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Nurses on the frontline of secular and religious knowledges

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Introduction

Nurses, in their roles of preventing illness and caring for those who are sick, have long been negotiating secular and religious knowledges in a porous exchange (Stammers and Bullivant 2012). These plural and situated knowledges—involving scientific knowledges, religious knowledges, secular knowledges, and nursing knowledges—are entangled and do not operate in isolation from each other, nor from other forms of knowledge. Likewise, the notions of secular and religious are not natural, neutral, or universal, in the sense of being unaffected by historical, social, and epistemological constructions, or apart from politics and power. This chapter presents an overview of the positioning of nursing vis-à-vis secular and religious knowledges, and in so doing sheds light on contemporary landscapes of epistemological privileging in the context of healthcare, whereby some knowledges are routinely privileged and others side-lined.

Definitional matters of how religion and spirituality are spoken about in nursing are relevant to any exploration of religious and secular knowledges. A particular pattern of differentiation has taken hold in nursing and healthcare literature, with religion considered as ‘bad,’ political, harmful, and institutional; and spirituality as ‘good,’ apolitical, life-affirming, and personally meaningful (Bramadat et al. 2013). The intentions in preferring spirituality over religion relate to a construction of spirituality as universal (compared to the particularism of religion) and as less political or contentious than religion. To capture such varying perceptions, I employ the following conceptualizations in this chapter: Religion is difficult to define in any universalist sense but carries transcendent (sacred) and social dimensions with the practice of it often occurring through relatively formal social institutions, expressed in creeds and rituals. Spirituality, while also having to do with the metaphysical, has been interpreted as less institutionalized, and as a more individual expression of values and beliefs but nonetheless grounded in material concerns and relations of power (Reimer-Kirkham, Sharma et al. 2020).

This chapter draws on a programme of research on religious and spiritual plurality in hospitals and home care, including a recent project on the expression of prayer in hospitals in Vancouver, Canada, and London, England. The chapter begins with the voices of nurses in Vancouver and London, reflecting on how religion and spirituality ‘show up’ in clinical
settings (Reimer-Kirkham, Sharma et al. 2020). These nurses’ voices are historicized and contextualized, with a discussion of key junctures that have marked the repositioning of religion and medicine, beginning with Indigenous healers in pre-colonial Canada, who were suppressed and replaced by religious orders and Christian-affiliated hospitals that accompanied the European settlement of Canada. The secularizing processes that separated church and state in the 1900s coincided with a rise in scientific knowledges, the emergence of biomedicine, and the establishment of healthcare as an industry. During this time, nursing too turned from its Christian roots to scientific knowledges to legitimate itself as a profession. The chapter continues with a discussion of the forms that contemporary entanglements of secular and religious knowledges take and how these are navigated by nursing and nurses. The chapter is also forward-looking: nursing can arguably be seen as a bellwether, heralding social shifts and evolving epistemologies of illness and healing. The chapter concludes that any presumed boundaries between secularism and sacralization, science and religion, empiricism and spirituality are relatively porous, while still contested.

The voices of nurses

Nursing in itself is a contested term. Professionalization movements have attempted to draw clear boundaries around who refers to themselves as a nurse, to the extent that nurse is a legally protected title in many jurisdictions, Canada included. With a longer timeline in mind, there is debate about whether, as Strong-Boag (cited in Bates et al. 2005) suggests, the term nurse should be opened up to encompass more broadly women’s longstanding responsibility for maintaining family and community health. Although there are drawbacks to such an encompassing definition, for the purposes of this chapter, the notion of nursing is stretched from early lay caregivers and healers through to today’s accredited nurses, who operate within a prescribed scope of practice in exchange for the legal entitlement to be called a registered nurse. My intent is to include those whose primary occupation has been to care for the sick, and who have in the process navigated and mixed secular and religious knowledges. With this approach, one could arguably include physicians and others who care for those who are sick; however, for the purposes of this chapter, I am honing in on those caregivers whose trajectory ends up in today’s category of registered nurse.

With this stretching, any story of nursing in relation to secular and religious knowledges carries inescapable gendered tones, given that the large majority of nurses have been and continue to be women. Care work, both formal and informal, continues to be constructed along lines of gender, with qualities such as compassion, nurture, and empathy, along with the practices of child-rearing, caring for elders, and the physical work of bathing, positioning, and feeding, deemed inherently feminine (Barnes et al. 2015; Boris and Perrenas 2010; Gilgigan 1993; Tronto 2013). Social structures of employment opportunities and pay, plus patriarchal privilege in domestic and public spheres reinforce these gendered narratives (Hochschild 1979). This strand of how gender shapes the ways nurses take up secular and religious knowledges weaves throughout this chapter.

