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The social relations of prayer in healthcare: Adding to nursing's equity-oriented professional practice and disciplinary knowledge

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Abstract

Although spiritual practices such as prayer are engaged by many to support well-being and coping, little research has addressed nurses and prayer, whether for themselves or facilitating patients' use of prayer. We conducted a qualitative study to explore how prayer (as a proxy for spirituality and religion) is manifest—whether embraced, tolerated, or resisted—in healthcare, and how institutional and social contexts shape how prayer is understood and enacted. This paper analyzes interviews with 21 nurses in Vancouver and London as a subset of the larger study. Findings show that nurses' kindness can buffer the loneliness and exclusion of ill health and in this way support the "spirit" of those in their care. Spiritual support for patients rarely incorporated prayer, in part because of ambiguities about permission and professional boundaries. Nurses' engagement with prayer and spiritual support could become a politicized site of religious accommodation, where imposition, religious illiteracy, and racism could derail person-centered care and consequently enact social exclusion. Spiritual support (including prayer) sustained nurses themselves. We propose that nursing's equity-oriented knowledge encompass spirituality and religion as sites of exclusion and inclusion. Nurses must be supported to move past religious illiteracy to provide culturally and spiritually sensitive care with clarity about professional boundaries and collaborative models of spiritual care.

KEYWORDS
equity, nursing practice, prayer, qualitative analysis and interpretation, racialized religion, religion, spirituality

1 | INTRODUCTION

That hospitals, long-term care homes, and clinics are sites of illness and suffering, crisis, and transition is a given—one could say the *raison d'etre* of these healthcare settings is the address of such experiences. As members of interprofessional healthcare teams, nurses employ a multitude of clinical, pharmaceutical, and relational interventions to arrest disease and ameliorate suffering. Amid advanced technologies and skilled clinicians, another text is interwoven; namely, the enactment of spiritual practices and the negotiation of religious plurality, also in response to illness and suffering, crisis, and transition. Prayer is among these spiritual practices, and according

to recent polls continues to be practiced among religious and nonreligious alike (Angus Reid Institute, 2016; Bullivant, 2017). During the COVID-19 pandemic, google searches for "prayer" surged worldwide (Bentzen, 2021) with studies showing both private and public prayer as religious coping (DeRossett et al., 2021; Szała-chowski & Tuszyńska-Bogucka, 2021).

In this paper, we present findings of an international project[1] in Vancouver and London hospitals that examined how prayer is expressed—whether embraced, tolerated, or resisted—in healthcare, and how institutional and social contexts shape how prayer is understood and enacted. We foreground nurse participants as a subset of the data, examining how they provide and receive spiritual support, and the contexts that shape prayer encounters. A line of inquiry is how the social relations of prayer can inform equity-oriented care in nursing. We follow the commonplace understanding of prayer as a connection between humans and the divine or another being or energy life force, which can be shared among and between those religious and nonreligious. It can also be considered an approach to mindfulness, meditation, and personal meaningfulness that emphasizes the inner world of the individual in relation to the external (Giordan & Woodhead, 2013, 2015; Reimer-Kirkham, Sharma, Brown, et al., 2020; Sharma & Reimer-Kirkham, 2020). In designing the project, we anticipated that prayer might not always be welcome. With this in mind, we were interested in how prayer (with religious and nonreligious meanings) as a "place holder" for religion and spirituality[2] might disrupt the order of things, including the seemingly rational and secular nature of healthcare, as well as settled conceptions of faith, religion, and spirituality. We also queried nurses' approaches to prayer and whether they foreground (religious) equity among the diverse populations in which they work.

The settings of our study, Vancouver and London as two expensive cities with high levels of religious and ethnic diversity, in countries with publicly funded healthcare systems, served as productive laboratories for the study of the relationships between spirituality and health, and nurses' engagement with the negotiation of religion and diversity in the public sphere. British Columbia is one of the most secular and nonreligious regions of the continent, with 52% of residents indicating no religious affiliation (Bramadat et al., 2022; Statistics Canada, 2022a). In Vancouver, those who identify as Christian comprise one-third (34%) of the population, compared to Canada's 53%; Statistics Canada, 2022a). This region also has higher levels of immigration (42% of Vancouverites are foreign-born, compared to Canada's 23%; Statistics Canada, 2022b), with 14% of citizens reporting as Sikh, Buddhist, Muslim, or Hindu (in order of frequency; compared to Canada's 12%; Statistics Canada, 2022b). London is the most religiously diverse region of England', according to the recent Census (Office for National Statistics [ONS], 2022, p. 5). In London, 40.7% identified as Christian and 25.3% with a religion other than "Christian" (ONS, 2022). After Christian, the "next most common religious groups in London were Muslim (15%) and Hindu (5.1%)" (ONS, 2022, p. 5). Despite London's religious diversity, the overarching story of England is that people identifying as Christian have decreased and those with no religion have increased (ONS, 2022).

2 | LITERATURE REVIEW

Little nursing research exists specific to prayer and nursing, though indirect reference to prayer is made in nursing literature on spiritual caregiving, and since the pandemic an increase in research on prayer is emerging (e.g., Choudhary et al., 2022; Lekhak et al., 2022; Pierce et al., 2021; Taylor, 2020). Empirical literature on prayer in healthcare has mostly focused on its instrumental effects, in relation to physical and psychological well-being, with mixed results as to its salutogenic effects (see, for instance, Chin et al. [2021], Roberts et al. [2009], Simão et al. [2016]). Also muted in the nursing literature is an equity or social justice reading of religion and spirituality.

