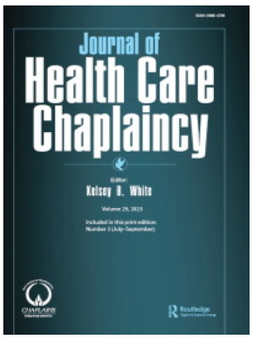

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Sonya Sharma & Sheryl Reimer-Kirkham

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Exploring racism and racialization in the work of healthcare chaplains: a case for a critical multifaith approach

Sonya Sharma[a] and Sheryl Reimer-Kirkham[b]

[a]Social Research Institute, University College London, London, UK; [b]School of Nursing, Trinity Western University, Langley, Canada

ABSTRACT

The global COVID-19 pandemic has revealed healthcare settings as sites of much-needed scrutiny as to the workings of racism and racialization in shaping healthcare encounters, health outcomes, and workplace conditions. Little research has focused on how healthcare chaplains experience and respond to social processes of racism and racialization. We apply a critical race lens to understand racism and racialization in healthcare chaplaincy, and inspired by Patricia Hill Collins, propose a "critical multifaith approach." Drawing on research in healthcare in Canada and England, we generated four composite narratives to analyze racialization's variability and resistances employed by Indigenous, Arab, Black, and White chaplains. The composites disclose complex intersecting histories of colonialism, religion, race, and gender. Developing a critical multifaith perspective on healthcare delivery is an essential competency for chaplains wanting to impact the systems in which they serve in the direction of more equitable human flourishing.

KEYWORDS

Chaplains; healthcare; intersectionality; multifaith; racialization; racism

Introduction

In a time of pandemic and post-pandemic, the world is asking questions about social inequities and fairness—at the level of who gets a vaccine, who holds a frontline service role, or who carries the burden of chronic disease. In hospitals, these questions shine a light on the experiences of racialized patients, families, and healthcare providers. The COVID-19 pandemic has heeded the role of chaplains in providing last rites, contact with loved ones via virtual means, and supporting staff under duress. Many chaplains provide spiritual care across religious traditions typified in generic and multifaith approaches that can inadvertently obscure the workings of racism and racialization. This obfuscation is partly because of how religion rather than race has become a signifier of difference (Yuval-Davis, 2011). Little attention has been given to how healthcare chaplains experience and respond to racism and racialization, nor how racism and racialization map onto religion, resulting in constructing "differentiated social collectivities" (Miles, 1989, p. 75) and representational processes of defining an Other (usually, but

CONTACT Sonya Sharma sonya.sharma@ucl.ac.uk IOE | Faculty of Education and Society, Social Research Institute, University College London, 27–28 Woburn Square, London WC1H 0AA, UK

not exclusively) somatically. Drawing on research in Canada and England, we apply critical race and intersectional lenses to understand racism and racialization in healthcare chaplaincy. This enables us to propose a critical multifaith approach to address a crucial gap within chaplaincy studies.

Racism and racialized healthcare have long histories in Britain and Canada. Britain's imperializing and colonizing reach extended globally with propagations of Christianity, visions of modernity, and the supremacy of Whiteness with resources and labor brought back to Britain to create a center of wealth and influence. Canada, as a settler-colonial nation of British and French domination, continues with a hegemonic English-speaking White center, where Indigenous peoples and newcomers to Canada face marginalization and health inequities on account of the disparate distribution of wealth and resources.

