Religious Diversity, Health and Healthcare in Canada

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Abstract *Is religion still a factor in how Canadians understand and experience health? And if yes, how?* This chapter will examine religious diversity as it relates to health and healthcare, and will include a consideration of individual experiences of health and well-being, healthcare workers and institutions, and population health. Particular attention will be paid to the ways that religious groups and individuals have played a formative role in building the Canadian healthcare system, as well as hospitals and medical schools. I will document the ways that recent shifts in immigration have raised new issues for healthcare institutions and workers by opening up new debates around the meaning of health, and in particular raising questions around religious healthcare considerations for patients. The chapter concludes with an exploration of current pressing public health issues in Canada as tied to religious diversity and suggestions for further study and research.

Keywords Healthcare system · Public health · Social determinants of health · Biomedicine · Religious diversity · Relations of ruling · Spiritual caregiving

1 Introduction: Religion and Health in Question

The focus of this chapter is religious diversity, religion, and health. I begin with a somewhat simple question: *Is religion still a factor in how Canadians understand and experience health?* The short answer to this question would be, no. Popular wisdom suggests that Canada is a secular state entering a "post-Christian era" (see Grossman 2010), and as such, is increasingly defined by religious pluralism (Smith 2007). Indeed, the most recent data from Statistics Canada in 2001 and the National Household Survey in 2011 confirm that overall, religion and religious believers are on the decline, when compared to the past. However, as Seljak et al. (2007) observe,

> Since the 1970s, Canada has become both more secular as well as more religiously diverse. At the same time, historical forms of prejudice and discrimination have been left unaddressed and new forms are emerging because of the increased religious diversity of Canadian soci-

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> ety as well as international conflicts between religious communities that play themselves out on Canadian soil. In the 1980s and 1990s, Canadian Sikhs, Muslims, Hindus, Buddhists, Chinese and Jews struggled to be integrated into structures that had been defined first by Christianity and then by Canadian-style secularism (p. 1).

Speaking more specifically about health and healthcare, it is widely acknowledged that Canadian hospitals, healthcare systems, and medical schools, have long-standing ties with religious groups, most notably, Christian and Jewish. Today, it would seem that these institutions function independent of religious influence. However, scholars of health and religion tend to adopt a broader understanding of these terms. For example, the World Health Organization, defines *health* as "… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization 2018). Speaking of *religion* as "lived religion", Orsi (2002) states, "Religion is always religion-in-action, religion-in-relationships between people, between the ways the world is and the way people imagine or want it to be" (p. 172). If we follow the guidance of the WHO and Orsi, we can begin to see that the answer to the above question is not so simple. In a report entitled, *Standards of Spiritual and Religious Care for Health Services in Canada*, the Catholic Health Association of Canada (2000) observed that interfaith negotiations are increasingly central to the work of health in a multicultural context. When confronted with questions of life and death, pain and suffering, Canadians continue to draw on religion, albeit in a combination of old and new ways, ultimately raising new and at times perplexing questions for discussion and debate within health and healthcare.

The continued importance of religion to health is perhaps not surprising. Questions of life and death have always been part of religion and, as such, most religious traditions have something to say about the body and, by extension, health and well-being. As Stephenson (2004) has observed,

> The transformations of pregnancy, and birth (new bodies) and death (the culmination of bodies) ramify throughout both religious practices and beliefs about medicine. Thus, the body is a kind of contested arena where life processes meet with both religion and medicine (p. 202).

For example, Tibetan Buddhists practice meditation to move beyond suffering (both physical and mental); the ailments of the body are something to move beyond to attain enlightenment. Within Christian Science, "Sickness is part of error which truth casts out. … We classify disease as error, which nothing but truth can heal, and this mind must be divine not human" (Eddy 1934, cited in Nancarrow Clarke 2016, p. 340). Brown (2001) observes that Australian Indigenous spiritual traditions tend to express a more holistic view of health that extends beyond one individual. For example, for many Australian Indigenous peoples, health cannot be separated from one's spiritual well-being. Further, health refers to the physical and mental well-being of an individual, as well as the overall condition of the community. These are just a few examples of how different groups understand the connection between religion / spirituality and health.

I come to the study of health and religion as a sociologist. Central to the practice of sociology is applying the sociological imagination. This means gaining a deeper understanding of the intersection between two key forces: individual biography and social / historical conditions. As Mills (1959) observes, "Neither the life of an individual nor the history of a society can be understood without understanding both" (p. 3). Health and religion offer up a considerable and wide-ranging set of issues to explore and provide excellent terrain for employing the sociological imagination. Below I have outlined three dimensions that inform this chapter and help further elucidate a sociological analysis of religion and health.

1. The human dimension: Religion and spirituality, like health, are experienced by people within day-to-day life. The human dimension draws our attention towards individual experience and subjectivity. For many individuals, religion and spirituality play pivotal roles in how they understand who they are, as well as their place within the wider community and society they inhabit. As a result, health, and health treatment choices, engage with an individual's sense of self and belonging. From a practical standpoint, those working in healthcare fields often need to take religion and spirituality into consideration when interacting with patients and delivering services. Take the time to consider this: As a nurse, how might you respond if a patient requested religious or spiritual care as part of their treatment?
2. The structural dimension: A variety of institutions, systems, and social structures manage, administer, and organize both health and religion. In Canada, the *healthcare system* exists to improve, but equally maintain, the health of Canadians. Healthcare policies and institutions are further supported by both formal and informal social systems and processes. As we will explore in this chapter, the delivery of healthcare raises ethical questions about life and death, as well as the right of individuals to make choices in line with religious belief systems. Religion and spirituality continue to inform how individuals understand health and wellness, and as such, religious groups and individuals often seek to shape the form and content of healthcare. Take the time to consider this: As a doctor, how might you respond if someone refused treatment on religious grounds?
3. The population dimension. Modern societies are characterized by a concern for the overall well-being of the population, as characterized by the rise of *public health* initiatives and increased knowledge about *social determinants of health*. Social *epidemiology* refers to the notion "that not only are health disparities socially produced, leading to the perpetuation of social inequality, but also that the conditions that make people healthy are socially produced" (Segall and Fries 2011, p. 207). Increasingly, healthcare systems and structures are challenged to deliver health services to a diverse population and take into consideration factors that can contribute to the experience of inequalities in health. In line with this, recent studies have examined religion as a social determinant of health (Wolpe et al. 2014). Others have considered the benefits of religion and spirituality for overall health and well-being (see Larimore et al. 2002; Masters 2005; Masters and Spielmans 2007; McCullough 1995). Religion is also often understood as an

intervening variable that can lead to differential health outcomes, in combination with other factors, such as race, social class, and ethnicity (Brotman et al. 2010). Take time to consider this: As a healthcare administrator, how might you respond if you noticed poor health outcomes within a particular minority religious group?

These dimensions are not meant to be exhaustive or mutually exclusive. They are inter-related and inform one another. Further, they involve and are shaped by power and power relations. The aim here is to gain a deeper understanding of health, healthcare, and religion as social phenomena by activating our sociological imagination. Doing so helps us to see that religion and health, like all parts of society, are shaped by people, within the communities, cultures, and societies that they are a part of.

This chapter begins by introducing the social study of health, religion, and religious diversity. The chapter then turns to a consideration of the broader history played by religion and religious groups in forming the structures of healthcare, and assesses recent demographic shifts in Canada. This chapter explores several significant sites of contention, as well as more recent shifts around the place of religion and spirituality within health and healthcare in Canadian society. Following this, I present results from a qualitative research study examining the controversy around the Quebec Charter of Values. A central focus of these debates related to the presence of religion in public institutions, like hospitals, and the wearing of "ostentatious" religious symbols by hospital employees. The chapter concludes with a consideration of current challenges and future opportunities within the field of health and religion. Many of the cases discussed in this chapter emerge out of conflicts over values and power struggles that often serve to reinforce the dominance of the majority group. However, attention will be drawn towards the ways that these conflicts are also active in shaping the meaning of health as it relates to spirituality, religion, and religious belief, for an increasingly diverse Canadian population.

2 Health, Religion, and Religious Diversity

> All Church members typically sign an "Advance Decision to Refuse Specified Medical Treatment," outlining their wish to refuse blood transfusions. As well, the Church carefully follows expectant mothers in its flock to ensure its prohibition of blood transfusions is enforced. According to one document obtained by *Maclean's*, on Sept. 3 the Church reminded its "brothers" that the Church's "Care Plan for Women in Labour Refusing Blood Transfusion" was to be given to expectant mothers (Patriquin 2016).