Balboni et al. (2011) reported on a cross-sectional, multisite, mixed-methods study in the United States that described the viewpoints of patients, doctors, and nurses concerning the appropriateness of clinician prayer. Most respondents viewed clinician-initiated prayer as at least occasionally appropriate (nurses were more likely to hold this view than patients and physicians). In the same year, British authors French and Narayanasamy (2011) framed prayer offered by nurses as a question of ethics, including informed consent with cautions of coercion, imposition, disrespectful care, and harm. A Canadian study (Sharma et al., 2013) reported some nurses engaging in prayer, though doing so with disease, and sometimes reprimand from colleagues. Taylor et al. (2018) conducted a cross-sectional survey that found US nurses thought initiating a conversation about spirituality or religion was more appropriate than initiating prayer. Those with higher religiosity were more likely to initiate conversation or prayer, compared to those with lower religiosity who waited for patients to initiate, a finding shared by O'Connell-Persaud et al. (2019). In the Netherlands (van Nieuw Amerongen-Meeuse et al., 2020), nurses in mental health clinics were open to the possible use of prayer, and few patients had objections against prayer and focused instead on benefits like tranquility and relief. In a paper on the ethics of nurse-initiated prayer during the COVID-19 pandemic, Taylor (2020) weighed ethical and therapeutic cautions in relation to the vulnerability of patients, nurses' limited education on spiritual care and prayer, and pandemic cautions prohibiting the physical presence of those who perform priestly functions. The literature provides international examples of a handful

[1]The findings of the overarching project are published in the book, *Prayer as transgression? The social relations of prayer in healthcare* (Reimer-Kirkham, Sharma, Brown, et al., 2020). Ethnographic data collection in Vancouver and London involved participant observation with interviews, focus groups, and photography; analysis of research diaries; and review of relevant organizational policies. In total, we interviewed 109 participants (50 in Vancouver, 44 in London, and 15 in a pilot study). With this paper, we conduct a focused analysis of the nurses' interviews ($n = 21$) as a subset of the data.

[2]We are cautious about the prevalent dichotomy between religion and spirituality in the healthcare literature. In broad stroke terms, religion carries transcendent and social dimensions, with the practice often occurring through relatively formal social institutions. Spirituality, while also having to do with the metaphysical, is less institutionalized and a more individual expression of values and beliefs, though nonetheless grounded in material concerns and relations of power (Reimer-Kirkham, Sharma, Brown, et al., 2020).

of descriptive studies that, when taken together, provide a mixed picture of the appropriateness, ethics, and responses to nurses facilitating prayer with patients.

A parallel but limited body of research has studied prayer as a coping strategy for nurses themselves. A survey of American perianesthesia nurses (Cain, 2019) found they experienced prayer positively as a coping strategy, through the mechanisms of providing assistance, providing acceptance, providing calm, and deferring. In Malaysia, prayer (*Salat*) contributed to alleviating job stress and enhancing well-being and life satisfaction for Muslim nurses (Achour et al., 2019). A recent study in the United States (Klitzman et al., 2022) explored how hospital chaplains developed rituals to support medical staff (including nurses) during the pandemic. Challenges arose, including hospital leaders' wariness, resistance or lack of support, and staff time constraints, making briefer rituals more practical. A Canadian study (Lapum et al., 2021) found how prayer brought nurses together at the start of a shift no matter what their religion or if they were religious. A survey of nurses found that interactions with chaplains were associated with decreased employee perceived stress for nursing staff caring for severely ill patients (Liberman et al., 2020). In sum, the evidence suggests that, although challenges may arise, prayer can be a positive coping strategy for nurses and can serve as a connecting point on a team.

Viewing prayer through the lens of social relations foregrounds those social interactions and structures in societies through which relations of power play out to result in social and health inequities (Vonneilich, 2022). The last years have seen a robust nursing literature develop on such social relations in relation to ethnicity and racialization (Hilario et al., 2018; Kimani, 2023; Racine, 2021), often with an intersectional lens but remarkably little of this literature incorporates religion/spirituality, and even less relates to prayer. Where nursing literature on prayer picks up on social relations, the focus is on prayer as patients' coping strategy in the face of racism (Jones et al., 2019; Spates et al., 2020) and on inequitable religious accommodation for those who desire prayer (Kidd et al., 2020). Several stories have surfaced in Canadian and British media about nurses offering prayer, and about nurses not respecting religious practices. For example, in 2016, a British nurse (Alexander, 2019) was fired after offering to pray with patients ahead of surgery. In Canada, a nurse was disciplined for cutting the beard of an elderly Sikh man (Canadian Broadcasting Corporation, 2010; Kang, 2022). Also in Canada, the 2020 *In Plain Sight* Report provided an incisive detailing of the pervasiveness of systemic and individual Indigenous-specific racism in British Columbia healthcare had as “root cause” the willful ignorance of Indigenous “knowledge of bodies, both physical and spiritual” (British Columbia Ministry of Health, 2020, p. 4). The British example shows how religion can be contentious in the context of healthcare, and the Canadian examples show the importance of religious literacy for nurses so they understand the significance of religious and spiritual practices. Through an equity lens, these examples begin to show the contested political terrain of religion and spirituality in healthcare, and point to the need to examine taken-for-granted assumptions, such as the neutrality and universality of spirituality, while analyzing social relations of power, including racialized religion and religious patriarchy, which may result in social exclusion (Clark and Saleh, 2019; Reimer-Kirkham, 2014, 2019). The literature review points to the limited research addressing nurses and prayer, and thus provides a rationale for the study. When prayer is understood through a broad lens (i.e., prayer as a connection between humans and the divine, another being, or energy life force), as religious or nonreligious, and as embedded in social relations, new understandings can brought to an understudied and complex aspect of the discipline.

