion training. Incorporate education on structural vulnerabilities and barriers that impact on spiritual, emotional, and physical wellbeing, so that staff can adequately and sensitively respond to patients and families.

2. Provide education for chaplains and healthcare professionals to enhance religious literacy, focusing on those traditions most common in the surrounding community. This should include foundational knowledge about spirituality in the context of health and healthcare, and the spiritual needs and rituals of nones. Such education should also be incorporated into pre-registration education.

3. For Canadian sites, relationship building with Indigenous communities is vital. More work on integrating the spiritual traditions of Indigenous persons and communities is needed both within healthcare delivery and in partnership with existing spiritual care teams.

4. Consider intersecting factors that may necessitate practices that address individual preferences. Patient vulnerability and gender preferences may transgress assumed cultural or religious norms. For example, a female Muslim patient may prefer a female Christian spiritual care practitioner rather than a male Imam.

5. Foster relationships with faith leaders in the community, other stakeholders and networks in an effort to enhance spiritual health services for all. Explore the creation of roles such as religious or cultural brokers who could assess social and religious change, using this information to bridge constituent needs with healthcare services.

6. Aim to provide spiritual care in the preferred language of the patient. This will in many cases require the use of interpretation and translation services.

7. Review and adjust the diverse representation of a chaplaincy team, such that a range of identities are included.
Chaplains across research sites highlighted a desire to raise their professional profile and augment their legitimacy as members of the multi-disciplinary healthcare team. Spiritual care volunteers and community-based faith leaders desired acknowledgement for providing a valuable service within healthcare settings. The following recommendations can strengthen the contributions of chaplaincy:

1. Spiritual care interventions should be understood as part of holistic and clinical care. This requires ongoing professionalization of the discipline.

2. The model of chaplaincy services, grounded in the social composition of its constituency, may require a combination of generic and multi-faith approaches in order to provide spiritual care to all patients, families, and staff.

3. Encourage inclusion of chaplains in multi-disciplinary clinical rounds. Not all patients may want chaplain participation, but everyone should have the opportunity to opt in to chaplaincy services.

4. Facilitate access to patient electronic medical records. Without access, spiritual care assessments, interventions, and subsequent evaluations may be left undocumented, or documented as a separate record, thereby negatively affecting the continuity of care. Spirituality as a clinical issue is then less visible.

5. Provide education and information for staff and the public on the role of chaplaincy within healthcare settings.

6. Support the provision of spiritual care throughout the life span, not only in relation to death and dying. Continuing professional education should be equipping staff to provide spiritual support in all clinical areas, integrated into day-to-day healthcare encounters.

7. Create an ethos where all contributors to spiritual health, including community-based faith leaders and spiritual care volunteers, are valued and welcomed. This can be as simple as allowing for a secure place to store personal items while on site or extending invitations to spiritual health team meetings. Multi-faith networks can do much to support healthcare services in general, and spiritual care specifically.

8. Support further research related to spirituality in healthcare settings, including where chaplains take the lead as principal investigators.
Chaplains, as well as hospital staff, identified a need to create, expand, or reconfigure indoor and outdoor sacred space within their respective healthcare organizations. The following recommendations address how to make sacred space available and accessible:

1. Dedicated sacred spaces are sanctuaries from high-pressured biomedical clinical areas. Religious services and sacred rituals continue to be meaningful in hospital settings and invite prayer. The provision of a prayer request book facilitates the expression of spiritual concerns in meaningful, healing ways.

2. Establish measures and procedures that will accommodate a variety of physical and psychological limitations for those patients seeking to access sacred spaces. Visible and clear signage is an important aspect to making sacred spaces accessible.

3. Just as the spirit is fluid, so is sacred space. Create spontaneous sacred space with the use of visual cues (e.g., butterfly decals or purple dots to signify a temporary repurposed sacred space). The integration of the performing arts within public spaces of healthcare, such as dance and song, can create occasions of spiritual expression for some, while the display of fine arts invites meaningful spaces for reflection for others. For many, indoor/outdoor gardens, water features, and soundscapes can generate serene spaces.

4. Consider the aesthetics of a sacred space with the use of color, lighting, material artifacts, ventilation, and building materials. Create inviting and inclusive spaces. Non-religious rituals and services also require space and can create opportunity for spiritual reflection, meaningful comfort and solace for patients, families, and staff. Some organizations choose to provide a multi-faith space; others provide faith-specific space; others provide both. In either case, intentionality, consultation, and representation are important in creating an equitable spatial experience.
How healthcare organizations respond to diversity is vital. From our study, it was evident that London and Vancouver healthcare organizations set the tone for spiritual care within their respective institutions. This organizational response is closely tied to government agendas and resource allocation that can support or dissuade spiritual care provision. The following recommendations guide organizations in the support of spiritual care services:

1. While prayer may not easily fit into competing organizational and clinical priorities, our research findings suggest that organizational mission statements and core values can integrate religion and spirituality as part of holistic care. Whether secular or faith-affiliated, to support a diverse constituency, healthcare organizations can make more explicit their support of spiritual health and spiritual care as a core value. This will give permission to those staff with hesitations about spiritual care to support the spiritual beliefs and practices of patients and families.

2. Explicit organizational support needs to be followed up by resource and space allocation so that staff and the environment supports the spiritual beliefs and practices of patients and families.