Health, and decisions about health, are things that can easily be taken for granted. A recent article in Macleans tells the story of Éloïse Dupuis, a young mother who died due to complications after giving birth. The journalist questions whether she could have been saved by a blood transfusion and indicates that there may be further investigations into whether her health was put at risk by her religious community. Dupuis was a member of the Jehovah's Witnesses. As indicated by the excerpt from the article, blood transfusions are strictly forbidden for Jehovah's Witnesses. The

story features the photo below, Fig. 1, of Éloïse as an expectant mother, glowing with health. This image stands in stark contrast to the title of the article: "A Jehovah's Witness and her deadly devotion". According to the journalist, the question of health is straightforward, and religion should play no role in a person's decision. Indeed, who would not do anything they could to save the life of a new mother? However, as already mentioned, this chapter aims to move beyond taken-for-granted assumptions about where religion fits within decisions about health, by adopting a sociological perspective. In this section I introduce the reader to the social study of health and religion, and provide an introductory consideration of the place of religious diversity within these broader fields of study.

2.1 Defining Health, Religion, and Religious Diversity

Within *biomedicine* or a biomedical understanding of the body, health is typically understood in relation to the presence or absence of disease (see Germov and Hornosty 2017; Nancarrow Clarke 2016; Segall and Fries 2011). The presence of disease indicates illness, while the absence of disease indicates health. Healthcare and medical interventions are delivered with the intention to treat illness and

Fig. 1 Éloïse Dupuis

preserve life, and the prevention of death is seen as natural and normal. In line with this, a doctor is trained to identify conditions in the physical body—loss of blood—and offer treatment—blood transfusions. However, as mentioned at the outset of this chapter, sociologists seek to embrace a more holistic understanding of health that would take into account, among other things, differing belief systems about life and death. For some individuals, life should not be preserved at all costs, and further, intervening may run contrary to sincerely held religious beliefs.

Sociologists of health seek to understand health, illness, and well-being as *social constructions*, meaning they are shaped by social relations and the society we live in. According to Segall and Fries (2011), "...both the health and illness of our bodies and the manner in which we understand these concepts are influenced by social factors" (p. 6). Understanding health as a social construction allows us to include illness, disability, mental health, but also broader notions of well-being, such as the quality of family relationships, the health of the communities where we live, and even the environment. For sociologists, health is impacted by the spaces where we live our day-to-day lives and the relationships that inform our understanding of who we are. "Health is not understood solely as a biophysical state experienced in the same manner by all people in all times and places, but, rather, as a social constructed experience that varies according to cultural factors" (Segall and Fries 2011, p. 7). Sociologists of health thus consider individual experiences, as well as the broader structure of public and community healthcare services, delivery, and systems. This allows sociologists to consider the impact of policies beyond specifically health related fields. For example, sociologists of health would also examine the health implications of policies within social work and community development because within these fields individuals aim to overcome broader systemic inequalities and as such, impact individual and population health (Gerhardt 1989, 1990; Mikkonen and Raphael 2010; Raphael 2012).

Similar to sociologists of health, sociologists of religion typically adopt a broad understanding of religion. According to Reimer-Kirkham (2009), within health scholarship, religion and spirituality are often understood as opposed. Where, religion "carries transcendent (sacred) and social dimensions, with its practice typically occurring through relatively formal institutions" (p. 407). In contrast, spirituality "…although having to do with the metaphysical, has been interpreted as a less institutionalized and more individual expression of values and beliefs" (p. 407). Reimer-Kirkham argues that we ought to see "religion and spirituality not interchangeably, but as closely related" (p. 407). Similar to Orsi's argument for the study of *lived religion*, this understanding of religion and spirituality allows us to consider context and the ways that individuals construct meaning in daily life. This chapter employs both religion and spirituality throughout depending upon the scholarship, research, or policy in question.

Secular is a term used to refer to the separation between religious institutions and the public functions of the state. In a secular society, it is assumed that the government and all its officials are no longer tied to religion or religious institutions. In Canada, critical scholars of religion point out that while, on the surface, Canada appears to be a "secular" nation, the traces of our Christian past can still be detected.

The most obvious example is the naming of "God" in the preamble to the *Canadian Charter of Rights and Freedoms*. The recognition that Canadian society has historically been characterized by a predominantly Christian worldview, coupled with the reality that this is no longer the case as religious diversity has increased with new waves of immigration, has led to a rising sensitivity to diverse religious traditions and cultural pluralism within pastoral care in hospitals. We will return to this issue later in this chapter.

Compared to other nations, and despite rising evidence of secularism, Canada has a considerable degree of *religious diversity*. For example, there were over 108 different religious groups listed in the 2011 National Household Survey; the list included Buddhist, Catholic, Hindu, Jewish, Muslim, Sikh, and Aboriginal, as well as other religions, including, Baha'i, Jain, and Pagan. A separate grouping allowed individuals to specify "no religious affiliation", with categories ranging from agnostic, atheist, to no religion. The relatively high degree of religious diversity in Canada makes it an interesting site from which to begin a study of health and religion, in part because we are likely to find differences in values and beliefs, as individuals and groups struggle to find space within what was, and in many ways remains, a Christian-dominated settler society.

The *Canadian Charter of Rights and Freedoms* enshrines freedom of conscience and religion. "Ideally, this means that everyone living in Canada is free to believe (or not believe) whatever he or she chooses. It also means that the government is responsible for eliminating barriers for those wishing to practice their religion—even if governmental inconvenience or cost is the result" (Anzovino and Boutilier 2015 p. 106). However, as we will explore in subsequent sections, there have been and continue to be many instances where minority religious groups have struggled to find recognition within Canadian society. This is all the more surprising given that Canada is perceived as a multicultural mecca, where diversity is encouraged and embraced.

2.2 Social Study of Health and Religion

When health intersects with religion and religious diversity, our attention is drawn towards ongoing debates between *structure* and *agency*. Structure refers to the social forces (institutions, politics, social norms and expectations) that shape our experience and limit individual choices. Agency refers to "…our capacity to shape our socially-constructed lives" (Ravelli and Webber 2015). For example, religious institutions have actually played a significant role in shaping the formation of state-delivered health services, like hospitals. Further, within Canadian hospitals we find a multitude of individual experiences of religious believers as they negotiate questions of life and death within constrained circumstances.

Within sociology, the classic example of the social study of health and religion comes from the work of Emile Durkheim (1897), and in particular, his study of suicide. In *Le Suicide*, Durkheim examines the relationship between social

integration (as tied to religious affiliation) and rate of suicide. Those individuals with a higher level of social integration (Catholics) were found to be less likely to commit suicide. Whereas, those with lower levels of social integration (Protestants) were found to be more likely to commit suicide. Durkheim's research invites us to explore the relationship between religion and health outcomes in a population. In more recent research, Koenig et al. (2001) found that those who participated in "non-organized spiritual practices" experienced positive health benefits. Further, Dein et al. (2010) note that those who identified with and were actively involved in a religious community experienced even more significant benefits to overall health.

One of the most well-known studies examining the role of prayer in healing was completed by Randolph Byrd, a physician at the San Francisco General Medical Center. Byrd was interested in the impact of prayer on cardiac patients. In a random and controlled experiment, Byrd found that prayer by a group located elsewhere had an impact on his patients (Pargament 1997). Similarly, Levin and Vanderpool (2008) have examined religious factors in physical health and the prevention of illness. They argue that "religion-health connections are a nearly universal feature within the cosmologies of religious traditions and are supported by empirical evidence from various scientific disciplines" (p. 41). The positive health benefits of religion and spirituality have led Miller (2013) to argue that spiritual healthcare should be part of the curriculum for all future doctors and nurses. In line with this, many American medical schools now include a discussion of religion and spirituality in healthcare training, and similar shifts are occurring in Canada. However, factoring religion into discussions of health remains difficult in part because the dominant model of understanding health remains rooted in a biomedical understanding, and reflects the shift to a secular system of healthcare delivery (discussed in the following section).

Beyond a consideration of the benefits of religion and spirituality, the social model of health is helpful for highlighting those factors that contribute to health inequalities or the social determinants of health. Fig. 2 is an infographic produced by the Canadian Medical Association. According to Homeless Hub, we tend to focus healthcare delivery on maintaining physical health from a primarily biological perspective. In fact, characteristics of "your life", including income, disability, education, and race, all play a significant role in determining the health outcomes you experience.

According to the World Health Organization:

> The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems (WHO 2017).