The voices of nurses in Vancouver and London reflecting on how religion and spirituality ‘show up’ in clinical settings ground this chapter. Consider Lucy and Chen, nurses who are from immigrant communities in Canada; Lucy is part of the Chinese diaspora from Hong Kong and a practising Catholic, and Chen, also of the Chinese diaspora, has Muslim identity. Both told us that they see spirituality as highly relevant to healthcare, as reflected in
Lucy’s comment: ‘you can’t remove spirituality from healthcare.’ Lucy goes on with more detail to explain how religion shapes her practice:

We spend a lot of time talking with the patient. We share with them, support them. And I find religion is important for me to be able to do this. It helps me to have patience. When I pray, I find peace. It helps me to bring some comfort and happiness to the patients.

With these comments, the gendered, emotional labour (Hochschild 1979) of nursing becomes visible, along with religious motifs of comforting and supporting.

Lucy drew on religious beliefs to ground her caregiving, with a description of praying with a patient: ‘I have known this patient for a long time, and each time I start an intravenous on her, we’ll say a prayer in the language we share.’ Lucy also described Catholic and Buddhist patients praying with prayer beads. Chen likewise described the integration of spiritual practices and values: ‘There are staff members, we meet together for Muslim prayers. For patients who are not Muslim, I try to find common ground, whether it be human kindness or touch.’ With Lucy, Chen, and their patients, we see religion actively brought into the healthcare context by their individual identity and spiritual practices (as opposed to the institution itself imposing a religious ethos, though they work at a Catholic-affiliated organization).

Lucy and Chen were more overt with their spiritual practices and more comfortable supporting patients with prayer than most nurses in our study. Shanice, an African-Caribbean Christian 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.’ Many nurses in the London arm of the study shared this sentiment. Emma (a white English woman 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. She also pointed to how healthcare settings do not easily allow for the expression of spirituality:

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 express one’s spiritual identity. We don’t bring faith matters in.

She emphasized that institutionalized practices tend to erase individual preferences: ‘you can’t be free to express your own identity. You have to adhere to the hospital routines.’ Likewise, Zaria, a Black African non-practising Muslim nurse in London, observed,

we don’t understand how spirituality or religious identity translates into practice. We don’t have continuing education, nor information on the wards to prompt spiritual support. We don’t encourage Muslim patients and their families to attend Friday prayers, or Christians to seek out the resources in the multi-faith centre on Sundays.

From Shanice, Emma, and Zaria we glean a picture of contemporary fields of practice where physical environments, workflows, resources, and education mitigate tending to aspects of spirituality and religion. While nurses such as Shanice were tuned to the risk of impositional,
institutionalized power, they valued a person-centred approach that included spirituality. Maryanne, a Euro-Canadian nurse who identified as ‘no religion,’ observed that there is no healing without looking at the spiritual parts of a person. We can provide your surgery, look after your heart failure, but if I want to help heal you as a person, then we need to look after those spiritual things. Spirituality is hugely important, but tends to be buried in tasks.

What do these nurses’ voices tell us about the entanglement of religion and medicine? What authoritative knowledges are they negotiating? Historicizing and contextualizing nursing knowledges helps to answer these questions.

**Historicizing and contextualizing nursing, secular, and religious knowledges**

Several turns (i.e. developments) over the years have shaped the negotiation of secular and religious knowledges in relation to nursing. While this chapter originates in the Canadian context, similar junctures characterize nursing in other countries. In broad stroke, these turns might be interpreted as on a historical continuum from religious and spiritual knowledges toward secular and scientific knowledges, but the nurses’ voices show how these knowledges are concurrent and mixed, rather than sequential and discrete.