Canada and Britain have publicly funded health systems that mollify, to some extent, health inequities that occur in populations marked by social and economic disparities. Yet, population-level health indicators show that people of color and Indigenous ancestry in Canada and Britain consistently experience higher levels of morbidity and earlier death (Marmot et al., 2020; Raphael et al., 2020). The pandemic has illuminated and deepened racialized health disparities (Hooijer & King, 2022). Contemporary calls to decoloniality in health professions education present an opportunity to incorporate non-European knowledges and re-distribute systems of power (Blanchet Garneau et al., 2018). For those who are "color blind," inattentive to hierarchies of social privilege, or otherwise employing "settler moves to innocence" (Tuck & Yang, 2012, p. 9), institutional racism may be invisible as to racializing processes, such as implicit bias, unequal access to healthcare services, and poor clinical communication that lead to health disparities (Elias & Paradies, 2021). In Canada, Joyce Echaquan, an Indigenous woman, endured racist insults from healthcare workers as she was dying in a Quebec hospital (Bilefsky, 2021), and in British Columbia, accounts from more than 8000 Indigenous people and healthcare professionals confirmed widespread Indigenous-specific racism (British Columbia Ministry of Health, 2020). In Britain, racism in the National Health Service results in higher maternal mortality rates among Black women, a lack of responsiveness to complaints of racial harassment in medical schools, and an increased incidence of disciplinary procedures against ethnic minority doctors (Adebowale & Rao, 2020). Although chaplains are not directly cited in these cases, that they provide services in these same healthcare systems raises questions of how chaplaincy is implicated in the delivery of racialized healthcare services, and the extent to which chaplaincy studies are heeding the widespread social call to anti-racism in today's institutions and societies.

Little research exists on racism and racialization in healthcare chaplaincy. Bryant's (2018) research on ethnic minority healthcare chaplains in England found that Muslim women chaplains were repeatedly not recognized by staff in their official role as chaplains, a male Hindu chaplain was mistaken for medical staff, and Bahai and Buddhist staff were asked to what church they belonged. Her study revealed how "chaplain" is often associated with the "somatic norm as the corporeal imagination of power naturalized in the body of white, male, upper/middle-class bodies" (Puwar, 2001, p. 652). Christianity is embedded in this somatic norm, historically linked to Whiteness because of European colonialism (Joshi, 2020). Research in Canada and England demonstrates that when religion and race are read onto women healthcare chaplains their presence is

queried (Sharma & Reimer-Kirkham, 2022). Cadge et al. (2021) note the sexism and racism that Black chaplains experience in American healthcare and the invisibility of Black women chaplains. Ironically, religious, and ethnically diverse chaplains are often racialized into the profession via diversity and inclusion policies, a substitute for actual structural change (Ahmed, 2012). Hutt (2019) argues that the workings of racial hierarchies need more interrogation within spiritual care provision.

Materials and methods

Critical race and intersectional lenses open possibilities to recognize and challenge racism and racialization in healthcare chaplaincy. Racism is defined as:

> … the belief that a group of people are inferior based on the colour of their skin or cultural background. This belief drives discriminatory behaviours and practices, such as negative racial profiling, and policies that oppress, ignore, or treat racialized groups as 'less than' non-racialized groups. The result is substantive inequity – where members of racialized and culturally distinct peoples, such as Indigenous peoples, do not receive the services they require or enjoy equitable opportunities or outcomes with citizens from non-racialized groups. This is systemic racism – wherein acceptance of these discriminatory and prejudicial practices is normalized across our society, in public services and institutions (British Columbia Ministry of Health, 2020, p. 6).

This definition infers that "racism dehumanizes its object and those who articulate it" (Miles, 1989, p. 10) and its resulting consequences: systemic racial inequity. The concept of racialization refocuses attention from racial identities to relational processes of exclusion, signification, and ascription that structure advantage and disadvantage, belonging, and non-belonging (Murji & Solomos, 2005). Racialization is "socially produced, relational and assumes significance because racialization is a continuous process" (Fanon, [1967] 2008; Phoenix, 2005, p. 105). Processes of racialization vary across time and place, and in combination with other forms of social difference, such as religion. Nayak (2005) argues that it is assumed that racialization typically pertains to Black and ethnic minorities minimizing the racialization of ethnic majorities, such as those deemed "White" (p. 147). He notes "that white people live racially structured lives, even if it places them within ever-mobile systems of privilege … " (p. 147) and by not appreciating this "it allows whiteness to escape racialization and maintain its position as dominant, normative and set apart from the question of race" (p. 147). Numerous studies apply a critical lens to Whiteness, a field that emerged in the 1990s from work by Ware ([1992] 2015) and Frankenberg (1993). Frankenberg (1993) theorized Whiteness as "a location of structural advantage, of race privilege; a "standpoint," a place from which white people look at ourselves, at others, and at society; and a set of cultural practices that are usually unmarked and unnamed" (p. 1). Of our four chaplain composites, one is White because "the somatic norm of whiteness gets overlooked" (Puwar, 2004, p. 10), especially within chaplaincy studies. "White" and "Black" are co-constitutive. "Understanding how the articulation of one racial identity is always dependent upon the production of others, discloses the interconnectedness of all socially constituted racial demarcations" (Nayak, 2005, p. 147). Our focus on racism and racialization in the work of chaplains pays attention to their configuration in the everyday. Further, race does not function as a single axis of analysis (Crenshaw, 1989) but intersects with other