Canada, like many other Western liberal capitalist states, has embraced this broad definition and includes social determinants of health within policies that determine healthcare delivery and development. For example, the Public Health Agency of Canada (2016), identifies the following as social determinants of health that influence "the health of populations":

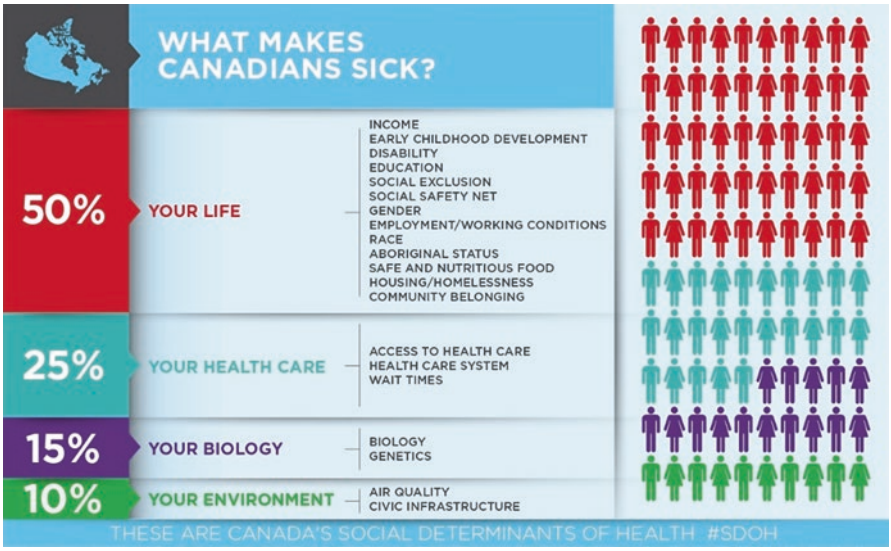

Fig. 2 What makes Canadians sick? (CMA)

> …income and social status; social support networks; education; employment/ working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture.

de Leeux and Greenwood (2011) observe that social determinants of health allow us to acknowledge the complexity of factors influencing health outcomes for "vulnerable and marginalized populations", such as Indigenous peoples, immigrants, and refugees. Gender, ethnicity, socio-economic status, sexual orientation, and age "interact with and affect one another to produce differentially lived social inequalities among people" (p. 55).

For example, researchers commonly cite the "healthy immigrant effect", where immigrants report better health outcomes when compared to the Canadian-born population (see Dunn and Dyck 2000; McDonald and Kennedy 2004). Segall and Fries (2011) point out that in some sense, this is not surprising as "individual health status is one of the most important criteria used by the Government of Canada to screen those who attempt to immigrant to this country" (173). However, this reality does not explain why health outcomes for immigrants become worse over time. Meaning the more years' immigrants spend in Canada, the poorer health they can expect (Beiser 2005). Researchers have also found significant differences in health when occupation and education are taken into account. For example, in a study examining health status and social capital of recent immigrants in Canada, Zhao et al. (2010) found that "skilled workers have the largest share of healthy immigrants, followed by family class immigrants and refugees" (p. 10). Further, "Refugees are more likely to report their health as fair or poor initially because they

often come from areas of conflict with poor public health infrastructure and are more likely to be at risk for malnutrition and infectious diseases" (p. 10).

In a study examining cervical cancer screening amongst women in the Sikh community, Oelke and Vollmann (2007) found that "immigrant women tend not to take advantage of screening" and that "culturally appropriate screening services for immigrant women are few" (p. 174). Their research findings suggest that training for nurses ought to include discussions about how to offer services for particular populations, for example, Sikh women. Beiser and Hou (2001) have examined rates of depression amongst newly arrived immigrants. In their study, a majority of participants expressed experiencing discrimination because of their ethnicity. Symptoms of depression would dissipate when participants were finally able to find work. In both cases, the biomedical model would limit our understanding to the incidence of a particular illness with an identifiable medical response, as opposed to the underlying systemic and societal factors that impact health outcomes and overall well-being.

Further, if we understand health as tied to social processes, we can consider religion, spirituality, and religious diversity as potential factors in the experience of seemingly 'natural' biological processes. Childbirth is a good example of this. Several studies have explored the religious and spiritual dimensions of giving birth for women within conservative religious traditions (see Callister et al. 1999; Semenic et al. 2004). In discussions with Orthodox Jewish-Canadian women, Semenic et al. (2004) identified the following themes tied to the "spiritual/cultural dimensions of the childbirth experience": "(a) birth as a significant life event, (b) birth as a bittersweet paradox, (c) the spiritual dimensions of giving birth, (d) the importance of obedience to rabbinical law, and (e) a sense of support and affirmation" (p. 80). Similar to the more general studies discussed above that examined the connection between religion and health outcomes, the studies summarized here point to the need to factor in religion and spirituality, from both a practical and ethical standpoint, in terms of healthcare delivery. And yet, despite the breadth of research available on religion as a social determinant of health, religion and spirituality are rarely directly listed. This has led to a paucity of available quantitative data that provides an over-arching view of this intersection. Often religion is lumped in with culture, race, and/or ethnicity, leaving researchers to infer what is influencing what. I will return to this challenge later in the chapter.

To wrap up this section, the aim is not to eliminate or discredit the biomedical approach, but rather to add and employ the social model where appropriate. Arguably, drawing on both models has added substantially to the health professions, as reflected in the increasing tendency to include postcolonial critiques, intersectionality, and critical disability studies within consideration for healthcare service delivery. Religious diversity and the challenges it presents should thus be understood as a starting point for dialogue, debate, and discussion that can lead to a more complete reflection of the people who make up Canadian society.

3 Religion, Health, and Healthcare Within Canadian Society

> I'm sure that the standard of public morality we've helped build will force government in Canada to approve complete health insurance (Tommy Douglas).

If I were to ask a group of Canadians what defines Canada, chances are many would place universal and free healthcare near the top of the list. Medicare, the system of state-provided "free" healthcare, is perceived by many to be a defining feature of Canadian identity and society. However, I would suspect that not all Canadians know that the founder of modern Canadian healthcare, Tommy Douglas, before turning to politics, was a Baptist minister. Like many of his time, his passion for social justice and equality was deeply inspired by his religious beliefs. Indeed, a brief scan of the history of Canadian healthcare, reveals that Douglas is not alone. A multitude of Jewish, Catholic, and Protestant individuals and groups laid the foundation for hospitals and medical schools in Canada. Furthermore, religious groups continue to play a significant role in shaping healthcare delivery to this day at both the national and international level (Karpf 2007). At the same time, Canadians, like many other individuals living within late-modern capitalist states increasingly understand their lives through a radical lens of individualism (Rose 1996). Many individuals are increasingly understanding religion and spirituality as tied to individual choices, as opposed to affiliation with a particular group or institution. This section offers a somewhat brief overview of the historical relationship between health and religion, before turning to a consideration of the contemporary Canadian landscape.

3.1 Religion and Health: A Brief History

In the past, across Western societies, religion and religious practitioners played a central role in the administration of health and healthcare. As mentioned at the outset of this chapter, most religious traditions consider, in some capacity, questions of life and death, as well as pain and suffering. However, in the past, the separation between religious healthcare and "other" healthcare was minimal. Healthcare was religious care (Weiss and Lonnquist 2009). "Before the development of medical science, quasi-religious views of health and illness were dominant, whereby illness was connected with sin, penance, and evil spirits: the body and soul were conceived as a sacred entity beyond the power of human intervention" (Germov and Hornosty 2017, p. 13). Across most Western societies, science has come to dominate within fields related to medicine, health, and illness. For example, in contemporary Canadian society, the authority of doctors and scientists is typically given more weight than a religious or spiritual leader or practitioner. The shift away from religion as a site through which to understand health problems took place gradually over the past several hundred years and is marked by corresponding changes in

other social institutions, as well as changes in broader patterns and social systems of power, truth, and knowledge, as tied to the human body.

In Western Europe, during the Medieval era, the monastery and later, the Church, were responsible for health and illness. We began to see secular doctors near the close of the Medieval era (Weiss and Lonnquist 2009). Speaking specifically about disability, Covey (2005) observes that within early Christianity, disease and illness were understood "…as a punishment for sin or as a test of one's faith and commitment to God. For example, people with disabilities were viewed as sinners or as the offspring of parents who had sinned. This view prevailed until the seventeenth century" (p. 107). The Scientific Revolution reflected a move towards a scientific understanding of "medical knowledge and practice". Weiss and Lonnquist document this change below:

> The Renaissance period marks the beginning of a more scientific approach to medical knowledge and practice. This was a period of significant intellectual growth and discovery; the teachings of the Church were being challenged and Christianity began to lose authority and control to the state. … Medical specialization became more pronounced. Physicians, that is, graduates from a school of medicine, provided diagnosis and treatment to the wealthy. Surgery, however, was practised mostly by barbers and had lower status (2009, p. 21).