3 | METHODS

The purpose of our qualitative study was to explore ways that prayer is manifest—whether embraced, tolerated, or resisted—in healthcare, and how institutional and social contexts shape how prayer is understood and enacted. To extend the findings reported elsewhere (see book *Prayer as Transgression? The Social Relations of Prayer in Healthcare* by Reimer-Kirkham, Sharma, Brown, et al. [2020]), this paper reports a subanalysis on the data pertaining to nurses and prayer. Objectives specific to this paper are to (1) Critically examine how nurses integrate spiritual support, including prayer, in patient encounters, given institutional routines and social contexts; (2) Explore how nurses seek and experience spiritual support and prayer for themselves; and (3) Analyze how nurses' approaches to prayer can promote or counter equity-oriented care. For this focused analysis on nurses, we employed interpretive description (Thorne, 2016), a method designed to answer questions of relevance to a clinical discipline in which understanding something of the nature of the focus of that discipline's action is considered important (a point that we return to in the discussion).

Qualitative data collection in Vancouver and London involved interviews with 21 nurses, some of whom held clinical and senior leadership positions (see Table 1). Nurses were recruited by clinical collaborators who distributed a research project brochure and email message to potential participants. Interested participants contacted the project coordinator. Informed consent was obtained with the distribution of study information and the consent form via email before the interview. We answered any questions before receiving the signed consent form. We conducted in-depth, semistructured interviews lasting approximately 1 h. Many of the interviews occurred at the nurses' workplace, which allowed for contextual insights. Using a data-driven inductive approach (Thorne, 2016), our analysis was iterative and reflective. Data management software, NVivo™ 11, provided a comprehensive platform for organizing and conducting our analysis. Initially, data were coded independently by researchers into themes and subthemes with ongoing discussion and revision with the research team. Differences were resolved through discussion and themes and subthemes were amended accordingly.

TABLE 1 Sample of nurses.

Demographic characteristics	Vancouver (*n* = 15)	London (*n* = 6)	Total (*n* = 21)
Nurses	15	6	21
In clinical practice	8	4	12
As leaders	5	2	7
Retired	2	–	2
Religious affiliation (self-identified)			
Christian	2	1	3
Catholic	5	1	6
Quaker	1	–	1
Seventh day Adventist	1	–	1
Muslim	2	1	3
Hindu	1	–	1
No religion	3	3	6
No response	–	–	–
Ethnicity			
African	–	1	1
African-Caribbean	1	–	1
Asian (incl. Philippines, Chinese)	6	–	6
Middle-Eastern	–	–	–
Southeast Asian	2	–	2
Canadian	6	–	6
European (English, Irish)	1	5	6

3.1 | Methodological considerations: Scientific quality, ethics, and limitations

Scientific quality was ensured with triangulation accomplished through multiple data sources, an interdisciplinary research team, and diverse research sites. Extensive field notes and memoing, along with regular team conversations, contributed to reflexivity, with thoughtfulness about our views on prayer and our religious identities. Ethics approval was obtained from health authorities and universities in Canada and Britain. Limitations of the study relate to the representativeness of the data collected. Given self-selection into the study, there is a degree to which an inherent bias to positivity toward prayer may exist. We actively sought out those who described themselves as nonreligious to broaden the representativeness of the sample. Because of some religiously affiliated research sites in Vancouver, our findings from these cannot be considered generalizable to other Canadian healthcare organizations.

4 | FINDINGS

4.1 | Nurses and prayer

With prayer as a proxy for spirituality and religion in healthcare settings, our study showed concurrent trends of secularization and sacralization in healthcare settings. Across participant groups, descriptions of prayer fell within a broad catchment of communication between humans and the divine or another being or life force (see Sharma and Reimer-Kirkham, 2020). Some participants held religiously embedded views, such as a retired nurse (Vancouver, Catholic, Euro-Canadian) who said prayer was "my reflection time with God." At the other end of the spectrum were those who held nonreligious views of prayer, as described by a nurse in London (no religion, English[3]) as "an internal chant providing spiritual guidance." Prayer could be formal or informal, scripted or free form. With this range, conceptions of prayer might involve a connection with a superior being, deity, or one's own deeper self.

When looking more closely at the data from nurses for this paper, quickly apparent was the extent to which they were imbricated in the social processes of prayer. The first theme relates to nurses' spiritual support for patients. By the very closeness to a patient's intimacies and vulnerabilities at the point-of-care, nurses were looked to for spiritual support, though this rarely involved prayer. Nurses' kindness could buffer the loneliness and exclusion of mental illness and dementia and in this way support the "spirit" of those in their care. The second theme presents findings about spiritual support (including prayer) for nurses. Spirituality and prayer could be deep reservoirs to sustain a nurse through grueling work. With an equity lens, the third theme sheds light on nurses' engagement with prayer and spiritual support as an axis of social differentiation and site of equity-oriented responses.

4.2 | Spiritual support for patients, sometimes involving prayer

When we asked nurses in our project about offering prayer to patients or responding to patient-initiated requests for prayer, the picture was that of providing some spiritual support for patients by facilitating patients' spiritual practices, which sometimes included prayer. Of the 21 nurses in our study, nine nurses said they had at some point prayed with a patient. Sometimes this was as an invited participant, as in the case of a London nurse (no religion, English) when a palliative patient asked their health team to pray around his bedside. Another nurse described how she would "say a prayer along with the priest in unison" when communion was offered to a bedbound patient. Another nurse (Vancouver, Christian, African-Caribbean) who sang (for herself) as she worked, said patients sometimes asked her to pray, as they would recognize by the

[3]To assist with contextualizing our interpretations, we provide location/city, religious affiliation, and ethnic ancestry as provided by the participant.