Any historicizing and contextualizing of nursing knowledges in Canada must begin with acknowledgement of Indigenous healing traditions that tend to be overlooked in typical Euro-oriented historical narratives of nursing. The pattern has been to portray nursing as arriving with European settlers, however, Indigenous healers and midwives occupied important caregiving roles in their communities long before the arrival of European settlers (Benoit and Carroll 2005; Wytenbroek and Vandenberg 2017). To this day, Indigenous views of healing and wellness are perceived to encompass the balance and inter-relationships of the physical, mental, emotional, and spiritual aspects of a being (Calestani et al. 2012; FNHA n.d.), in relation to one’s community, the land, and the creator. Healing traditions incorporate ceremonies; plant, animal, or mineral-based medicines; energetic therapies; or physical and hands on techniques (FNHA n.d.).

Such Indigenous healing practices were actively suppressed and made illegal as part of Canada’s history of dispossession of land, community, and language—a history summed up as ‘cultural genocide’ by the Truth and Reconciliation Commission of Canada (2015). The extensiveness of this oppression cannot be overstated. The Canadian Constitution (also known as the British North America Act) in 1867 included ‘Indian legislation,’ which in 1876 became the Indian Act, laws that were paternalistic, punitive, and dehumanizing (Joseph 2018). The central goals of this policy, as described by the opening words of Truth and Reconciliation Commission of Canada’s Final Report, were to eliminate Aboriginal governments; ignore Aboriginal rights; terminate the Treaties; and, through a process of assimilation, cause Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada. The establishment and operation of residential schools were a central element of this policy.

(TRC 2015: 1)
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Roman Catholic, Anglican, United, Methodist, and Presbyterian churches were the major denominations involved in the administration of the residential school system. The last of these federally supported schools remained in operation until the late 1990s (TRC 2015). The history of these colonial church-run residential schools has resulted in profound intergenerational trauma for Indigenous peoples as over a period of more than 100 years children were forcibly separated from their families to be indoctrinated into the culture of the legally dominant Euro-Christian Canadian society (TRC 2015).

Medicine and Christianity were partners in colonialism throughout the British Empire. In Canada, from the 1920s—1980s (Lux 2016) Indigenous-focused hospitals served as mechanism to eliminate Indigenous healing practices and to segregate settlers from Indigenous peoples in newly forming community hospitals. These hospitals were also a partial response to the horrific health outcomes being experienced by Indigenous communities on account of the colonizing practices of the state and settler society—repressive legislation and economic dispossession—which had plunged Indigenous communities into hunger and disease. This legacy from the schools, hospitals, and the political/legal policies is reflected in today’s health and social disparities between Indigenous peoples and other Canadians.

These days, Indigenous people access healthcare services which serve as a daily ‘contact zone’ reminiscent of the colonial powers wielded by church-run residential schools and Indian hospitals. A comment made to Chen by an Indigenous woman reveals how the historical trauma experienced en masse by Indigenous peoples over the centuries carries forward into the 21st century, to the frontlines (bedside) of day-to-day nursing practice.

Chen: An Indigenous person made a comment, ‘you coming to our country, you just invaded us and you come to abuse us.’ I took these comments very seriously, so we involved the operations leaders, the social workers. And we ensured that her care would involve more support from the Aboriginal Health team.

The 2015 Truth and Reconciliation Report brought new attention to the responsibility of healthcare organizations to address historical injustices experienced by Indigenous people, by educating healthcare providers and improving Indigenous health services (e.g., with access to smudging rooms and other Indigenous healing ceremonies).

As critical as the mainstream uptake of the TRC’s Calls to Action is in transforming healthcare services, the voices of Indigenous nurses reveal how Indigenous knowledge has always been fundamental to how they undertake nursing practice, regardless of the systemic and historical barriers faced when providing healthcare for Indigenous peoples (Bourque 2014). In the words of Madeline Dion Stout, a regarded Indigenous nurse scholar,

We found grievous fault with these institutions [government funded, church-run residential schools] because they made us strangers on our home and native land, directly assaulted our children and parenthood, and added immensely to our mental stress. But our biggest criticism was directed to the intergenerational trauma, unequal power relations, and the identity politics residential schools have fuelled.

(cited in Bourque 2014: 187)

This thread of Indigenous healers, the colonial legacy, and the wellbeing of Indigenous communities provides a sustained counter narrative to the hegemony of either religious or secular knowledges. I will return to the influence of this Indigenous history later in the chapter,
make the point that through the reconciliation processes currently underway in Canada, there is realization that Indigenous healing traditions and ceremonies with their spiritual dimension must be accommodated in healthcare, and taught in health professions education. The Canadian example of the on-going legacies of the imperial nexus of Christianity and medicine shows how religion is not monolithic in healthcare settings, but rather takes on contextual and historical forms.