By the nineteenth century, new findings in health treatment, along with a rising interest in *public health,* led to a further displacement of religion and religious authority. The findings of John Snow led to an increased awareness of the city landscape and geography in the spread of diseases, such as cholera (Ball 2009). Around this time, hospitals as places to treat illness became more common and widespread (Weiss and Lonnquist 2009). The Canadian state came into being during this transitional period. Thus, while the history of Canadian healthcare institutions reflects religious foundations, this history has been increasingly erased under Canadian secularism.

3.2 The Contemporary Canadian Mosaic and Health

John Murray Gibbon's (1938) classic work, *Canadian Mosaic*, has in part, formed the modern day understanding of Canada as a society where diversity is encouraged and nourished. It is worth mentioning that Canadians are not responsible for the existence of diversity. The first occupants of the land now known as Canada, Aboriginal peoples, have a rich and diverse set of spiritual traditions and beliefs. However, under colonization, Catholics and Protestants became the overwhelming majority (Anzovino & Boutilier 2015). Until very recently, most immigrants came from Christian, specifically, Protestant countries. As of 2011, the National Household Survey reveals that 40.6 per cent of the population is Catholic, 20.3 per cent is Protestant, and 23.9 per cent is not religious; the remainder of the population is Muslim, Jewish, Hindu, Buddhist, or Sikh (Anzovino & Boutilier 2015; Statistics Canada 2003). As discussed in Tomlin's chapter in this volume, one of the groups that is growing incredibly quickly are those who indicate "no religion"—or the religious-nones.

The dramatic drop in religious observers as indicated by statistics and the increasing reality of empty-churches, has led many to pronounce the demise of religion in Canada. However, while some churches are emptying, the situation is quite different for faith groups comprised of certain Christian denominations and newer immigrants. While some churches are empty, mosques, temples, and evangelical Christian churches are full (Anzovino & Boutilier 2015). "Between 1991 and 2001, the population of Muslims in Canada doubled from approximately 250,000 to over 500,000. Muslims went from 1% to 2% of the Canadian population in only 10 years (Statistics Canada 2003). In the present, religious diversity is particularly apparent in urban centres. However, the expectation is that this will gradually extend to rural areas as well. Stephenson (2004) observes,

> When people of different ethnic traditions, holding dissimilar or even contradictory religious beliefs about the meaning of life come together to make decisions about the care and treatment of those who are suffering, the experience may be fraught with difficulties. The contested body may reflect a collision of cultures rather than a helpful consultation over the course of treatment, especially where life is transformed either through renewal, or death. Some systems of religious belief and practice make special use of meditation, chanting, and deprivation (fasting) in order to induce altered states of consciousness as well. This may be understood in many ethnic groups to have beneficial consequences for overall health—of the body as well as the mind. Religious belief and practice can also be brought into question after migration to a new country with different standards of behaviour and cultural norms, so religion is often bound to mental well-being, and to suffering as well (p. 202).

There is no doubt that Canada is being reshaped by the influx of immigrants. Many, though not all newcomers hold religion as a central tenet of their lives.

The Canadian sociologist Reginald Bibby (1993) notes that while traditional religion is on the decline, more individual forms of spirituality are alive and well. Under this new regime of the self, spirituality, understood in a broad sense, is seen as a form of healthcare. The use of yoga as a "catch-all" form of destressing to be added into an overall regimen of "good health" is a good example of this shift. Consider the following passage from a Canadian health publication.

> She considers walking in nature an active spiritual practice, one that gives her comfort and makes her feel less alone in the world. "I believe spirituality is something you have to practise every day," says Green (Best Health 2016).

This article is a good example of what Robert Bellah (1985) calls "Sheila-ism". Increasingly, as Shipley's chapter explores in this volume, Canadians construct their own rules in relation to beliefs and values. Spirituality is often used to reflect this move away from traditional belief systems and towards more fluid understandings of meaning.

This brief account of the religious underpinnings of the contemporary Canadian landscape has hopefully offered some insight into the ways that religion has shaped health and healthcare in Canada. In the following section, we turn to instances of conflict and contention in relation to religion and health. While public discussion and concern is often directed towards new immigrant populations as a source of difference, it is worth noting that many of the cases relating to religious rights and

health have actually emerged within Christian communities who are by no means new to Canada.

4 Religion and Health: Conflicts and Possibilities

> It's not normal that a public institution such as a hospital … denies women services such as abortions because of the hospital's affiliation with a particular religion," says Dr. Henry Morgentaler, who operates 8 abortion clinics across Canada. "Hospitals should be providing care according to the dictates of the Canadian Medical Association and according to the dictates of good medical practices" (Gagnon 2003, p. 331).

> After the birth of my first baby, the women in my small group from the Church of the Highlands showed up each night with meals. I was new at the motherhood game, fumbling, and desperately trying to keep my wailing son happy by never putting him down. We all might have starved to death had it not been for those women. Shortly after that, we moved away for a new job and left the church community. Everything they did for us was done with no expectation of reciprocity, as they all knew about our pending relocation. These are acts of kindness I will never forget (Thomas 2016, p. 112).

Debates over who has the right to shape decisions relating to health and healthcare draw us into a wider consideration of power and power relations, not to mention inequality. In the passage above, Dr. Henry Morgentaler defiantly challenges existing power relations, patriarchy, and gender inequality that persist under the guise of justice and fairness, and advocates for the right of a woman to abortion services. This section will delve into the Morgentaler case and other controversial cases, where religion and health have been at the forefront. Like the sociologist Dorothy Smith, Morgentaler sees institutions as reflections of the everyday *relations of ruling* (Smith 1987), whereby the power of the dominant group is maintained and ultimately given legitimacy. Mechanisms like the *Canadian Charter of Rights and Freedoms* can thus be understood as powerful tools for challenging inequality, but with ultimately mixed results. Regardless, the outcome of Charter challenge cases, and the ensuing debates, raise questions about the nature of equality within our society. On the other hand, as we have already discussed, for many people, religion and religious communities can play an important role in fostering more intangible, but equally important factors that influence health, such as social cohesion. This view is expressed by Kate Hendricks Thomas in the quotation above.

4.1 Health and the Individual

> "The Pope has simply lost all relevance for me." "I don't really care what he said in the encyclical," she says, "because I've already made up my mind" (CBC 1968).

The above quote comes from a CBC television special that featured young female university students confronting a panel of Catholic priests at the University

of Toronto. Like many of the young women who participated in the panel, she is a devout Catholic but takes issue with the pope's stance on birth control. The panel included Monsignor Austin Vaughan, president of the Catholic Theological Society of America, Reverend Edward Sheridan of Regis College, Reverend Walter Principe, and Reverend Robert Crooker of St. Michael's College. At the time of the panel, Pope Paul VI had taken a very firm stance against the birth control pill. In a letter to Catholics entitled, "Of Human Life", the pope made the controversial claim that using the birth control pill was a sin.

The rejection of the organizational structures and dogma of the church, and in particular, the Catholic church, were fundamental to the rise of the Women's Health Movement, which emerged during the latter half of the twentieth century (Tone 2001). Though centered in the United States, similar social transformations and struggles occurred in Canada (McLaren and McLaren 1997) and other parts of the Western world. Among other issues, the movement sought to reshape existing power structures, like patriarchy, that limited health outcomes for women. *Patriarchy* is defined here as the systemic and wide-spread domination of men over women. Given that many of the decisions about healthcare at the time were guided by religious dogma and authority, it is not surprising that the Women's Health Movement targeted and sought to eliminate the influence of religious authority within the delivery of healthcare for women. Within this context, religion and religious authority were understood, rightly so, as a barrier to women's autonomy. In Canada, the legal barriers placed on abortion and access to contraception, both of which were illegal until 1969, were widely supported by the dominant religious authorities of the time, in particular, the Catholic church.

Even after the introduction of the Omnibus bill, access to abortion was permitted only under very limited circumstances. It was not until 1988, in the decision for *R. v. Morgentalar*, that the Supreme Court officially struck down Canada's abortion law on the grounds that it violated Section 7 of the Charter, which protects "security of the person". Dr. Henry Morgantaler, the plaintiff in the case, has become widely known as an advocate for women's right to abortion. He has also argued that all hospitals ought to be free of religion and religious influence (Gagnon 2003, p. 331).