social categories including religion that encompasses beliefs, practices, and power structures. Religion is racialized through signifiers, such as clothing, skin tone, language, and practices (Garner & Selod, 2015). When religion is side-lined as an important aspect of people's lives it can affect health and well-being. Likewise, when religion is gendered and racialized it can affect experiences of inclusion and exclusion.

Our empirical data is derived from a program of research in Vancouver and London. We employed critical ethnography to understand how prayer is manifest in healthcare settings and a window into religion in the public sphere ($n = 94$) (Reimer-Kirkham et al., 2020). Of these, 21 were chaplains. Emerging from this study we came to see the gendered nature of chaplaincy and designed a study to elicit the experiences of women chaplains in Vancouver and London ($n = 12$) (Sharma & Reimer-Kirkham, 2022). The 106 participants in these two studies represent more than 25 research sites. We utilized qualitative methods, including semi-structured and walking interviews, research diaries, photographs, and participant observation, with an inductive approach to data analysis. All transcripts went through an initial process of line-by-line coding in NVivo™ by multiple researchers, followed by thematic analysis. Further analysis for this manuscript involved a matrix approach to our in-depth thematic analysis of 33 chaplain transcripts. Of these participants, 23 were of White Anglo-European heritage and 10 were of African, Arab, Asian, Austronesian, and Indigenous heritages. Studies received ethics approval from University Ethics Committees and Health Authority Boards. All anonymized participants, after an explanation of the research process, gave informed consent to participate.

With the social upheaval of the pandemic and heightened and overdue attention to racism and racialization, we returned to this data set to re-read it with critical race theory and intersectional lenses, to bring criticality to investigations of religious pluralism in healthcare. Our approach is that of generating composite narratives to distill this data to four focused exemplars that tell a compelling story of racism and racialization in healthcare chaplaincy from those best suited to speak to the harms of systemic racialized oppression (Samuels-Wortley, 2021; Willis, 2019). The composite method allowed us to foreground Black and ethnic minority chaplains in a way that is not typical, considering the over-representation of majoritarian religions and White Anglo-Euro ancestry in both our study and the chaplaincy field. Each composite draws on two or more interviews using verbatim quotations and contextual details. "Helene" is a composite of two Indigenous participants in Canada. "Reema" is a composite of two Muslim chaplains of Arab heritage and "Clara" is a composite of three Black Christian chaplains of African heritage all living in England. "Charles" is a composite of ten White Christian chaplains of Anglo-European heritage living in Canada. Our small sample is a limitation and moreover, the composite method can obscure uniqueness and flatten experiences. This is outweighed by its strength, bringing together a collection of voices to address visible and invisible operatives of racial oppression and advantage.

Results

Helene

Indigenous peoples make up 4.9% of the Canadian population and face disproportionate levels of sickness and higher hospitalization rates (Bougie, 2021) on account of

historical, structural, and systemic processes. These include land dispossession, colonial logics that continue to privilege settler Canadians and pathologize Indigenous peoples, and cultural genocide through erasure and assimilation. The Indian Act (1876), as an instrument of British imperialism, renders Indigenous people, resources, and land as without agency, subject to a separate system of Canadian law with legal definitions developed for Indigenous peoples without their input. Yet, as asserted by the *UN Declaration on the Rights of Indigenous Peoples* (UNDRIP) (2007), Indigenous peoples have the right to self-determination, self-reliance, and nation-to-nation relations. Canada has been criticized for its reticence in endorsing and implementing UNDRIP (Lightfoot, 2016), which undoubtedly has a trickle-down effect on how Indigenous-specific racism is expressed and addressed in healthcare.