Christian songs she sang that she was a person of faith. Two nurses recounted praying regularly with a patient whom they had cared for over long periods of time. In both cases, there was concordance between their religious affiliations, which were points of connection with these patients. Only one nurse (Vancouver, Catholic, Euro-Canadian) told of offering prayer to patients (i.e., nurse-initiated prayer), and this was when she perceived there was no other intervention:

> There are patients who are lost or depressed with all those very strong emotions in the middle of the night. When there's nothing I can give them as an intervention, I say "Can I pray with you?" and they usually nod. I'll just say a short prayer and the person and I feel better afterwards because there was nothing else I could offer that patient.

This nurse also offered a therapeutic touch, describing the positive effects of the person feeling calmer, at peace, able to sleep, eased pain, or "they can think clearly."

4.2.1 | As person-centered

Several nurse participants connected the support of religious practices to person-centeredness. A palliative care nurse (Vancouver, Catholic, Euro-Canadian) said:

> We try to assist the family and the patient to die the way that they had lived, which means that if they're Buddhist and they have certain number of hours they need to do some chanting as a group in the room, we say "It's okay, you can do that." Because it's part of the grieving, mourning process. Or some Jewish people need to have certain things done within a short period of time before the body is buried, we help them with that. Some like to be washed and be dressed as if they're going somewhere, which they are, so we do that as well.

Many named presence and kindness when they spoke about how they offered spiritual support. A nurse (Vancouver, Muslim, Chinese) described attending the ceremony of a Buddhist patient who had died:

> They are reciting in a different dialect, singing, and I don't understand what they're doing. But in looking at the expression from the family, I feel that our presence is a support for them. We're giving some human love. Human kindness, right?

4.2.2 | With professional boundaries

There was variation among participants in their understanding of whether professional standards and codes of ethics allowed prayer with patients. Social workers, therapists, and physicians were less concerned with professional boundaries to prayer compared to nurses, with one physician going as far as "prescribing prayer." In both Vancouver and London, nurses as compared to other healthcare professionals were less likely to expect that they would engage in prayer with a patient. It is likely that the public cases in Britain of nurses being disciplined on account of praying with patients influenced how prayer was perceived. Nurses' ambivalences might well also have to do with variation in what they were taught about spirituality, spiritual caregiving, and prayer.

4.2.3 | As interprofessional practice

Most nurses referenced the role of chaplains in providing prayer and spiritual support to patients, and noted the contribution of chaplains to multidisciplinary teams. Nurses' attunement to spiritual and existential concerns could facilitate expert care of chaplains (by referral). Indeed, chaplains were reliant on nurses, as an entry point to referrals. A Catholic spiritual care volunteer in London explained: "when I come to the ward, I usually introduce myself to the nurses. Some nurses say to me there's somebody who doesn't want to be seen, or there's somebody who they think might need my service." In one site with a relatively well-resourced chaplaincy service, nurses tended to divert spiritual care conversations to "the experts" (i.e., chaplains). Yet, one nurse (Vancouver, no religion, Euro-Canadian) mused that the nature of nurses' 24/7 presence with patients means "those questions come up at 11 p.m. and there is no spiritual call person on call, nursing is the best sometimes to have those discussions" about "ruminating" matters pertaining to the spiritual. Her astute interpretation was that patients opened up to nurses based on the relationship they had with the nurse.

4.2.4 | As varying by context

Despite the intimacy and proximity of nurses' work, nurses explained that the contexts of care did not always lend themselves to spiritual support and prayer, given all "the medicineness and nursingness." A London nurse (self-described as "spiritual" and English) was thoughtful about whether a patient could express their religious preferences on a six-bed ward, noting how "institutionalized" patients "lose their identity in the hospital": As a patient, you are in a bay with six others. "I don't feel people are really able to engage in spiritual practices. While it is not exactly frowned upon, it is difficult to do." The findings presented a variated approach to spiritual support, depending on the clinical area. While nurses in palliative and long-term care settings spoke to facilitating prayer and ritual, other settings like Emergency did not lend themselves to creating a quiet space for prayer. An emergency room (ER) nurse (Catholic, English) in London said, "In ER; most of my colleagues, if I thought about it, would probably run a mile if somebody said, 'would you stay and pray with me.' This is not an appropriate place to pray." Thus, prayer for patients by nurses

tended to be seen as transgressive, crossing the boundaries of professional standards, clinical priorities, and hospital spaces. When prayer was offered by nurses, which was rarely, it was typically in situations of a long-standing relationship and shared beliefs, or as a last resort to offer some comfort.

4.3 | Spiritual support (involving prayer) for nurses

Prayer was also offered for the well-being of nurses, whether by nurses themselves or by others such as chaplains.

4.3.1 | Praying for oneself

Spiritual support for nurses was vital for many in our study. Some nurse managers were tuned to the link between nurses' well-being and spiritual support, as reflected by a manager (Vancouver, no religion, Euro-Canadian) who described asking nurses who faced a difficult circumstance (e.g., after a critical incident): "what supports do you have at home and what do you lean on to get better from this? Some people will say, 'my faith.'" Several nurses spoke of praying for their own strength and wisdom before, during, or after their shifts. A nurse in Vancouver said: "I try to go to the chapel just before I go home to say a quick prayer" (Catholic, Asian). In our fieldwork, it was not unusual to see a nurse stop by one of the sacred spaces to meditate and pray, and to write in the prayer book. One nurse who did so also said they would pray silently for a good outcome when performing a skill such as starting an intravenous. Another nurse explained, "saying a prayer, having a quiet moment has allowed me to put one foot in front of another" (Vancouver, Catholic, Euro-Canadian). Nurses also told of praying with other staff, or attending Muslim prayer or Mass. A Muslim nurse in Vancouver spoke of how difficult it was to find time and space at work to pray, including the problem of not having access to sufficient washing facilities: "this does not feel like a sacred space in which to pray." While Christian nurses spoke of praying comfortably at the Catholic chapel as they arrived or left work, this Muslim nurse did not have the equivalent access to prayer space.