I feel it is useful at this point to offer some insight into the complex ways that religion and spirituality can factor into the politics of reproductive health. Nuance is important here. Not all those against abortion and contraception argue on the basis of religious grounds. For example, some individuals argue for the sanctity of life on secular grounds (drawing on philosophical arguments). Further, many devout religious followers have advocated in favour of women's reproductive rights. For example, John Rock, one the co-creators of the pill, was himself a devout Catholic (Tone 2001). Furthermore, several studies have considered the ways that conservative religious women negotiate birth control within the context of specific life circumstances, as well as other factors, such as relationship status (Amaro 1988; Kaplan et al. 2001; Romo et al. 2003). That said, religion remains a powerful factor in religious beliefs that seek to remove women's access to abortion. It is important to separate institutional power structures from individuals, and sometimes individuals from institutions.

In this case, a nuanced approach remains difficult, particularly where abortion is concerned. Abortion provision remains a swing issue in Canadian politics and gains won by women's movements are tenuous at best. Despite the fact that abortion is legal, access to abortion remains difficult in many locations across Canada (Sethna and Doull 2012). Prince Edward Island only recently opened an abortion clinic and already doctors are protesting on religious grounds (Ross 2016). The protest took place outside the hospital where the clinic is being built and was organized by the PEI Right to Life Association. Although many of the members are motivated by religious beliefs, religion is not mentioned on the organization's website. However, the organization targets abortion and euthanasia as key sites for intervention.

Like abortion, euthanasia and physician-assisted suicide engage with questions of individual autonomy and the right of the state to intervene in individuals' choices. As with abortion, religious values are not the only factor here. However, some of the most outspoken proponents on both sides of these debates come from religious groups. Those interveners who have spoken against the legalization of euthanasia include the Christian Medical and Dental Society (CMDS) and the Canadian Federation of Catholic Physicians' Societies. The Canadian Unitarian Council have often spoken in favour of decriminalization. In the cases of euthanasia and abortion, what is at stake are competing notions of rights within the context of different and contrasting belief systems. Ultimately, these views are not reconcilable. Furthermore, religious views of morality are increasingly seen as out of place. In Canada, like many modern societies, religious authority is seen as irrelevant in determining the moral questions of the day (Giddens 1991). Within this context, religion becomes one of many "competing authorities in the modern world of expertise" (Hornosty and Strazzari 2017 p. 253).

4.2 Spirituality (and Sometimes Religion) Welcome Here…

> We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients (Truth and Reconciliation Commission of Canada 2015, p. 3).

In contemporary Canadian society, religion within the context of health is often framed as a problem that generates conflict. Religious groups and believers are often portrayed and perceived as naïve, out of touch with reality or dogmatic traditionalists. In contrast, there is a growing body of scholarship that encourages, promotes, and in some cases, demands the inclusion of spirituality. For example, the above excerpt from the recent Truth and Reconciliation Report makes explicit reference to the inclusion of traditional healing practices within healthcare. The inclusion of traditional Aboriginal spirituality within healthcare is seen by many as key to repairing the damages of colonialism. Similar shifts are taking place in Australia where Indigenous groups are reclaiming traditional spirituality within health

treatment as a part of the broader process of decolonization (see Kirmayer et al. 2000, 2003; Tse et al. 2005).

While the importance of spirituality is particularly prevalent and stated in the treatment of mental health and wellness, demands for holistic and culturally-appropriate healthcare are increasingly a general and defining feature of healthcare delivery for Aboriginal peoples in Canada. The recognition of the importance of traditional Aboriginal spirituality within healthcare has led to key changes in policy and practice that have, in part, started with shifting definitions. For example, a recent summary report, produced by Health Canada and the Assembly of First Nations, entitled *First Nations Mental Wellness Continuum Framework*, defines mental wellness as follows:

> Mental wellness is a balance of the mental, physical, spiritual, and emotional. This balance is enriched as individuals have: *purpose* in their daily lives whether it is through education, employment, care giving activities, or cultural ways of being and doing; *hope* for their future and those of their families that is grounded in a sense of identity, unique indigenous values, and having a belief in spirit; a sense of *belonging* and connectedness within their families, to community, and to culture; and finally, a sense of *meaning* and an understanding of how their lives and those of their families and communities are part of creation and a rich history (Health Canada and Assembly of First Nations 2015, p. 1).

Similarly, the Winnipeg Regional Health Authority recently produced a guide entitled *The Culture of Well-Being*. The report employs the following definition of mental health:

> When people of any cultural background are feeling mentally healthy, they can feel good about themselves most the time. Traditionally, the Aboriginal cultural view of mental health and well being is a balance of the body, mind, emotions and spirit which is maintained through good relationships within oneself, with others, with the community and Creation (Winnipeg Regional Health Authority 2014, p. 2).

The boundary between spirituality and culture is not clearly defined in these publications. This disjuncture is worthy of further exploration, however, space does not permit a deep analysis of this issue. For the moment, the inclusion of language that implies and makes reference to spiritual traditions is obvious and evident, particularly within the context of a supposedly "secular" healthcare system.

At least on the surface, medical education in contemporary Canadian society is no longer grounded within religious institutions. Even so, today, several universities across Canada offer programs with the aim of forming hospital chaplains capable of offering pastoral care services. The continued presence of these training programs, reflects in part a link to the religious foundations of healthcare. At the same time, nursing programs and medical education increasingly recognize the value of training around religious diversity and cultural pluralism. In spite of this, it is important to acknowledge the subtle and not so subtle ways that Christianity continues to shape contemporary Canadian society, and inform state institutions, such as hospitals. Nevertheless, contemporary discussions about spiritual caregiving for nurses and doctors has begun to reflect an awareness, and place importance on the reality of increased religious diversity within the patient population.

Today, *spiritual* or *pastoral care* is included in the hopes of improving healthcare delivery and meeting needs that cannot be addressed with biomedical interventions alone. Further, scholars of nursing have "…turned their attention to developing culturally responsive and spiritually sensitive nursing practice" (Reimer-Kirkham et al. 2004, p. 149). Van de Creek and Burton (2001) outline the reason for this renewed interest in spirituality:

> Spirituality demonstrates that persons are not merely physical bodies that require mechanical care. Persons find that their spirituality helps them maintain health, cope with illnesses, traumas, losses, and life transitions by integrating body, mind and spirit. …Many persons both inside and outside traditional religious structures, report profound experiences of transcendence, wonder, awe, joy, and connection to nature, self, and others, as they strive to make their lives meaningful and to maintain hope when illness strikes (p. 82).

Pastoral care is frequently employed in the treatment of Post-Traumatic Stress Disorder for war veterans (Nieuwsma et al. 2013). Similarly, Buck (2007) observes that "Historically, compassion, comfort measures, and spiritual care for the sick and dying were the cornerstones of hospice care" (p. 115). Buck notes persistent societal bias "…that result[s] in an overemphasis of the value of physicians and medical institutions to society, while overlooking the significance of the role that families, religious groups, and nurses have historically played in community-based care of the dying" (p. 135). At least while when we suffer or all hope is lost, it would seem, spirituality (not religion) is welcome.

To conclude, this section began with a consideration of key sites of conflict over the place of religion in individual choices in relation to health. Throughout Canadian history, religious groups have often acted as special interest groups, and sought to shape the provision of healthcare and health policy. Reproductive health and euthanasia are key examples of this influence. Following this, the reader was introduced to instances where religion, and most often spirituality, are encouraged and even demanded in relation to healthcare and treatment. Key changes in the underlying principles guiding Aboriginal health and health care have led to increased space for spirituality. Other examples of the inclusion of a spirituality and religion relate to the continued importance of pastoral care as part of healthcare delivery. These cases demonstrate that despite the aforementioned conflicts, religion and spirituality remain powerful sites for personal and social transformation.

5 Where *Should* Religion Fit? Hospitals, Healthcare Workers, and Religious Neutrality in Quebec

In this section, I turn to the broader question of religious diversity and health, by presenting a sub-section of results from a qualitative study examining the public hearings for the Quebec Charter of Values (see Beaman and Smith 2016), as well as some brief reflections on Bill 62. Following this, I summarize current research in the field of spiritual caregiving. In the case of the former, religion is a source of contention, while in the latter, spirituality is seen as the answer to the problem.

Fig. 3 Ostentatious religious symbols. Source: Gouvernement de Québec, 2013

However, arguably, both instances have grown out of and can be better understood in light of the rising pluralism previously noted, as well as a more general awareness of religious diversity within the delivery of healthcare services. However, as we shall see, these issues are particularly salient in Quebec, where the place of religion in the public sphere has been hotly debated.