Helene was an Indigenous elder dedicated to Indigenous peoples in educational and healthcare settings. She provided support outside of the chaplaincy team. She received an honorarium for each hospital visit, rather than holding a salaried position, and was not part of daily chaplaincy team collaboration and resources. She was aware of the inequity, wherein a particular region 30 paid spiritual care positions were held by non-Indigenous peoples, and Indigenous Elders worked on contract; in her words: "Elders receive a piddly honorarium and yet are working for 7 day/s a week. It is unacceptable." She traced this disparity to colonial government policies that allow for a lesser standard of care for Indigenous peoples, and elevation of certain spiritualities (read: Christianity) over other forms, such as Indigenous spirituality: "it is racist policies coming down from the federal government that mandated for generations of people to think of First Nations as being lower."

At one site, a designated Indigenous sacred space was kept locked, perhaps reflecting caution that the room would be desecrated, vandalized, or misused by non-Indigenous visitors, but which resulted in less accessibility and a sense that the space was not integral to the hospital. The sacred space was hard to find and away from patient care areas. This lack of accessible space meant Helene did not have a place for her ceremonial bag and other belongings when she visited the hospital.

Along with the institutional racism of unequal allocation of human and spatial resources, Helene experienced everyday racism, where staff were blatantly discriminatory:

> I could write a book on what doctors and nurses have said to me. I can't tell you how many times I would stand there with my ceremonial bag, my nametag is on. I have the code to get in, but they ask, 'Are you supposed to be here?' I stand there and stand there. They are on their computers or chatting, and I'm standing there. They roll the eyes and sigh – I have faced this many times. But I am graceful and thank them.

Even as she contributed to the care of Indigenous patients, she was excluded from the team. Helene worked within the bureaucracy, refusing to be side-tracked from her connections with hospitalized Indigenous people. In her words, "we follow the rules and honor the bureaucracy and are respectful, and then we can make changes." Her attitude was that of claiming her rightful place and status, an act of self-determination and decolonization.

Helene explained, "no spiritual care is above any other spiritual beliefs; we are all equal and have a right to choose." She signaled the intent of the 2015 Truth and

Reconciliation Commission in Canada (2015) that includes amongst its 94 Calls to Action the injunction to "respect Indigenous spirituality in its own right" (p. 7). Spiritual care departments in Canada have, to varying degrees, partnered with Indigenous elders to provide spiritual support to Indigenous patients. Where Helene worked, spiritual support of Indigenous patients was left to contracted Indigenous elders, a situation that on the one hand allowed for culturally-appropriate care, but on the other, did not lead to chaplains becoming familiar with Indigenous spirituality "in its own right."

Reema

Muslims have long lived in Britain—the result of economic waves of migration. During Britain's colonial period, shipping employed thousands of seamen from Africa, the Arabian Peninsula, and India 2022 who faced "colonial racial hierarchies" and poor conditions (Tabili, 1994). While many South Asians (i.e., Pakistanis and Bangladeshis) make up the Muslim population because of economic reconstruction after WWII, earlier groups are of Yemeni and Middle Eastern heritage, with more recent groups from Somalia, Turkey, and Eastern Europe (Gale & Hopkins, 2022). Muslims are a varied demographic, and many experience discrimination because of their race and religion. "Religion is 'raced' and Muslims are racialized" (Vakil, 2010, p. 276). Since 9/11, anti-Muslim racism has layered onto historical racial inequities.

These histories operated in the background of Muslim chaplain participants. Reema exemplified this group. She was of Arab heritage and migrated to England for work opportunities. She was a paid chaplain and viewed her role as important to the chaplaincy team. Aware of the hegemonic history of Christianity in chaplaincy, she stated "Muslim chaplains need to fight for their role more than Christian chaplains because of racism and gender." Reema often served beyond her hours due to the complex nature of being in/visible as a Muslim/chaplain. Race, religion, and gender work simultaneously to include and exclude Muslim chaplains.

