

'The Elephant on the Table': Religious and Ethnic Diversity in Home Health Services

Sheryl Reimer-Kirkham¹ · Sonya Sharma² · Sonya Grypma¹ · Barbara Pesut³ · Richard Sawatzky^{1,4} · Doreen Wolfs¹

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Abstract Healthcare services are increasingly being provided in the home. At the same time, these home contexts are changing as global migration has brought unprecedented diversity both in the recipients of care, and home health workers. In this paper, we present findings of a Canadian study that examined the negotiation of religious and ethnic plurality in home health. Qualitative analysis of the data from interviews and observations with 46 participants—clients, administrators, home healthcare workers—revealed how religion is expressed and ‘managed’ in home health services.

Keywords Religion · Ethnicity · Homecare · Diversity · Ethnography

✉ Sheryl Reimer-Kirkham
Sheryl.Kirkham@twu.ca

Sonya Sharma
Sonya.Sharma@kingston.ac.uk

Sonya Grypma
Sonya.Grypma@twu.ca

Barbara Pesut
Barb.Pesut@ubc.ca

Richard Sawatzky
Rick.Sawatzky@twu.ca

Doreen Wolfs
Doreen.Wolfs@twu.ca

¹ School of Nursing, Trinity Western University, 7600 Glover Road, Langley, BC V2Y 1Y1, Canada

² Faculty of Arts and Social Sciences, Kingston University London, Penrhyn Road, Surrey KT1 2EE, UK

³ School of Nursing, University of British Columbia-Okanagan, 1147 Research Road, Kelowna, BC V1V 1V7, Canada

⁴ Centre for Health Evaluation and Outcome Sciences, Providence Health Care, Vancouver, Canada

Introduction

Internationally, healthcare services are increasingly being provided in community settings, typically informed by the philosophy of ‘home is best’ and by a common concern to curtail healthcare costs associated with hospitalization. At the same time, communities are seeing rising levels of diversity as part of global migration, a trend that results in diverse clientele and diverse healthcare workers. Much of the attention of diversity management in healthcare is focused on hospital-based care, not home healthcare. Moreover, attention to diversity has predominantly focused on ethnicity and culture, apart from the religious and spiritual diversity that also accompanies global migration. How home health¹ services are delivered in the context of diversity—and particularly religious and spiritual diversity—is not well understood, and little has been written about spiritual care in home health. In this paper, we discuss the findings of a three-year Canadian study that examined the negotiation of religious, spiritual, and ethnic diversity in home health from the viewpoints of administrators, clients, and home healthcare providers. Described as ‘*the elephant on the table*’ by one of the administrators in this study, religion and spirituality were influential and relevant in the context of home health and yet were largely unaddressed. Although most administrators were sympathetic to the relevance of religion to home health, a concurrent lack of organizational support in the form of resources and policies meant that healthcare providers and clients (and their families) were left with the challenge of filling these organizational gaps. Thus, care in contexts of difference was ‘worked out’ in day-to-day encounters with considerable variation that depended on individual propensities. In some cases, deep connections were made that resulted in spiritual support and holistic, person-centred care, and in other cases religious identities became sites of unequal relations of power and marginalizing practices. In this particular Canadian context, priority was not placed on managing diversity or providing spiritual care, though both were acknowledged as relevant to home health.

Background

Conceptualizing Religion and Ethnicity

This exploration at the juncture of religion, ethnicity, and home health takes an intersectional approach to examine how multiple social identities operate simultaneously and how everyday encounters are shaped by broader social structures that create advantages and disadvantages (Sharma and Llewellyn 2016a; Dhmoon and Hankivsky 2011; Crenshaw 1989). The study of religion and the study of ethnicity often happen in siloes (e.g. sociology of religion; ethnic and immigration studies). Yet, the lived experience of religious and ethnic identities is not tidy, a point we return to in our discussion. Moreover, most academic and policy attention has been devoted to ethnic and racial forms of difference, while religious diversity has been understood to be a private or communal matter, but not a concern that belonged in the public sphere (Bramadat and Seljak 2009). As global migration has brought religious diversity to the West, particularly non-Christian traditions, the relevance of religious diversity to social life has become more apparent. Conceptually,

¹ We use ‘home health’ in keeping with local terminology. Elsewhere, equivalent terms might be ‘homecare’, ‘domiciliary care’, or ‘district nursing’.