In Quebec, 2013, in the spring, the government began discussing the Québec a Charter of Values as a way to finally resolve issues related to reasonable accommodation that had begun with the Bouchard-Taylor Commission. On November 7, 2013, the Charter was presented as Bill 60. The aim of the Charter of Values was to amend the Québec Charter of Human Rights and Freedoms, establish a standard of neutrality for all civil service employees, and create a framework for accommodation requests. One of the main aims of the Charter revolved around the banning of religious symbols or ostentatious religious symbols within public institutions, such as hospitals (Beaman and Smith 2016). The problematic symbols are depicted in the pamphlet below—turbans, kippas and head scarves—which was circulated throughout the province of Québec (Fig. 3).

Both individuals and representatives for key social institutions debated the restrictions on religious dress in the formal hearings, as well as within the media. Those who were pro-Charter (including both individuals and groups) found the presence of religious dress in the public sphere unacceptable and evidence of the continued presence of religion in what should be a secular space. Anti-Charter individuals and groups were concerned that the restrictions of religious symbols

would pose problems for many individuals working in the public sector. In the case of health, concerns were voiced in relation to nurses, doctors, and other healthcare providers (Beaman and Smith 2016).

Several health-related organizations spoke at the public hearings, including the Federation of Quebec Nurses Union, McGill University Health Centre, the Jewish General Hospital, the Federation of Resident Doctors of Quebec, and the Confederation of Organizations for Handicapped Persons of Quebec. In most submissions, the promotion of laicité in hospitals and amongst healthcare workers played a secondary role to the bigger questions of education and neutrality of the state. However, within the submissions of health organizations, the everyday working conditions of employees was front and centre.

For example, McGill University Health Centre (CUSM), stated in the brief presented to the hearing, "…the McGill University Health Centre has never officially had an issue where an employee is proselytizing while working with patients or other staff members. We do not foresee this becoming an issue in the future". The position of the CUSM was that the presence of religious symbols had never been an issue, so why should these symbols be banned? Similarly, the Federation of Medical Residents of Quebec were in agreement that the state should be neutral and secular. They did not, however, see the need to extend this requirement to people working in the public sector. In particular, they took objection to the condition that doctors and health professionals cannot wear religious symbols.

> The neutrality of the State is different from the neutrality of individuals. We are strongly opposed to creating two classes of citizens by limiting the fundamental human rights of those who work within the public service sector especially given that these limitations do not exist in the private sector.

In line with this, the Quebec Confederation of Organizations for Handicapped Persons stated, "Fundamental rights are interdependent and should not be placed in opposition to one another; those who need those rights protected are not the majority, but are rather those groups who face discrimination because they are seen to apart from the majority." During the public hearing, many hospitals and health-care institutions across Quebec asked for a permanent exemption from the ban on workers wearing religious symbols. The concern was that the healthcare sector would lose staff members if the Charter actually became a law.

The Federation of Quebec Nurses Union (FIQ) spoke in support of the secular Charter. The results of a telephone survey conducted by the FIQ were reported in the media as follows:

- 60 per cent support the secular charter;
- 97 per cent support the principle of equality between men and women;
- 74 per cent support neutrality of the state;
- 61 per cent support a ban on the wearing of religious symbols for all employees who work in the public sector.

The FIQ maintained that despite the potential for negative repercussions on nurses wearing religious symbols, the pressing need of *laicité* could not be

under-stated. Ultimately, the positions of the various groups that participated in the public discussions can be broken down into pro-Charter or pro-religious diversity versus anti-Charter or anti-religious diversity. However, our research argued that they are ultimately more similar than different, as all groups approach religion as an either/or scenario (Beaman and Smith 2016). In both cases, the presence of religion is over simplified, and there is little to no distinction between religion and spirituality, nor a recognition of the complex ways that religion can inform health and decisions about treatment and illness. According to the FIQ, healthcare delivery ought to be fully *laique*, with no room for a grey zone.

The Quebec Charter debates arguably laid the foundation for Bill 62 which was introduced October 18, 2017. The new Bill prohibits those working in the public service, and those accessing public services, from covering the face. While the government argues the Bill addresses pressing safety and security concerns, critics argue that the restrictions in the Bill clearly target women who wear the burka or niqab. As such, the new Bill excludes workers and clients of public services alike. Further, the Bill amplifies the social exclusion of an already marginalized group in Quebec society, Muslim women. Further, the public nature of these debates has made it difficult to allow for in-depth discussions about the challenges of navigating across differences in belief systems, and tactics for addressing and dismantling systemic and institutional discrimination and racism.

In seeking to articulate an alternative framework, I draw on the scholarship of Sheryl Reimer-Kirkham on nursing and diversity. In her work, Reimer-Kirkham considers diverse themes, such as *spiritual caregiving* (Reimer-Kirkham et al. 2004), ethics and religion (2009) in healthcare delivery (2014), and religious and spiritual plurality in health care (2012). In reference to spiritual caregiving, she explores the "…moral dilemmas faced by nurses and chaplains in intercultural spiritual caregiving, and how these moral dilemmas are shaped by social context" (Reimer-Kirkham et al. 2004, p. 154). She observes that the practice of spiritual caregiving has been complicated by a paucity of literature within nursing about spirituality and care.

> As our societies become increasingly diverse, the nursing profession is faced with new challenges across its practice and scholarship domains. To support nurses in the provision of care across a breadth of ethnic, religious, gender, class, and sexual orientation diversity, significant attention has been directed to the areas of culture and spirituality over the past decade or two (Reimer-Kirkham et al. 2004, p. 149).

It is widely assumed that Canada is a secular society. As such, it is also assumed that religion and spirituality are no longer a part of public institutions, such as hospitals, and public life, such as health. The reality of religious diversity offers a challenge to nurses, but equally an invitation to think carefully about the differences between religion and spirituality, as well as the tendency "…to subsume religion under culture and ethnicity" (Kirkham-Reimer 2004, p. 154). Drawing on Orsi's notion of "lived religion" within the context of healthcare, Reimer-Kirkham observes that "…the negotiation of religious and spiritual plurality" is an ongoing process. Ultimately, Reimer-Kirkham's work is helpful in articulating a path forward without dismissing existing differences and difficulties. Further, she under-

stands religious/spiritual diversity and pluralism as a process, rather than a static and unchanging reality.

6 Current Challenges and Future Opportunities

I would like to draw the reader's attention towards current challenges that indicate opportunities for future research within the field of religion and health. First, in many settings, the secular state is seen as a *fait accompli*. As we have discussed in this chapter, it is true that, when compared to the past, adherence to the Anglican and Catholic churches in Canada has declined significantly. This has not meant that religion and spirituality have disappeared from the public realm, nor that individuals do not continue to identify with or draw on religious and spiritual beliefs. However, the denial of religion and spirituality as important for people makes it difficult to study in the broader context of health and illness. Further, the belief that religion and spirituality no longer matter has meant that available data on religion as it relates to health outcomes is sparse compared to other social determinants of health, such as race, ethnicity, or social class. As such, researchers interested in this area are often left to infer from other factors. More research in this area is needed.

Second, the rising diversity of the population and of religious adherents is definitely a challenge, but ultimately an opportunity for scholars interested in religion and health. There is an ongoing need to bring the education of healthcare professions in line with the shifting religious and spiritual landscape that defines contemporary Canadian society. Further research is needed to provide best practice guidelines in developing training and education for delivering healthcare to a religiously diverse society. And religious diversity should include a consideration of religious-nones. Do they have spiritual care needs? And if yes, what are they? Furthermore, just because someone identifies with a particular religious group does not mean they have spiritual needs. New forms of religion and spirituality particular to the contemporary social landscape challenge previous categories that have been employed to make sense of the relationships between religion and health.

7 Concluding Thoughts

This chapter began with a somewhat simple question: *Is religion still a factor in how Canadians understand and experience health?* It is true that religious adherents are on the decline, and the number of religious-nones is rising. And yet, at the same time, we have seen an incredible increase in the diversity of religious groups in Canada. Given that health and illness are intimately tied to religion and spirituality, we have seen some of the complex, multi-faceted, and interesting ways that conflicts and possibilities emerge out of this contemporary landscape. Through a careful examination, it becomes apparent that the answer is far from simple. To gain a deeper understanding of the relationship between religion, health, and religious diversity, this chapter has examined:

- key terminology and theoretical perspectives in the social study of health, illness, spirituality, and religion;
- the sociological study of medicine, health, and illness, as related to religion, spirituality, and religious diversity;
- the history of health and religion, with a particular focus on the Canadian context;
- key sites of conflict centered on religion and health, but also instances where religion and spirituality are seen as fundamental to health;
- the Quebec Charter of Values, with a focus on hospitals and healthcare workers, within the wider context of discussions about religious diversity and healthcare;
- current challenges and future opportunities in research and scholarship in religion and health.