Nursing took a distinctive turn with the arrival of French colonialists and settlers to New France (now Canada) in the 1600s. The need for nursing services in the new settlement was enormous, according to French Catholic missionary reports, and soon trained nurses who were members of religious nursing orders, and some ‘lay nurses’ who were not nuns, began arriving from France (Young and Rousseau 2005). They founded hospitals, with Hotel-Dieu in Quebec City in 1639 becoming the first hospital in North America, and Montreal’s Hotel-Dieu following in 1642. These ‘hostels of God’ (in English translation) proved to be the precursors of a widespread network of Catholic hospitals across Canada founded and run by female religious nursing orders, entrenching a religious dominance in healthcare services in Canada that would continue for centuries. Violette (2005) reports that for more than three centuries, over fifty religious orders were associated with the development of the Catholic hospital network across Canada. The early hospitals saw Catholic sister nurses wielding significant power and authority as hospital owners and administrators (Wall 2012), and as educators in the hospital-based apprenticeship nurse training programmes that were to follow.

The religious story of nursing6 varies from country to country, sometimes with immigrant nuns, and sometimes as Protestant deaconesses. Yet, without question, as asserted by nurse historian Sioban Nelson (2001), religious nursing has been formative of the profession of nursing. The hospital was ‘a religious space in terms of both its origins and its purpose’ writes Violette (2005: 58). Catholic nuns and their Protestant equivalents of deaconesses (Legath 2020; Nelson 2001) were motivated by the need to do charitable works such as caring for the poor, old people, orphans, and widows, as the embodiment of the suffering Christ. Their work was motivated by the spiritual dimension and the hereafter—baptizing and ‘saving’ the souls of those in their care, and ensuring the salvation of their own souls through the selfless care they were providing (Violette 2005). The religious motifs of Christian duty and suffering persist in today’s nursing imaginary. As nursing historian Sonya Grypma writes:

The notions of nursing as a lifelong ministry and ‘a consecrated service performed in the spirit of Christ’ were not sectarian ideals meant for a fragment of the nursing populace, missionary or otherwise. Instead, they were central to the professional nursing envisioned, developed, and propagated by a string of capable nursing leaders. . . . The profession that [British and American nurse] leaders envisioned was rooted in Christian perspectives on suffering as a symptom of a broken world, with nursing as an enactment of Christ’s care for the poor, sick and weak.

(Grypma 2012: 146)

In the mid-1800s, the arrival in Canada of the first graduates from the British hospital nursing schools, subsidized by the Nightingale Fund, began to reform nursing as a less explicitly Christian vocation, and a more ‘modern’ profession (Paul 2005). To this day, however, a remnant of the tradition of religiously affiliated hospitals continues in Canada, though representing only 5 per cent of hospitals (Hoskins 2017). These hospitals are typically administered by a religious group (such as the Catholic Health Association) but funded and operated within the public healthcare system, with an agreement in place as to the parameters of service provision.
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The respondents in our study who worked at Catholic-affiliated organization were, to a person, loyal to their employer, perhaps because of its reputation for healthcare excellence and leading-edge medical science. They perceived that the organization offered some uniquely religious values, such as respecting and accommodating religious plurality, and emphasizing more than medical care alone. With the legislation of Medical Assistance in Dying (MAiD) in Canada in 2016, some religiously affiliated healthcare organizations have taken a stance against the procedure being provided in their facilities. As a result, attention has again been given to those situations in which the authority of religious knowledge (in this case, a view on the sanctity of life) is imposed by the organization on employees and care recipients. Indeed, some of our participants indicated they did not agree with the stance of their hospital to not offer MAiD, just as the hospital’s stance on reproductive services was not supported by all employees and affiliates.

In summary, the arrival of missionizing nurses from Europe to Turtle Island (as the ‘New World’ was named by Indigenous peoples) 400 years ago brought caregiving and healing interventions to meet an expressed need in the colonies at the time, and over time expanded a network of religious hospitals across the country. Remnants of the religious knowledges represented by this turn continue to shape nursing to this day, in the religious motifs embedded in the nursing profession and the Christian-affiliated healthcare organizations that provide healthcare services today. However, the gendered monopoly on healing and managing hospitals that marked the occupational group (nursing) would need to re-invent itself for professional legitimacy given the onset of secularization and empiricism, and the rise of male-dominated medicine.