3. Create policy (or fully implement existing procedures) for collecting and accessing patient data relevant to their belief system and health. Generate a systematic referral process rather than leaving it solely to patients and family members to request, or for chaplains and volunteers to seek out.

4. Resource professionally-trained spiritual care staff. Accurate and comprehensive spiritual assessments are fundamental to safe and effective spiritual care where needs are recognized and adequately addressed.

5. Healthcare professionals should also be educated to provide point-of-care (or primary) spiritual support such as compassionate presence, referrals to spiritual care, and facilitating the practise of religious rituals (e.g., by ensuring patients can attend a religious service or arranging for the visit of a community faith leader).

6. Acknowledge that spiritual suffering within the context of healthcare is not limited to patients and their families but extends to healthcare staff too, as they witness the suffering of others and bring their own personal suffering as part of who they are. Integrate workplace spiritual health as an organizational priority.

---

2 In the UK NHS, spiritual care is increasingly included in national healthcare policy. In Canada, provinces and regional health authorities vary in the funding provided to spiritual care.
References


### APPENDIX I: Participant Demographics

<table>
<thead>
<tr>
<th>DEMOGRAPHIC CHARACTERISTIC</th>
<th>VANCOUVER (n = 50)</th>
<th>LONDON (n = 44)</th>
<th>PILOT (n = 15)</th>
<th>TOTAL (n = 109)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ROLES</strong> (n = 109)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaplain</td>
<td>13</td>
<td>8</td>
<td>11</td>
<td>32</td>
</tr>
<tr>
<td>Spiritual Care Volunteer</td>
<td>4</td>
<td>8</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>Healthcare Professional</td>
<td>18</td>
<td>7</td>
<td>-</td>
<td>25</td>
</tr>
<tr>
<td>Administrator</td>
<td>8</td>
<td>10</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Citizen/Family/Former Patient/Residents</td>
<td>7</td>
<td>11</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td><strong>RELIGIOUS AFFILIATION, SELF IDENTIFIED</strong> (n = 109)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>35</td>
<td>22</td>
<td>11</td>
<td>68</td>
</tr>
<tr>
<td>Catholic</td>
<td>17</td>
<td>7</td>
<td>-</td>
<td>24</td>
</tr>
<tr>
<td>Church of England / Anglican</td>
<td>1</td>
<td>7</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Christian (non-specific)</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Baptist</td>
<td>1</td>
<td>-</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Evangelical</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Protestant</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Pentecostal</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Mennonite</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Seventh Day Adventist</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Quaker</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Orthodox</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>First Nation Christian</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td><strong>Minority Religion</strong></td>
<td>6</td>
<td>10</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Jewish</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Muslim</td>
<td>2</td>
<td>5</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Sikh</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Hindu</td>
<td>1</td>
<td>3</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Baha’i</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td><strong>Non-Religious</strong></td>
<td>4</td>
<td>10</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>6</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Spiritual</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Pagan</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Atheist</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Humanist</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td><strong>No Response</strong></td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td><strong>ETHNICITY, SELF IDENTIFIED</strong> (n = 94)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African</td>
<td>-</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>African-Caribbean</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>8</td>
<td>1</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Southeast Asian</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>North American</td>
<td>9</td>
<td>-</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>3</td>
<td>-</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>European</td>
<td>17</td>
<td>29</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Central American</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>South American</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX II: Data analysis

Using a data-driven inductive approach (Thorne 2016), the analytic process assumed an iterative and reflective process. Use of the data management software, NVivo™ 11, provided a comprehensive platform for organizing and conducting our analysis. Initially, data (transcripts, prayer journals, observational field notes, researcher memos, pictures) were studied and coded independently by researchers into themes and sub-themes with ongoing discussion and revision with the research team. Differences were resolved through discussion and themes and sub-themes were amended accordingly. Reflexivity was a vital component of the knowledge construction process. Throughout this study, we were embodied constituents that influenced and shaped our study’s findings based on our respective lived experiences (Sharma et al. 2009). In addition to revealing new discoveries within the data that might otherwise remain unexplored, our reflexivity extends to the study’s limitations more generally. Perhaps the most striking limitation is the lack of representation of larger number of nones and religions other than Christian, within our sample. Additionally, because of some religiously-affiliated research sites in Vancouver, our findings from these sites cannot be considered generalizable to other Canadian healthcare organizations.

We developed the study’s initial codebook using the study’s objectives, the theoretical perspectives informing this work, and the interview questions. Ongoing data collection clarified, verified, and expanded it. The final version of the codebook consisted of 24 parent nodes and 106 sub-nodes. Also, within the codebook, node descriptors and corresponding examples facilitated consistent coding among researchers thereby enhancing the reliability of our analysis and study’s findings.

A significant component of our analytic process was a 3-day Think Tank held in September of 2017 in Richmond, British Columbia. Distinguished academic collaborators from the disciplines of sociology, anthropology, theology, chaplaincy studies, religion, and nursing generously provided their scholarly expertise and maximized the study’s theoretical contribution.

Research ethics review and clearance was obtained in London and Vancouver:

IRAS Project ID: 203830
TWU Ethics: 15F14
KU Ethics: 151624
UBC-PHC REB Number: H15-02051