4.3.2 | Chaplains' prayer for nurses

Nurses might reach out to chaplains for prayer, as was the case of a nurse (Vancouver, Catholic, Asian) who quietly asked a chaplain to pray for her mother: "can we pray here Father"? They took a brief moment to pray together on the ward. An unexpected finding related to nurses' requests for room blessings, which was apparently not an uncommon practice after the death of a patient. Intensive care unit (ICU) nurses approached a chaplain after a room had had several deaths in a row. Their invitation was: "We want your prayer, as God seems to listen to you and brings peace and calmness to situations." In another case, a nurse (Vancouver, Buddhist, Asian) would ask the long-term care chaplain to bless a room after a resident died, as a kind of ritual, so that it would be "free of spirits before the next resident moves in." The blessing involved the staff—from a variety of faith traditions and none and who all wanted a blessing so that the room would be a place of peace and comfort—gathering with the chaplain who prayed for the person who had died, for her family, for the new person about to arrive and for the care team who have to say "good-bye" and then "hello" so frequently and so quickly. Apart from the metaphysical dimension of the prayer, there was a social and spiritually supportive aspect to the chaplain acknowledging in her prayer the emotional labor of those caring for dying residents. Room blessings solidified the sometimes-liminal team membership of a chaplain and gave insight into the ways nurses draw on religious beliefs in everyday practice. Nurses' prayers at work also reflect religious accommodation, whether as support from a hospital chaplain or access (or lack of access) to a prayer space.

4.4 | Nurses as agents of equity and religious accommodation

Aligned with our interest in analyzing the social relations of prayer, a third theme relates to nurses as agents of equity and religious accommodation. There were poignant examples of nurses facilitating rituals and spiritual practices in the spirit of spiritual support, human connection, and person-centeredness. Some nurses were advocates for and enablers of social inclusion at the point of care by their presence with a patient to provide spiritual support (sometimes through prayer) and their facilitation of ritual and spiritual practices, but they could also through omission or commission enact social exclusion and thereby deny religious accommodation.

4.4.1 | Religious accommodation

As examples of religious accommodation, facilitating spiritual practices could involve ensuring access to material objects, such as a rosary or sage for smudging, which required a degree of knowledge about the meaningfulness of a religious tradition. A nurse manager of professional practice (Vancouver, no religion Euro-Canadian) told how she encouraged nursing staff to accommodate a Buddhist tradition after death:

> At first some nurses said, "oh you can't have that. They can't stay for 12 hours." And I asked, "why can't they?" "Well everybody would be upset." I said, "I'm pretty sure that they're not going to be upset but I'll tell them." So I just explained to people that there was a religious practice that was going to occur and they might hear a dinging of a bell. It still gives me goosebumps, because of the peace and quietness that descended on that unit for 12 hours.

Notable in this example is that a nurse in clinical leadership sets the tone regarding religious accommodation as an expected and vital aspect of care. Though not commonplace, where careplans provided information as to accommodation of religious ritual or spiritual practices, nurses were likely to facilitate these. A nurse manager (Vancouver, Muslim, Indo-Canadian) in a long-term care setting explained how she would create a careplan that included a resident's preferences for religious attendance so that they could be ready for prayers at 0500.

4.4.2 | Religious illiteracy

The rare occurrence of nurses' offering prayer was typically accompanied by ambiguity, in that nurses were awkward with their interview responses, wondering whether they had "permission to pray" as one nurse put it (London, no religion, Irish-British). This ambiguity could be on account of religious illiteracy as illustrated in the preceding paragraph, or a lack of education about professional boundaries and obligations regarding religious accommodation. A White English nurse who described herself as "spiritual" had come to view spirituality as very important to her palliative care practice, but said it had been only "touched on" in her nursing education. For others, any question about permission was answered with firm prohibition. An African-Caribbean Christian nurse in Vancouver, said, "I've been a nurse for 25 years and it's always been very clear, you do not bring your religious opinions to work and you do not share them. Do not bring religion to work." Along similar lines, a nurse in Vancouver (Christian, Euro-Canadian) was reprimanded for prayer with a patient, being told by a colleague, "we don't pay you to pray." These examples hint at the politics of prayer, where prayer is seen as not fitting with the delivery of health services, regardless of a patient's preference.

Where nurses were not agents of religious accommodation, this omission could be on account of their lack of knowledge, or on account of resistance and racism. The religious and ethnic diversity of Vancouver and London resulted in nurses caring daily for patients with a variety of spiritual practices and beliefs. Despite this everyday occurrence, there was a troubling degree of religious illiteracy (Dinham & Francis, 2015), where nurses seemed to not know how to provide spiritually supportive care. The following excerpt shows a London nurse (Muslim, Black African) coming to recognize how they might accommodate a patient's religious practice:

> Two days ago I had a Sikh gentleman who had a stroke. Because the stroke affected his hand he couldn't control his turban. He said to me, "nurse, do you realize how much this has affected me? I feel lopsided with my turban. I'm not able to fix it because my hand." I talked to the Sister in charge: "you know in reflection, more could have been done for him. Maybe we could have spoken to him about his religion, his religious practices and done more to help him with his recovery." He was very anxious and unsettled and maybe religion was one need that was not fulfilled. Perhaps by addressing his religious practice and his spiritual need, his anxiety would also have been addressed.