The next turn involves the secularization processes that entailed hospitals moving from religious oversight to state-run administration, and nursing education moving from (religious) hospital-based programmes to (secular) universities. Hospitals in the eighteenth and nineteenth centuries were charitable institutions, some administered by Catholic nuns and others by local elites fulfilling their social obligations to their community’s destitute and poor, but often with abysmal conditions and poorly trained nurses (McPherson 2005). From a nursing perspective, timelines for this transition pick up with the influence of the British nurse, Florence Nightingale, who changed the course of nursing with a shift from lay knowledges and religious orders, to one informed by her meticulous study of empirical disease patterns. The first hospital nurse training programme in Canada, based on the Florence Nightingale model, was established in 1874. Soon thereafter, most hospitals opened nurse training schools, which would flourish for 100 years or so, operated by various religiously affiliated organizations (e.g. Methodist and Presbyterian deaconesses, Catholic nuns, and Salvation Army officers). Initially the mandate was to focus on service, rather than on the academic or professional development of nurses. The mandate for nursing in the nineteenth century was to complement the traditional male-female relationships that characterized the professionalizing aspirations of physicians and their increasing domination of health services (Kirkwood 2005). ‘The practical, domestic skills of nurses were to complement the intellectual, scientific skills of medicine’ (Kirkwood 2005: 183). Notably, in North America, the structuring of the caring professions vis-à-vis medicine also side-lined the female-dominated healing group of midwives (Kukura 2016; Suarez 1992).

By the twentieth century, provincial governments in Canada were expanding healthcare services, with more and more power and resourcing being put to hospitals, eventually displacing the community-based care being provided by groups such as the Victorian Order of Nurses (VON). The VON had been established by the activism of the national Council of Women of Canada in the late 1800s as a symbol of the national obligation (in contrast to a religious
responsibility) for the welfare of poor women and children (Boutilier 1993). The VON was active for decades, providing public health in home settings, but was eventually marginalized by the increasing provision of healthcare in hospitals.

Remarkable during this shift was the transference of power from women (often nuns) overseeing the operational function of a hospital to men holding the power as the medical professionals. Biomedical advances (such as the germ theory of disease and the development of anaesthetics that allowed for surgery) and the corresponding rise of the medical profession saw hospital and health insurance programmes come into existence to make institutional care affordable for a greater number of patients. Federal hospital construction grants helped municipalities expand their hospitals (McPherson 2005). With this state investment, and the need for an expanded nursing workforce within the hospitals, the vision for a better-educated nursing profession was born. Over time, nursing educators had become increasingly unhappy about their loss of control of nursing education as doctors often oversaw nursing programmes; they were also keen to develop areas of nursing expertise (e.g. the prevention of illness and the maintenance of health) beyond what was considered medicine. The first university-based nursing programme opened at University of British Columbia in 1919, followed by the Weir Report of the 1930s which recommended the transfer of all nursing programmes from hospitals to universities and community colleges.

Nursing education, with its arrival into university settings, set out to establish the distinct body of ‘nursing knowledge’ that would give nursing credence as a profession, alongside the dominant profession of medical doctors. Nurse educators developed nursing models to capture the distinctive view of human beings as social and behavioural systems, whereas physicians view humans as biological systems (see, for example, Johnson 1980). As further example, the North American Nursing Diagnosis Association (NANDA) drew up a long list of nursing diagnoses that was to set the parameters for nursing’s unique contribution to the care of the sick. Among this list (that 50 years later is still present in nursing fundamental textbooks, but less visible in day-to-day care), were diagnoses specific to spirituality, including ‘spiritual distress’ and ‘spiritual wellness’ (NANDA 2005). The Canadian Nurses Association included the term ‘spiritual wellbeing’ in its definition of health in 2005, in response to lobbying by its own Parish Nursing Interest Group (Klassen 2011). This case, which extended to lobbying the World Health Organization (WHO) to likewise include spirituality in its definition of health, illustrates nurses as influential arbiters of ‘knowledges’ and definitions of spirituality (See also Rodrigo Tonial’s chapter in this volume).