Because of anti-Muslim racism, many Muslim patients do not declare their religious affiliation for fear of ill-treatment. Some found their belongings, such as their headscarf put away in a cupboard by staff, making it difficult to reach and uncomfortable to see visitors and chaplains. Reema did not rely on patient lists because they often do not indicate patients' religion. If she did look at the lists, she "looked for Muslim names" to identify them. She would also walk the hospital looking for Muslim patients. Staff sometimes mistook her for a visitor. Often Muslim women, if they wear the *hijab* as Reema did, are "visually recognized and marked as religiously raced and gendered" (Mirza, 2013, p. 13). Thus, "headscarves are read unproblematically as signs of oppression" (Garner & Selod, 2015, p. 16). Reema, with her rounds of the hospital, does what other professional Muslim women do in their workspaces, she "challenges and transforms hegemonic discourses of race, gender, and religion in [the] transnational diasporic space" of the hospital (Mirza, 2013, p. 5).

Establishing Muslim prayer spaces in healthcare settings was a way to resist marginalization. As part of the UK's Equality Act (2010), public institutions are expected to recognize protected characteristics, such as religion or belief by providing spaces for

related practices. Some allocated spaces can be viewed as an afterthought when poorly decorated, lacking cleansing facilities, and hard-to-find. More common are well-designed designated spaces for Muslim prayer. In our research, these came about through great effort and a commitment to "post-colonial resistance" from Muslim diasporic communities and committed chaplaincy staff to decoloniality in healthcare.

Clara

There is a misperception that Black people first arrived in Britain during the 1950–70s. Fryer traces the history of Black people in Britain up to the mid-twentieth century. "There were Africans in Britain before the English came here. They were soldiers in the Roman imperial army that occupied the southern part of our island for three and a half centuries" (Fryer, [1984] 2018, p. 1). Clara, who exemplified other Black chaplains in our study, was of African heritage. Her family migrated to England like others from former British colonies for work and educational opportunities.

Clara worked as a Christian chaplain and was "the first Black full-time chaplain." Her intersectional embodiment of race and culture (Mirza, 2013) was pointed out by some chaplain colleagues in micro-aggressive ways, such as "don't smell out the place with your food." Her material practices could be seen as "disturbing the normal institutional landscape … seen to be taking up more space than [she] actually occupies" (Puwar, 2004, pp. 48–49). Black bodies that take up spaces not typically reserved for them "generate unease when they walk into historically white spaces as figures of authority" (Puwar, 2004, p. 48). In response, she was reproached in several ways including by a White male patient refusing her prayers. Clara's presence as a Black woman chaplain brought about a discussion with a White male Christian chaplain on who she was "perceived or expected" to visit. She said:

> … they tend to refer me to Black patients. I said to him, 'You can refer me to patients who are not Black. I don't want to be typecast into 'just because I'm Black, I'm talking to Black people.' And he said, 'The reason why I suggested you was because they have been under-visited in the past.' But I think it might be because the chaplaincy's mainly White so it's who [they are] used to talking to.

The hegemonic structure of Whiteness was present in Clara's work. By noting which patients she was referred, she noted his racialization of her. Past prioritized visitations by chaplains could have been for a variety of reasons, but Clara alluded to racial and religious divisions created because of who was referred to whom, limiting the ability to learn from others and serve across differences. Black patients and families could signal historical racial inequities of the Church in their suspicion and bewilderment of being approached by Black chaplains often mistaken for healthcare professionals. Clara's position though was much needed, such as when a Black woman patient was left in a poor state. Clara voiced her concern and hydration and moisturizer were provided. Clara's work resisted what was typically done, addressing intersecting racial, religious, and health inequities.

Many Christian groups utilize hospital chapels. Black Pentecostal groups have had their singing and worship welcomed but commented on as "too noisy." "'Black' bodies in addition to their visibility are under assimilative pressure to conform to the

behavioral norm" of white spaces or social codes of whiteness—"exhibiting signs of 'civilization' and cultural refinement" (Puwar, 2004, pp. 150–151). Such comments keep intact the power of historically White Anglican and Catholic Christian customs that often characterize hospital chapels. Nonetheless, like Muslims gathering to pray, acts of decoloniality by Black majority faith groups reconfigure these spaces.