It was the nurse's participation in our study that nudged her to consider the role of accommodating religious practices in the context of nursing care; perhaps her religious identity as a practicing Muslim also sensitized her. Another nurse recognizing the impact of language discordance mused: "There may be opportunities where we didn't have that conversation with the patient or family because they didn't speak English and we wouldn't necessarily get an interpreter just to say, 'Do you want Pastoral Care or Spiritual Care?'" (Vancouver, Catholic Christian, Euro-Canadian).

4.4.3 | Racialized spiritual support

As another example of missing an opportunity for culturally specific accommodation of spiritual practices, when an Indigenous youth in ICU was referred to the spiritual care department, but not to the Indigenous wellness services, the youth and their family did not receive the culturally aligned care they desired. While some might explain this misaligned referral as an oversight, an equity-oriented interpretation would understand it as part of the larger pattern of willful ignorance that underpins systematic Indigenous-specific racism. An Indigenous elder told of their common experience of being ignored when she arrived on a unit to provide a sacred ceremony for an Indigenous patient, as nurses at the desk would either ignore her or she would be greeted with "eye rolling," both of which she experienced as Indigenous-specific racism rooted in centuries of colonialism.

Also indicative of racializing religious practices were instances where nurses were not tuned to providing a patient with supplies for washing before prayers. Such preparations were unwelcomed in some situations, as with a nurse (Vancouver, Christian, Euro-Canadian) who resisted providing washing facilities to a bedridden patient of South Asian ancestry and made the off-hand comment: "my God does not require me to be clean to pray." The nurse, speaking from a place of privilege as affiliated with the majoritarian religion of Christianity in Canada and as of White ancestry, is maintaining social structures of classification and belonging with her remark. This last theme provides a rereading of the data through an equity lens to elicit how prayer and spiritual support could serve as sites of social inclusion or exclusion.

5 | DISCUSSION AND IMPLICATIONS

Findings on nurses' involvement with prayer and spiritual support (i) present clinical implications for self-reflexive, religiously literate, and collaborative nursing practice; (ii) suggest organizational obligations

for workplace spirituality as a mechanism of support for nurses, religious accommodation, and equity-oriented care; and (iii) point to the need for more critical approaches to knowledge generation about the social relations of prayer and religion to address nurses' practices that unwittingly sustain racialized religion and social exclusion.

5.1 | Clinical implications for nursing practice

Given the reticence and inconsistencies regarding spiritual caregiving and offering prayer by nurses, and the diverse situations in which they provide care, clinical implications for nursing practice relate to self-reflexivity, collaborative practice, religious literacy, and cultural safety/antiracism. It was not unusual for nurses in our study to express deeper self-awareness and reflection because of participating in the study, with comments beginning with "this study has had me thinking….". In the recently updated Spiritual Care Competencies developed by a group of European nurse scholars (McSherry et al., 2021), intrapersonal spirituality with awareness and use of self is the starting competency for nurses, requiring the nurse's handling of their own values, convictions, and feelings in their professional relationships with patients, especially those who hold beliefs and religions different from their own (van Leeuwen, 2020). In their classic article on prayer, Winslow and Winslow (2003) offer practical guidance on ethical practices in the context of prayer, including that the nurse "seek a basic understanding of patients' spiritual needs, resources, and preferences; … follow the patient's expressed wishes regarding prayer; … should not prescribe spiritual practices or urge patients to adopt religious beliefs nor should nurses pressure patients to relinquish their spiritual beliefs or practices [i.e., spiritual practices must be voluntary]; … and that nurses understand their own spirituality" (pp. 172–175). Such guidance can guard against the risk of nurses' unethical and unprofessional imposition of beliefs and practices on patients during vulnerable times (Pesut & Thorne, 2007; Taylor, 2020).

For nurses to "run a mile" at the suggestion of prayer (as quoted above) implies the need for acknowledgment of the presuppositions and values about spirituality brought to clinical practice. Nurses perceived that they lacked "permission" in this domain as to professional boundaries, particularly in the social context of secularism. This perception was reinforced by a lack of practice support (whether clinical tools or resources, continuing education, or policies) to give guidance to spiritual assessment and support. The question of who provides spiritual care has not been well addressed in nursing literature. In nursing's claims for "holistic care," spiritual dimensions of care are often referenced with the inference that spiritual care is a mandated role for nurses, in a universalizing sense (see, for instance, the recently developed *EPICC Spiritual Care Competencies Model* [EPICC Network, 2023]) out of Europe that has as its foundational assumption that nurses provide spiritual care). Interprofessional practice is such that nurses, social workers, and physicians may well participate with chaplains in providing spiritual support, particularly when chaplaincy teams are not well-resourced (Taylor & Trippon, 2020). Differentiation is required as to the nature of this spiritual support. An emerging model of spiritual care as collaborative practice has been proposed by Donesky et al. (2020) with nurses providing primary spiritual interventions (specifically, offering support when the patient is alone, referrals to specialized spiritual care, facilitating religious or cultural practices, recognizing and acting on openings for spiritual conversations, practicing of presence, and intervening with grief and bereavement), compared to chaplains' specialty care (e.g., spiritual and theological reflection, mediation of religious, or culturally based conflict; providing religious resources and rituals). For the nurses in our study, this type of collaborative model would address their concerns about permission to engage with spiritual dimensions of care and would provide clarity about complementary professional roles and corresponding educational needs.