Several observations can be made of this turn toward professionalization, empiricism, and secularization. As nursing looked to sources of authoritative knowledge in science and empiricism, tensions followed as to how to manage its religious roots. By replacing the language of religion with that of spirituality (as illustrated in the NANDA diagnoses of ‘spiritual distress’ and the lobbying of the Canadian Nurses Association to include ‘spiritual wellbeing’ in WHO’s definition of health), nurses signalled that the domain of spirituality was relevant for their work, but that institutionalized religion was not to dominate healthcare. The on-going legacy of this shift can be seen in comments by Zaria in London:

As I was thinking about this research project, I recalled we used to have Bibles on the wards, but we don’t have them anymore. I don’t know the reason why, but they seemed to have just disappeared, just like that. I suppose we don’t want to promote just Christianity to patients, because we respect our patients from multiple faiths.
Zaria is, in effect, describing de-Christianization (Klassen 2014), as the shift from a society (and state-run institutions) identified with a majoritarian religion to a society marked by pluralism and the state not favouring or putting forward that majoritarian religion. This turn saw the converging trends of medicalization, professionalization, and secularization, and served to distinguish religious and secular knowledges for the nursing profession.

Contemporary entanglements: empiricism and spirituality

This trajectory, mapped from a Canadian vantage point, brings us to the current day. The secularization processes taking expression in the 1800s and 1900s have come to a matured manifestation. Nursing too has been shaped by the confluence of factors that sociologists of religion frame as secularization with its double-sided rationalization-disenchantment process (Christiano et al. 2015). Secularization (and de-Christianization) takes on particular forms in the context of healthcare, as hospitals have become institutions of science and technology, with physicians and nurses as their ‘scientists’ (Balboni and Balboni 2018). Reliance on science and measurement, technologies and pharmaceuticals is paramount in the biomedical treatment of diseases (See also Robert C. Fuller’s chapter in this volume). In parallel, managerial methods and efficiency discourses from organizational studies dominate the administration of healthcare organizations, including nursing. In this final section, contemporary tensions are presented in how nurses navigate empiricism with its corresponding scientific discourses, while providing care in pluralistic societies where patients may hold views that appeal to divine authority and spiritualized interpretations of health and illness. As already seen in this chapter, the boundaries between religious and secular knowledges are not entirely set nor impermeable.

On many healthcare fronts, the dominance of science and managerialism prevail, with care philosophies such as evidence-based practice orienting care to measurable, medical-related outcomes. Major medical advancements and technological expertise have afforded healthcare professionals (especially physicians) a great deal of authority, particularly as these advancements have dramatically extended life expectancies and improved health outcomes. Also entrenched in scientific discourses, administrators employ organizational practices that rely on presumed objective, empirical outcome measures to guide policy-making and resource allocation (e.g. the number of hip replacements in a hospital determines monies allocated) (Stetler et al. 2014; Thorne and Sawatzky 2014). In research, competition for funding has long privileged quantitative and biomedical research (e.g. randomized control studies) over ‘softer’ knowledges that attempt to pry open space for qualitative, ethical, or philosophic explorations. Reflecting this same dominance, some nursing doctoral programmes have transitioned from teaching ‘philosophy of nursing’ to ‘philosophy of evidence,’ signalling a privileging of much narrower forms of knowledge, purportedly as that which will bring best patient outcomes in an era of constrained research dollars (Thorne 2016). Despite the pre-eminence of scientific discourses in nursing and healthcare, other social developments are modulating this dominance, as explored in the next section.

Three social trends that Beaman (2017) refers to as ‘new diversity’ mark the contemporary terrain of negotiating religious and secular knowledges in healthcare. The nurses’ voices in this chapter point to these developments of global migration, the rise of emergent spiritualities and those who identify as non-religious, and reconciliation with Indigenous peoples and their spiritualities. These trends represent the decline of majoritarian religion (Christianity) in Canada and make porous any presumed boundaries in nursing
and healthcare between secularism and religion, science and religion, or empiricism and spirituality.

First, global migration, now from places other than those represented by earlier European settlers, has disrupted the dominance of Christianity as majoritarian religion in Canada. Newcomers to Canada, often with strong ties to religious communities, are found in hospitals as both patients and staff (such as Lucy and Chen), bringing with them diverse religious convictions and spiritual practices. The religiously diverse contexts in which nurses practise means they are continuously adjudicating when religion and spirituality can or cannot enter into their nursing care. For nurses like Chen, Muslim prayers intersperse the daily routine. Nurses such as Lucy provide for spiritual practices of large gatherings of visitors and bedside prayers for the Sikh patient. It is, once again, impossible to represent the hospital as ‘neutral,’ devoid of the presence of religious practices.