Charles

Our final composite—that of Charles, a White Catholic male chaplain—brings into focus operations of race and racialization in relation to White, Christian privilege. A decolonial reading examines not only places of oppression and disadvantage but also advantage and centering on account of one's ancestry. In Canada's settler-colonial context, accrual of privilege is for those of European ancestry, and even more for someone who is Christian and male. Joshi (2020) unpacks three mutually supporting phenomena of (i) Christian privilege (experienced at an individual level, manifest in unearned advantages that Christians receive and in the disadvantage of religious minorities and the non-religious); (ii) Christian normativity (Christian values are deemed intrinsic to mainstream culture and national identity, with Christian language, metaphors, and underlying theology as national standard); and (iii) Christian hegemony (referring to a society's unacknowledged or unconscious adherence to a dominant worldview). Developed during the era of European discovery and colonization, ideologies of White racial superiority and Christian religious superiority operate in tandem. For example, White Christians looked "to the Bible for rationales that supported subjugation and genocide of Indigenous peoples, Black slavery, and a view of Asians as threatening, exotic and heathen" (Joshi, 2020, p. 6). Although secularizing societies, such as Canada, are increasingly critical of religious institutions, beliefs, and practices (and Christians may face criticism or discrimination related to their faith), the foundational privilege of majoritarian religion persists.

Charles was a kind presence known by staff and residents in the long-term care home where he worked, and was tuned to diversity, explaining that "in one room, there are four beds, and four religions." He mused that although unable to "enter someone's own spirit of faith or speak to someone in the language of their faith," he could "somehow enter into a sacred space with them … with an exchange from an authentic place." Models of chaplaincy have transitioned from religion-specific pastoral care to generic spiritual care, reflecting such universalizing assumptions of a core spiritual dimension innate to each person, such that a chaplain could connect to religious and non-religious alike.

Charles' assertion that he provided spiritual support to all residents lacked personal reflection as to the privilege that would allow such a claim. His comments ("I hang loose with staff and see how they are doing, and when residents are having their breakfast") signaled his assumption of a level playing field, and his own position on it as a "universal human" (Puwar, 2004). However, in a Canadian context of predominantly White male leads of chaplaincy and against the backdrop of colonial, Christian dominance, his reality was likely not shared by women and Black, Indigenous, and Peoples of

Color who understand that these are not neutral spaces. Contrast his easy belonging with that of Helene's experience in a similar organization of being shut out.

Charles' belonging was reinforced by the structuring of sacred spaces in healthcare settings. We frequently observed how Christianity is privileged through the assemblage of chairs in rows in front of an altar. Though these spaces are sometimes re-arranged for use by other faith groups, the spaces are expected to be returned to the dominant arrangement typical of a Christian place of worship.

In a managerial position, Charles enjoyed "the privilege of being racially unmarked … as a crucial condition of being a universal figure of leadership" (Puwar, 2004, p. 11). Accrual of privilege for Charles involved an obviousness that he would be a leader as a White male, along with working in a faith-affiliated organization that was imbued with religious symbols (e.g., a crucifix in his office) and rhythms (e.g. starting a meeting with a contemplative pause) of a hegemonic Christian presence. Many chaplains in Canada were White, likely making them less tuned to racism and racialization circulating within and structured into healthcare. Although chaplains like Charles carried good intentions in providing spiritual support to everyone, the point of this analysis is the apparent lack of reflection on how their social location and colonial structures within which they operate might blunt these efforts.

Discussion

These composite analyses, while not representative of all chaplains in our study, disclose complex intersections and histories of colonialism, race, religion, and gender, offering ways forward for best practices via a critical multifaith approach. Drawing from Collins (2019), three composites (Helene, Reema, and Clara) "provide the perspectives of people who are subordinated within intersecting power relations" (p. 84), a shift in perspective from that of the fourth composite (Charles). The analytic maneuver of contrasting composites contributes to what Collins (2019) terms "resistant knowledge projects" (p. 84), which we interpret as part of a critical multifaith approach. These projects "grapple with the existential question of how individuals and groups who are subordinated within varying systems of power might survive and resist their oppression" (p. 88). We add "critical" to multifaith because it aims to interrogate intersectionally the world from those not typically at the center (Collins, 2019). This approach broadly involves reflexivity, relationality, antiracism and social justice, and education.