Today, in Canada, most individuals would consider health to be a fundamental human right. Nevertheless, we do not always consider the variety of ways that our health and well-being can be impacted by factors both beyond and within our control. From the time we take our first breath, to the time we take our last, our experience of health and illness are deeply and profoundly shaped by our unique experiences, cultural background, and the wider social system within which we find ourselves. From this perspective, decisions in relation to religion, spirituality, health, and illness, are far from straightforward.

8 Questions for Critical Thought

1. Do religion or spirituality play a role in how you understand health and illness? If yes, how so? If no, are there particular health circumstances where you would seek out religious or spiritual guidance? Why or why not?
2. The *Canadian Charter of Rights and Freedoms* offers the promise of protection for sincerely held religious beliefs. Do you think healthcare providers should be allowed to refuse services to patients on religious grounds when those beliefs are sincerely held? What arguments can you think of to support the position of a devout healthcare provider? What arguments can you think of to support the rights of the patient?
3. What are some of the challenges of healthcare delivery within the context of an increasingly diverse population? Are these challenges the same or different from other public institutions? For example, education?
4. Should hospitals aim to represent diversity? If yes, what form should this take? Where does religious diversity play a role? Are the issues the same or different from diversity more generally?
5. In a secular pluralist state, should all public institutions be free of religion and religious symbolism? Would you support a ban of religious symbolism in hospitals? Why or why not?

9 Online Resources

1. In this video from the Religion and Diversity Project, Professor Meredith McGuire discusses her research on *lived religion* in the United States, focussing on non-medical approaches to healing:

https://www.youtube.com/watch?v=z36j2D9ndSU

2. In this video from the Religion and Diversity Project, United Church of Canada member Charlotte Campbell discusses her use of walking as a meaningful spiritual practice:

https://www.youtube.com/watch?v=rOc8kIMjxvc

3. This project, lead by Sheryl Reimer-Kirkham, PhD, RN, investigates the role of prayer in healthcare institutions in Canada and Britain:

http://prayerastransgression.com/

10 References for Further Reading

Canadian Hospice Palliative Care Association. (2013, October 31). *How spiritual care practitioners provide care in Canadian hospice palliative care settings: Recommended advanced practice guidelines and commentary*. Ottawa: CHPCA Spiritual Advisors.

In this publication, students can explore guidelines for practice for spiritual care practitioners within Canadian palliative care. In particular, the document explores important definitions, as well as a discussion of the issues currently facing spiritual care practitioners.

Raphael, D. (2016). *Social determinants of health: Canadian perspectives*. Toronto: Canadian Scholars' Press.

Dennis Raphael is a prominent Canadian scholar within the field of Sociology of Health and Illness. This publication can act as a helpful resource for students in articulating the broader field of sociology of health and illness, as related to social determinants.

Reimer-Kirkham, S. (2014). Critical refractions: Nursing research on religion and spirituality through a social justice lens. *Advances in Nursing Science, 37*(3), 249–257.

Dr. Reimer-Kirkham's research is innovative and engaging and delves into pressing issues in relation to religious diversity, cultural pluralism, and nursing. In this article, Reimer-Kirkham applies a social justice lens to the incorporation of religion and spirituality within nursing.

11 Researcher Background

Lisa Smith is an instructor in the Departments of Sociology and Gender, Sexualities, and Women's Studies, at Douglas College, located in New Westminster, British Columbia. Lisa is first and foremost a devoted and passionate educator and is currently teaching a variety of courses within the areas of feminism, diversity, social control, and sociology of the lifecourse. She particularly enjoys collaborative research projects with community actors interested in pursuing social justice, anti-oppression, and social change. Her work has appeared in a variety of peer-reviewed publications including *Studies in the Maternal*, *Social Compass*, *Girlhood Studies*, and several edited collections.

References

Amaro, H. (1988). Women in the Mexican-American community (religion, culture, reproductive attitudes and experiences). *Journal of Communication Pyschology, 16*, 6–20.

Anzovino, T., & Boutilier, D. (2015). *Walk a mile: Experiencing and understanding diversity in Canada*. Toronto: Nelson.

Ball, L. (2009). Cholera and the pump on broad street: The life and legacy of John snow. *The History Teacher, 43*(1), 105–119.

Beaman, L., & Smith, L. (2016). "Dans leur propre intérêt": La charte des valeurs québécoises, ou du danger de la religion pour les femmes. *Recherches Sociographiques, 62*(2–3), 475–504.

Beiser, M. (2005). The health of immigrants and refugees in Canada. *Canadian Journal of Public Health, 96*, 30–44.

Beiser, M., & Hou, F. (2001). Language acquisition, unemployment and depressive disorder among southeast Asian refugees: A 10-year study. *Social Science and Medicine, 53*(10), 1321–1334.

Bellah, R. (1985). *Habits of the heart: Individualism and commitment in American life*. Berkeley: University of California Press.

Best Health. (2016). What it means to be spiritual but not religious. *Readers Digest Best Health*. http://www.besthealthmag.ca/best-you/wellness/what-it-means-to-be-spiritual-but-not-religious/. Accessed 5 Dec 2016.

Bibby, R. (1993). *Unknown gods: The ongoing story of religion in Canada*. Toronto: Stoddart Publishers.

Brotman, J., Moore Mensah, F., & Lesko, N. (2010). Exploring identities to deepen understanding of urban high school students' sexual health decision-making. *Journal of Research in Science and Teaching, 47*(6), 742–762.

Brown, R. (2001). Australian indigenous mental health. *Australian and New Zealand Journal of Mental Health Nursing, 10*, 33–41.

Buck, J. (2007). Reweaving a tapestry of care: Religion, nursing, and the meaning of hospice, 1945-1978. *Nursing History Review, 15*, 113–145.

Callister, L., Semenic, S., & Foster, J. (1999). Cultural and spiritual meanings of childbirth: Orthodox Jewish and Mormon women. *Journal of Holistic Nursing, 17*(3), 280–295.

Catholic Health Care Association of Canada. (2000). *Standards of spiritual and religious care for health services in Canada* (pp. 1–24). Ottawa: Catholic Health Association and the Canadian Association for Pastoral Practice and Education.

CBC. (1968, August 18). *The birth control pill sparks religious furor*. CBC. Retrieved from http://www.cbc.ca/archives/entry/the-birth-control-pill-sparks-religious-furor

Covey, H. (2005). Western Christianity's two historical treatments of people with disabilities or mental illness. *The Social Science Journal, 42*(1), 107–114.
Dein, S., Cook, C. C., Powell, A., & Eagger, S. (2010). Religion, spirituality, and mental health. *The Psychiatrist, 34*(2), 63–64.
Dunn, J. R., & Dyck, I. (2000). Social determinants of health in Canada's immigrant population: Results from the National Population Health Survey. *Social Science and Medicine, 51*, 1573–1593.
Durkheim, E. (1897). *Le suicide*. Paris: Felix Alcan.
Gagnon, L. (2003). Morgentaler's call for secular-only hospitals earns tepid response. *Canadian Medical Association Journal, 168*(3), 331.
Gerhardt, U. (1989). *Ideas about illness: An intellectual and political history of medical sociology*. London: Macmillan.
Gerhardt, U. (1990). Qualitative research on chronic illness: The issue and the story. *Social Science and Medicine, 30*, 1149–1159.
Germov, J., & Hornosty, J. (2017). *Second opinion: An introduction to health sociology*. Don Mills: Oxford University Press.
Gibbon, J. M. (1938). *Canadian mosaic: The making of a northern nation*. Toronto: McClelland & Stewart.
Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age*. Stanford: Stanford University Press.
Grossman, C. (2010, February 11). Christian churches in Canada fading out: USA next? *Faith and Reason*. Retrieved from http://content.usatoday.com/communities/Religion/post/2010/02/christian-churches-in-canada-fading-out-usa-next/1#.WRH3_9IrJPZ
Health Canada and the Assembly of First Nations. (2015). *First nations mental wellness continuum framework: Summary report*. Health Canada.
Hornosty, J., & Strazzari, M. (2017). Aging, dying, and death in the twenty-first century. In J. Germov & J. Hornosty (Eds.), *Second opinion: An introduction to health sociology* (pp. 234–256). Don Mills: Oxford University Press.
Kaplan, C. P., Erickson, P. I., Stewart, S. L., & Crane, L. A. (2001). Young Latinas and abortion: The role of cultural factors, reproductive behaviour, and alternative roles to motherhood. *Healthcare Women International, 22*, 667–689.
Karpf, T. (2007). Faith-based organizations play a major role in HIV/AIDS care and treatment in sub-Saharan Africa. *World Health Organization: Media Centre*. http://www.who.int/mediacentre/news/notes/2007/np05/en/. Accessed 5 Dec 2016.
Kirmayer, L. J., Brass, G. M., & Tait, C. L. (2000). The mental health of Aboriginal peoples: Transformation of identity and community. *Canadian Journal of Psychiatry, 45*(7), 607–616.
Kirmayer, L., Simpson, C., & Cargo, M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian aboriginal peoples. *Australasian Psychiatry, 11*, 15–23.
Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. Oxford: Oxford University Press.
Larimore, W. L., Parker, M., & Crowther, M. (2002). Should clinicians incorporate positive spirituality into their practices? What does the evidence say? *Journal of Health Care Chaplaincy, 21*(1), 1–13.
de Leeux, S., & Greenwood, M. (2011). Beyond borders and boundaries: Addressing indigenous health inequities in Canada through theories of social determinants of health and intersectionality. In O. Hankivksy (Ed.), *Health inequities in Canada: Intersectional frameworks and practices* (pp. 53–70). Vancouver: UBC Press.
Levin, J. S., & Vanderpool, H. Y. (2008). Religious factors in physical health and the prevention of illness. *Prevention in Human Services, 9*(2), 41–64.
Masters, K. S. (2005). Research on the healing power of distant intercessory prayer: Disconnect between science and faith. *Journal of Psychology and Theology, 33*(4), 329–338.
Masters, K. S., & Spielmans, G. I. (2007). Prayer and health: Review, meta-analysis, and research agenda. *Journal of Behavioural Medicine, 30*(4), 329–338.