The findings revealed nurses' ambiguity around spiritual support and prayer, and a general lack of attunement to religious practices, with comments that they had not been taught about such things. Nursing education has over the last decades taken a generic approach to spirituality with an emphasis on personalized values and practices, rather than religiously affiliated beliefs and rituals (Fowler et al., 2012; Timmins & Calderia, 2019). This approach has inadvertently contributed to religious illiteracy among nurses, whereby they have little knowledge about caring for patients with prescribed religious practices (such as the proscription of a Sikh not cutting hair). According to Dinham and Francis (2015), religious literacy refers to the appropriate language and understanding to engage with religion and belief in policy and practice. In addition to explorations of personalized spirituality, education should incorporate those traditions most common in a surrounding community to foster cultural and spiritual safety. Further, as Chan and Sitek (2021) propose, religious literacy situates the nurse–patient encounter in the context of societal influences and power relationships inherent in majority and minority traditions. For example, religious literacy can offer a framework to help practitioners perceive their place in a majority or minority tradition and their potential bias as a result, as opposed to learning about their bias through experience, which can be detrimental to the client and practitioner. Additionally, religious literacy can help identify how majority and minority traditions inform the local society in positive and negative ways, historically and today (p. 113).

Of note is how religious literacy can expand the frame of reference for a nurse, to understand the social dynamics of power at play in any nurse–patient encounter (Reimer-Kirkham, Sharma, & Corcoran Smith, 2020).

In Canada and other countries with decolonizing imperatives, religious literacy involves deep reflection on how structural and systemic racism is perpetuated through generic and apolitical approaches to spirituality and religion (Reimer-Kirkham, 2019). Religious literacy and an antiracist, equity lens can bring into focus the everyday interactions that reflect and prop up systemic racism. Sue and Spanierman (2020) interpret these as microaggressions, those verbal and nonverbal interpersonal exchanges in which the perpetrator causes harm to a target, whether intended or unintended.

A complex relationship exists between such interactions and the macrostructures, whereby "everyday microaggressisons are manifestations of systemic inequities in the larger society" (p. 9). The microaggressions in this study varied—sometimes unconscious and unintentional (e.g., overlooking the meaningfulness of prayer and spirituality for a patient and their family), other times verbal in nature (negating prayer and its accompanying practices as reflected in a comment "my God does not require me to be clean"), or even physical in nature (e.g., not offering access to prayer space, such that a Muslim nurse prays in a cluttered office space). Through an intersectional lens (Crenshaw, 2016), many of these microaggressions in our study were racialized, with resistance more likely to those practices of diasporic groups and racialized religion (Joshi, 2016). They may also reflect a hierarchy in which certain religions are privileged, typically with Christian-centered approaches as the center or norm. Pentaris (2018), writing in the context of end-of-life care in England, discusses the microaggressions that flow from assumptions made about someone's religious beliefs and practices, and the impact of invalidation of the significance of religion, even when done in subtle ways. Such microaggressions can be understood as stemming from and complicit with structural and systemic racism that characterizes nursing in Canada and elsewhere (Beagan et al., 2023).

Offsetting these racialized microaggressions was a second storyline of nurses creating connections across differences through prayer. Indeed, as Ahmed (2012) observes, "the body can be a meeting point"—and it is in vulnerable and intimate spaces where nurses can bridge socially inscribed differences through the incorporation of values and beliefs and the accommodation of religious practices. The relationality of nursing can create space for what has meaning. In our study, we saw that for many people transcendence, sacredness, and prayer continue to have deep meaning in relation to health and illness. Regardless of the clinical setting, the relational aspects were a prerequisite to prayer. The motivation for this connection was a profound regard for the personhood of each individual. Prayer was constructed as presence with another more so than connecting with the divine or a Higher Being: "praying with" rather than "praying for." Such results point to a mesh between nursing's knowledge generation in relation to current emphases on person-centeredness, and the imperative of an equity-oriented lens in response to contexts of diversity.

5.2 | Organizational obligations for workplace spirituality

The spiritual dimension and spiritual support were of importance to nurses themselves, on account of their own religious identities (Brown et al., 2020) and on account of the spiritual suffering they witness and endure (Quinn, 2020). That chaplains were involved in providing spiritual support to nurses in our study stands as an example of healthy workplace spirituality (Hildebrand et al., 2023; Pirkola et al., 2016; Reimer-Kirkham & Cochrane, 2016), where resources are provided to support the spiritual and emotional wellbeing of staff as an organizational priority. The room blessings described in our study provided this type of support for nurses, and exemplify the practicalities of nurses at the frontline of diverse societies. Balmer et al. (2022) describe such room blessings as offering meaning-making and ritual to support nurses in the substantial death and dying responsibilities they carry, particularly with the societal secularization of death and dying. Supporting spiritual wellbeing in the workplace was appreciated by the nurses in this study, and is increasingly referred to in the literature as a route to resilience and worker retention (Baber et al., 2023; Hildebrand et al., 2023; Kubitza et al., 2022). There is, however, a caution to an individualizing approach, where the nurse's resilience is seen as an area of personal growth for a nurse, rather than the impetus for organizational change to create healthier workplaces (International Council of Nurses, 2023).

An aspect not typically connected to healthy workplaces for nurses but one that showed up in this study was that of sacred spaces (formerly referred to as chapels). The hospitals in Vancouver and London had put resources into creating spaces for reflection and prayer, which were accessed by some of the nurses. In London, hospitals had spaces that reflected the multifaith society, with Christian chapels, Muslim prayer rooms, and other sacred spaces such as indoor gardens for all and the nonreligious. During our fieldwork we observed nurses accessing these spaces during their worktime to pray. In Vancouver, several of the nurses spoke of their prayers in a hospital's Christian chapel. There was not, however, equal access to prayer spaces in Vancouver, as reflected in a Muslim nurse's observation of not having a place that felt "sacred" in which to say prayers. Likewise, an Indigenous Sacred Space was kept locked and could only be accessed with permission. The UK Equality Act (United Kingdom Government, 2010) requires employers to recognize and treat equally and fairly a number of protected characteristics including race, religion, or belief. International (United Nations Human Rights Office of the High Commissioner, 1966), national (Canada Government, 1982), and provincial laws (e.g., British Columbia, 1996) recognize that employers must accommodate daily prayer breaks to the point of undue hardship. Employers are not necessarily required to provide designated prayer areas, though if this is something that can be arranged, it may be preferable to having the employees leave the workplace. In this way, religious accommodation represents a minimum standard for a healthcare organization.