The composites illuminate different levels of self-awareness of the workings of racism and racialization in workplace relations and structures, each responding differently because of historical and personal experiences. Charles' apparent lack of reflexivity regarding racism and racialization appears in stark contrast to the self-positioning of Helene, for example. She may appear to staff to be out of place, but she stood patiently to be acknowledged. Her "unfeeling" was a tactic from below to resist intersecting axes of oppression she confronts as an Indigenous woman (Yao, 2021). Charles operated from a different set of knowledges of the unmarked advantages of Whiteness and androcentricity that assumes a universality in being able to help everybody.

Relationality in a critical multifaith approach is about understanding how diverse non/religions and spiritual care are situated in a wider world of power relations and

structural inequities. This coincides with Hutt (2019), an African American chaplain and educator, who spends a "significant amount of time exploring with White chaplains on what it means to care for Black people in hospital" (p. 188). Many White chaplains she trains "have no Black friends, grew up in segregated White areas, and are woefully ignorant of Black history, culture, and religiosity" meaning that "this limitation in experience and the implicit bias that White supremacy creates reduces the opportunities for Black people to receive the type of care they deserve" (p. 188). Similarly, Indigenous health advocates note that "white and/or settler fragility" should not detract from advancing Indigenous health (Smylie et al., 2022).

Through the lens of critical multifaith chaplaincy, we envision healthcare chaplains recognizing the obligations they carry as members of healthcare teams to address systemic racism, and furthermore, responding to opportunities to ameliorate inequities in their day-to-day practice. In an analysis of chaplaincy and gender (Sharma & Reimer-Kirkham, 2022), women chaplains resisted gendered norms and tirelessly supported structurally vulnerable patients, and yet they rarely described themselves as activists. In our composites, chaplains helped to establish sacred spaces (as symbolic, interpersonal, and spatial) that made room for racialized religious others, found the racially and religiously excluded, and advocated for better care for the marginalized. Such everyday acts move toward antiracism and social justice.

Although there have been calls for implementation and education about multifaith in healthcare chaplaincy, the call to a *critical multifaith approach* carries broad-based implications, from everyday chaplaincy practices to research to educational programs and their accreditation. Hutt (2019) on spiritual care in hospitals contends that more education and competency on the philosophies, theologies, and worldviews of Black people (and People of Color) is needed. It is crucial to situate Indigenous knowledges as a vital source and field of expertise, alongside other fields of knowledge (Battiste, 2013). It means rejecting racism embedded in colonial systems of education and proposing new practices that go beyond tokenistic responses, taking seriously the cultural traditions and experiences of those not typically at the center. As Collins (2019) asks, what might have unfolded in European and North American contexts were other narratives a starting point (p. 87)?

Conclusion

This article addresses a gap in the healthcare chaplaincy literature. We have demonstrated ways racism and racialization occur in the work of healthcare chaplains, how chaplaincy can be implicated in the delivery of racialized healthcare, and how chaplains challenge racism in spiritual care services. Chaplains are uniquely situated to tackle racial inequities in ways that established religious institutions have been too slow to do. Chaplains however often occupy liminal positions in healthcare, hindering their ability to generate systemic change and antiracist practice. Further intersectional research is needed on chaplains of color and how chaplains can develop a critical multifaith approach to impact the systems in which they serve toward more equitable human flourishing.

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Ethical approval

Trinity Western University Health Research Ethics Board 15F14; Kingston University London Research Ethics Committee 151624 and 181938; IRAS Project ID: 203830.

Consent to participate

All anonymized participants, after an explanation of the research process, gave their informed consent to be part of the research.

Consent to publish

The authors affirm that human research participants provided informed consent for the publication of the anonymized data included in this manuscript.

Disclosure statement

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ORCID

Sonya Sharma http://orcid.org/0000-0002-6729-5363

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