McCullough, M. E. (1995). Prayer and health: Conceptual issues, research review, and research agenda. *Journal of Psychology and Theology, 23*(1), 15–29.
McDonald, L., & Kennedy, S. (2004). Insights into the "healthy immigrant effect": Health status and health services use of immigrants to Canada. *Social Science and Medicine, 59*, 1613–1627.
McLaren, A., & McLaren, A. T. (1997). *The bedroom and the state: The changing practices and politics of contraception and abortion in Canada, 1880–1997*. Don Mills: Oxford University Press.
Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts*. Toronto: York University of School of Health Policy and Management.
Miller, A. (2013). Incorporating theology into medical education. *CMAJ, 185*(1), 35–37.
Mills, C. W. (1959). *The sociological imagination*. London: Oxford University Press.
Nancarrow Clarke, J. (2016). *Health, illness, and medicine in Canada*. Don Mills: Oxford University Press.
Nieuwsma, J. A., Rhodes, J. E., Jackson, G. L., Cantrell, W. C., Lane, M. E., Bates, M. J., Dekraii, M. B., Bulling, D. J., Ethridge, K., Drescher, K. D., Fitchett, G., Tenhula, W. N., Milstein, G., Bray, R. M., & Meador, K. G. (2013). Chaplaincy and mental health in the Department of Veteran Affairs and Department of defense. *Journal of Health Care Chaplaincy, 19*(1), 3–21.
Oelke, N. D., & Vollmann, A. R. (2007). "Inside and outside": Sikh Women's perspectives on cervical Cancer screening. *CJNR, 39*(1), 174–189.
Orsi, R. (2002). Is the study of lived religion irrelevant to the world we live in? *Journal for the Scientific Study of Religion, 42*(2), 169–174.
Pargament, K. (1997). *The psychology of religion and coping: Theory, research, practice*. New York: The Guilford Press.
Patriquin, M. (2016, October 28). A Jehovah's witness and her deadly devotion. *Macleans*. Retrieved from http://www.macleans.ca/news/a-jehovahs-witness-and-her-deadly-devotion/
Public Health Agency of Canada. (2016). *What makes Canadians healthy or unhealthy*. Retrieved from http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#unhealthy. Accessed 15 Dec 2016.
Raphael, D. (Ed.). (2012). *Tackling health inequalities: Lessons from international experiences*. Toronto: Canadian Scholars Press.
Ravelli, B., & Webber, M. (2015). *Exploring sociology: A Canadian perspective* (3rd ed.). Toronto: Pearson.
Reimer-Kirkham, S. (2009). Lived religion: Implications for nursing ethics. *Nursing Ethics, 16*(4), 406–417.
Reimer-Kirkham, S. (2014). Nursing research on religion and spirituality through a social justice lens. *Advances in Nursing Science, 37*(3), 249–257.
Reimer-Kirkham, S., Pesut, B., Meyerhoff, H., & Sawatzky, R. (2004). Spiritual caregiving at the juncture of religion, culture, and state. *CJNR, 36*(4), 148–169.
Reimer-Kirkham, S., Sharma, S., Sawatzky, R., Meyerhoff, H., & Cochrane, M. (2012). Sacred spaces in public places: Religious and spiritual plurality in health care. *Nursing Inquiry, 19*(3), 202–212.
Romo, L. F., Berenson, A. B., & Segards, A. (2003). Sociolcultural and religious influences on the normative contraceptive practices of Latino women in the United States. *Contraception, 69*(3), 219–225.
Rose, N. (1996). The death of the social? Refiguring the territory of government. *Economy and Society, 25*(3), 327–356.
Ross, S. (2016, December 3). Abortion services not needed on P.E.I., protesters say. *CBC News*. Retrieved from http://www.cbc.ca/news/canada/prince-edward-island/pei-abortion-prince-county-hospital-1.3880384
Segall, A., & Fries, C. J. (2011). *Pursuing health and wellness: Healthy societies, healthy people*. Don Mills: Oxford University Press.
Seljak, D., Schmidt, A., Benham Rennick, J., Bramadat, P., & Da Silva, K. (2007). *Religion and multiculturalism in Canada: The challenge of religious intolerance and discrimination*.

Waterloo: Strategic Policy, Research and Planning Directorate Multiculturalism and Human Rights Program Department of Canadian Heritage.
Semenic, S. E., Callister, L. C., & Feldman, P. (2004). Giving birth: The voices of Orthodox Jewish women living in Canada. *Journal of Obstetrics, Gynecology, and Neonatal Nursing, 33*(1), 80–87.
Sethna, C., & Doull, M. (2012). Accidental tourists: Canadian women, abortion tourism, and travel. *Women's Studies: An Inter-disciplinary Journal, 41*(4), 457–475.
Smith, D. (1987). *The everyday world as problematic: A feminist sociology*. Milton Keynes: Open University Press.
Smith, M. (2007, April 6). Religion in a secular society. *The Star*. Retrieved from https://www.thestar.com/opinion/2007/04/06/religion_in_a_secular_society.html. Accessed 15 Dec 2016.
Statistics Canada. (2003). *Religions in Canada*. Ottawa: Minister of Industry.
Statistics Canada. (2011). *National household survey: Data tables*.
Stephenson, P. (2004). Health care, religion and ethnic diversity in Canada. In P. Bramadat & D. Seljak (Eds.), *Religion and ethnicity in Canada* (pp. 201–221). Toronto: Nelson.
Thomas, K. H. (2016). Warrior faith: A Marine's lesson in religion, health, and healing. *Social Work & Christianity, 43*(1), 108–123.
Tone, A. (2001). *Devices and desires: A history of contraceptives in America*. New York: Hill and Wang.
Truth and Reconciliation Commission of Canada. (2015). *Truth and reconciliation Commission of Canada: Calls to action*. Winnipeg: Truth and Reconciliation Commission of Canada.
Tse, S., Lloyd, C., Petchkovsky, L., & Manaia, W. (2005). Exploration of Australian and New Zealand indigenous people's spirituality and mental health. *Australian Occupational Therapy Journal, 52*, 181–187.
Van de Creek, L., & Burton, L. (2001). Professional chaplaincy: Its role and importance in healthcare. *The Journal of Pastoral Care, 55*(1), 81–97.
Weiss, G., & Lonnquist, L. (2009). *The sociology of health, healing and illness* (6th ed.). Upper Saddle River: Pearson Education.
Winnipeg Regional Health Authority. (2014). *The culture of well-being: Guide to mental health resources for First Nations, Métis & Inuit people in Winnipeg*.
Wolpe, P., Burnett, W., & Idler, E. (2014). Religion's role as a social determinant of twenty-first-century health: Perspectives from the disciplines. In E. Idler (Ed.), *Religion as a social determinant of public health*. New York: Oxford University Press.
World Health Organization. (2017). *Constitution of the World Health Organization: Principles*. http://www.who.int/about/mission/en/. Accessed 25 Nov 2016.
Zhao, J., Xue, L., & Gilkins, T. (2010). Health status and social Capital of Recent Immigrants in Canada: Evidence from the longitudinal survey of immigrants to Canada. *Citizenship and immigration Canada* (pp. 1–29).