Beaman (2021) raises a worry about framing organizational obligations as religious accommodation for the risk of automatically biasing discourse against those who are religious by implying that some people's religious views create additional or extraordinary demands on the system over and above the needs of "normal" (nonreligious) members of the community. She also raises the essentializing of religious identities that can occur through a religious accommodation framework. Here the literature on workplace spirituality can be helpful in its positive connotations of creating healthy workplaces while no less obligating employers to observe human rights requirements for religious accommodation (Héliot et al., 2020). This study on prayer thus unveils the complexity of prayer by

and for nurses in a healthcare setting, including the professional ethics of prayer, as well as the organizational ethics of providing space for prayer as a matter of religious accommodation and workplace spirituality.

5.3 | Critical approaches for generating knowledge

Our study findings also carry implications for nursing knowledge generation that unsettles conceptions of faith, religion, and spirituality. Nurses work in contexts of remarkable diversity, given how (i) migration and diasporic communities continue to transform cities such as Vancouver and London, even as (ii) ecological and new eclectically created spiritualities thrive, (iii) majoritarian religions decline, and (iv) colonial-imperial relations are addressed. These four elements (what Beaman [2021], refers to as "new diversity") signal shifts in power relations around religion, and all four were at play for the nurses in our study. Although often forgotten about or combined and subsumed under the study of race or culture, religion is a marker for social categorization and deeply affects inclusion and exclusion in a way that is similar to race, class, gender, and age. Nursing would do well to heed feminist critiques of diversity discourses as inferring "benign variation … which bypass power as well as history to suggest a harmonious empty pluralism" (Ahmed, 2012, p. 13). This is particularly true in nursing scholarship in relation to spirituality that tends toward the apolitical, even as diasporic religions continue to be marginalized through processes of racialization and exclusion. Where generic approaches to spirituality and spiritual care have been *de jour* (and defensibly so as a transition from majoritarian Christian-centered pastoral care), today's healthcare services ought to incorporate a critical multifaith approach (Sharma & Reimer-Kirkham, 2023).

Secular societies marked by multifaith citizenries, as Canada and England are, have legislated separation of church and state. As Taylor (2007) points out, these are not situations where the public sphere is devoid of religious presence (what he refers to as the "subtraction theory"). Rather, living well together (i.e., coexistence) involves expressions of religion and nonreligion (though not as state-imposed or administered). In a diverse contemporary society, there is thus an acknowledgment of remarkable religious diversity that includes nonreligion and religion alike, rather than suppression of it (Jukier & Woehrling, 2015). The state operates from a neutral space and recognizes the diversity of its citizens (referred to as "open secularism," Bouchard & Taylor, 2008). By this legislative framework, nurses (and healthcare) would not ignore, generalize, or deny spirituality and religion in attempt to maintain a "neutral" and religion-free healthcare space. While the administration of most health services in Canada and the United Kingdom are administrated by the state and are not faith-affiliated,[4] to offer person-centered and equitable care requires responsiveness to the meaning systems (values, beliefs, practices) of patients. The majoritarian religion of Canada and England (i.e., Christianity) continues to have the strongest affiliation (as depicted in the frequencies provided in the opening sections of the paper), but other expressions are equally belonging. The boundaries to the expression of faith, religion, and spirituality have to do with imposition and harmful practices, regardless of what faith tradition (or none).

Where a generic spirituality approach with its universalizing tendencies tends to assume sameness, the solution lies not in emphasis on difference (given the risks of essentializing and othering), but rather in those democratic spaces of similarity between universalism and particularism (Reimer-Kirkham & Beaman, 2020). The tendency in nursing and healthcare scholarship is to pose a binary of universalist and particularist approaches to spiritual care (as exemplified in the organizing structure for Liefbroer et al. [2019] systematic review of interfaith spiritual care). Our study shows a third way where nurses were able to "work things out" at the point of care with agonistic respect (Beaman, 2017), where there is "a willingness to engage with the Other without desire to change that person, but instead engaging in a manner that takes equality as a given" (Reimer-Kirkham & Beaman, 2020, p. 52). This third way ran counter to the microaggressions and religious illiteracy discussed above and was illustrated in the room blessings in our study.

6 | CONCLUSION

Today's biomedical, secular healthcare environments do not easily create space for matters spiritual in nature, and yet for many people, the illness experience carries spiritual dimensions. Nurses are inevitably interacting with people's values, beliefs, and practices (oftentimes without intentionality). Despite inconsistency in spiritual care competency, and for all the pressures of current-day nursing practice, most nurses in our study showed capacity and commitment to providing person-centered, humanizing care in the midst of the technological, institutional "medicineness and nursingness" and in the face of diversity. As agents of religious accommodation and through their relational practice, nurses created sites for connection and healing through spiritual support and religious rituals. In other situations, nurses reinscribed marginalization on account of their religious illiteracy, microaggressions, or overt discrimination. Recent receptivity in nursing to social justice commitments should be extended to encompass spirituality and religion as sites of inclusion and exclusion.

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[4]In Canada, Catholic-administered healthcare has gone from representing 35% of all healthcare in 1968 to just over 5% today (Glauser, 2022).

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available upon request from the corresponding author due to ethical/privacy restrictions.

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