A second social development is that of the rise of those who self-identify as ‘nones’ or non-religiously affiliated. For example, in the Pacific Northwest that spans from British Columbia in Canada down through Washington and Oregon in the United States, a recent survey reported 50 per cent of respondents self-identifying as ‘nones,’ making it one of the least religious geographic regions worldwide (Wilkins-Laflamme 2018). Yet, within this same category were people who described themselves as spiritual, similarly to the pattern described by Lee (2015). Emergent spiritualities involve the ever-growing phenomenon in modern Western society of the sacralization of nature, the self, and everyday life (Sharma et al. 2012). This trend aligns easily with the nursing (and healthcare) movement, since the 1980s, to replace the language of religion with spirituality, and to assume a generic spirituality as basic to humanity (Paley 2008; Pesut et al. 2008).

A third social development is the national movement toward reconciliation with Indigenous peoples in Canada (Truth and Reconciliation Commission 2015). This recent development has brought to light the degree to which Indigenous worldviews have influenced Canada, with their insistence upon multiple ways of knowing, seamless integration of spiritual practices, and holistic relationship with land/environment. The long overdue processes of reconciliation that have begun in Canada (and globally) are ‘indigenizing secularism’ (Colorado 2018). Indigenous spirituality has had a long influence on Canadian public life, and the TRC petitions for an increased role for traditional teachings and spirituality in public contexts. Perhaps more than anything else, integration of Indigenous worldviews into Canadian public institutions such as universities and hospitals is resulting in a modulation of empiricism and secularism, and the opening up of new spaces for the expression of spiritual practices. In Canada, nursing programmes are investing in Indigenizing curricula to varying degrees, a process that requires both a critical reading of religion and a willingness to acknowledge and engage the spiritual cosmologies inherent in Indigenous worldviews.

Nursing and spirituality in a ‘post’ era

Where then does this leave nursing, in the entanglement of secular, scientific, religious, and spiritual knowledges? While it is fair to say that all domains of the profession are firmly rooted in empiricism, a concomitant movement within the profession embraces the post-biomedical, post-secular, post-colonial, and post-patriarchal that also mark the current age. ‘Post’ terms, though often disputed as prematurely or inaccurately applied, can be useful for their heuristic capacity to reveal fissures in what are otherwise constructed as universal or coherent movements.
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In the case of post-biomedical (Klassen 2001, 2018) comes the recognition that people choose alternative, non-biomedical therapies in an agential position that is critical of biomedicine but knows that biomedicine can be depended upon if necessary. With post-secular comes the observation of the persistence of religion’s influence in contemporary public life (Beaumont and Baker 2011; Habermas 2008). Nurses negotiate religious and ethnic diversity as an everyday occurrence, though in a variety of ways that can involve cooperation, compromise, or coercion (Audy 2016). In any given day in a Canadian hospital, for example, nurses may encounter Chinese medicine, Indigenous healing ceremonies, Buddhist mindfulness practices, and Wiccan traditions, and may choose to facilitate the expression of these in the midst of high-paced, clinical settings.

A post-colonial lens puts attention to the legacy of colonial relationships (Loomba 2007). In settler nations, in particular, nurses are faced with the imperative of embodying the ethos of the United Nations Declaration on the Rights of Indigenous Peoples with its universal standards for the survival, dignity, and wellbeing of Indigenous peoples of the world. Moreover, a scan of the academic literature shows a remarkably polyphonic scholarship on spirituality and nursing; the field long dominated by Anglo-centric, Christian-influenced voices now encompasses scholars who have all too often been racialized, for example, from Iran (e.g. Davoodvand et al. 2017), South Africa (Chandramohan and Bhagwan 2016), Korea (Seo et al. 2014) and Thailand (Balthip et al. 2017). A post-colonial sensibility precludes the universalizing ‘one-size-fits-all’ approach to spirituality that has characterized nursing discourses. To illustrate, Garces-Foley (2013) questions whether the promotion of spirituality and devaluing of religion may inadvertently be contributing to a lack of acceptance of palliative/hospice care among ethno-racial and religious minorities, because the religious commitments of patients are ignored in a ‘one-size-fits-all’ concept of spirituality. In a post-colonial move, recent calls to cultural safety (Wepa 2015) and equity-informed palliative/hospice care (Reimer-Kirkham et al. 2016) create space for more nuanced and person- and people-centred understandings of religion and spirituality.

Post-patriarchal perspective are evident in nursing’s attention to religious and spiritual dimensions in health and healthcare provision. Gender analyses of religion and spirituality are helpful in eliciting the ‘gender gap’ that has women more involved with religion than men, with the concurrent power analyses that uncover male hierarchies, particularly in institutional religion, and religion’s central role in consolidating gender difference and inequality (Woodhead 2012). A question follows, as to whether the overall higher involvement of women in religion might be reflected in the continued (though varied) alignment to spirituality of nursing as a female-dominated profession.

Taken together, what do new spaces opened by these ‘posts’ represent or offer? What lessons can be taken from nurses’ engagement with religious and secular knowledges to give insight into the complex future? The nature of nurses’ work at the frontlines of human suffering, existential questioning, and the brink of life and death can bring into focus that which is situated beyond the purview of biomedicine. As observed by Swinton and Vanderpot (2017), the nursing profession has quite specific sensibilities around issues of religion and spirituality, given its grounding in healthcare and the way in which ‘the profound intimacy of the nursing encounter lends itself to the mysterious and the personal’ (215). At the point of encounter and in the face of suffering and illness, social differences are often transcended by shared humanity.

In this spirit, nursing scholars have opened up the meaning of spirituality, including religion but also non-religious or religiously deinstitutionalized spirituality. Nursing has long prided itself on its attention to its ‘art and science,’ or put another way, the aesthetic and
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empirical aspects of illness, healing, and caregiving. The relationship between art and science, also mapping onto the relationship of religious and secular, is not one of either/or, but rather both/and. In the words of one of our participants, Ronald: ‘We are secular. We are spiritual at the same time. I don’t see a wall between the secular and the sacred. The last thing I want is to create another silo.’ The nurses we interviewed saw holding the aesthetic and the empirical, the religious and the secular, in balance as the obvious thing to do, given the complexities of healthcare.

Concluding comments

In this chapter, I have traced the residues of historic and contemporary religious influences on nursing knowledge, as well as the influence of secularizing trends. Undoubtedly, there are situations when secular and religious knowledges come in conflict, and when one or the other takes an authoritarian or polemic position over the other. Nevertheless, because of the very real outcomes that are at stake in caregiving, nurses have time and time again found a way to bring into balance these entangled knowledges. Ideas—whether anchored in science or religion—do not survive if they are not relevant to life and death. In this way, nursing can be seen as a bellwether, heralding social shifts, and evolving epistemologies of illness and healing.

Notes

1 All names assigned in this chapter are pseudonyms to protect the anonymity of the participants. Three studies, spanning more than a decade of research on religion in Canadian healthcare, inform this chapter:

2 In British Columbia, Canada, for example, the Health Professions Act (Section 12.1) expressly prohibits a person other than a registrant of the British Columbia College of Nurses and Nurse Practitioners from using the title of nurse in any manner that expresses or implies that person is a nurse.


4 The Truth and Reconciliation Commission (begun in 2009 with the final report presented to the federal government in 2015), with its mandate to inform all Canadians about what happened in the Indian Residential Schools, has created a historical account and generated ninety-four Calls to Action, seven of which are targeted specifically to healthcare, to redress the legacy of residential schools and advance the process of Canadian reconciliation. A summary of the Final Report is available at http://publications.gc.ca/site/archivee-archived.html?url=http://publications.gc.ca/collections/collection_2015/trc/IR4-7-2015-eng.pdf

5 Indigenous peoples continue to live with health and social disparities. The social determinants of health are stacked against them: disadvantaged socioeconomic status, unclean drinking water, substandard and crowded housing, unemployment and lower levels of education, and access to quality health care are added onto the intergenerational trauma that continues as the residual legacy of the
residential school system, the loss of traditional lands, decimation of political and self-determination, aggressive social welfare policies that place their children into foster care, and high levels of incarceration (Greenwood et al. 2018).

See also, for example, Bernadette McCauley’s (2005) narrative of Catholic nurses in the United States; Aeleath Soine’s (2009) dissertation From nursing sisters to a sisterhood of nurses: German nurses and transnational professionalization, 1836–1918; and Colin Jones (1989) The charitable imperative: Hospitals and nursing in ancient regime and revolutionary France.

Bibliography