the definitions of ethnicity and religion overlap (as do their correlates of culture and spirituality). Ethnicity, as a social construct, typically refers to a group of people who are presumed, by members of the group itself and by outsiders, to feel a sense of attachment to common origin, history, place and cultural attributes that distinguish it from larger society (Christiano et al. 2015). Culture, as a ‘lifeway’ of values, beliefs, and practices, relates closely to ethnicity, though carrying a more voluntary affiliation and applying to various sources of shared group identity such as sexuality, community, or organization (Bramadat and Seljak 2009). The interrelationship between ethnicity/culture and religion/spirituality² is varied, where religion can constitute and transcend ethnicity on one end of a spectrum to where religion may play a minor or absent role in influencing ethnic identities on the other end (Saroglou and Cohen 2011). While definitions of religion and spirituality also overlap and are contentious each in their own right (Ammerman 2013), we draw on the approaches of sociology of religion that seek to integrate the religious and the irreligious, the spiritual and the non-spiritual. Earlier conceptualizations viewed religion as the innate human impulse to seek God, characterized by beliefs and practices which united adherents together in a moral community or church (Durkheim 1912), and emergent definitions of religion are more likely to reference that which is special, holds deep meaning, with less attachment to formal institutions for the enactment of one’s values and beliefs (Davie 2013). The relationship between religion and society has also continually and contextually evolved, with concurrent trends of the loss of the social significance of religion in some sites (often referred to as secularization), and sustained or even increased presence in other settings.

Constructions of Home and Canadian Home Health

The very thing that many call home has multiple meanings. Descriptions of the practical aspects of healthcare service delivery in the home foreground the material and symbolic meanings associated with ‘home’. Blunt and Varley (2004) conceptualize home as ‘situated within a range of complex meanings, emotions, experiences and relationships’ (p. 4). They view home not as a fixed bounded site, rather the home is always in process and ‘embedded within wider social, political, cultural and economic relations on scales from the domestic to the global’ (Blunt and Varley p. 3). The home is to be viewed not as a private space distinct from other public spaces, but as a crossing point between the internal intimacies of home and the wider world (Blunt 2005). As a result, the home is shaped by political, social and ethnic relations, intimacy and care. Because of the ambiguity and power of such influences, the home is not always a secure, safe place where everyone finds and feels a sense of belonging. It can also be a place of danger or fear (Blunt and Varley 2004). And while the home might be thought of as a place of care, health and healing, it is also a place where illness and death are experienced.

These ways of thinking about and experiencing home are shaped by the organizational contexts of home healthcare. Canadian home healthcare encompasses a wide range of publicly and privately funded services: (1) health promotion and teaching; (2) curative intervention; (3) end-of-life care; (4) rehabilitation, support and maintenance, social

² For the sake of this paper, we use religion as shorthand for the continuum of religion and spirituality and likewise use ethnicity for the domain of race, ethnicity and culture. This pragmatic choice comes with its problems, partly because of the tendency in healthcare and nursing literatures to frame religion as a negative term in contrast to spirituality as a more inclusive term (Clarke 2009; Fowler et al. 2011; Hill et al. 2000; Sharma et al. 2011). However, given that the theoretical grounding for this project comes from the sociology of religion, we have followed that disciplinary semantic.

adaptation and integration; and (5) support for the informal/family caregiver (CHA 2009). However, because Canada does not have a national homecare program, there are variations in the funding, provision, management, organization, and distribution across the country (Armstrong and Armstrong 2016; Walsh 2014). Typically, an interprofessional team of regulated and non-regulated healthcare providers offers healthcare in the home, including nurses, social workers, physiotherapists, nutritionists, occupational therapists, pharmacists, and home support workers. Palliative home care services are likely to also involve physicians, counsellors, and spiritual care practitioners.

Financial pressures associated with global economies and rising healthcare costs, combined with improved medical technologies, have resulted in the global de-institutionalization movement and the glorification of home and community-based care, marked by the philosophy that home is a better site for care (Aronson and Neysmith 2001; Bryant 2016). Neoliberal ideologies shape this shift towards home and community-based care, whereby market economies with profit motivation, the mobilization of capital and workforces across borders, and the decline of the welfare state and government investment in social and health services are put forward as common sense and inevitable (Bryant 2016). Whether people prefer to be cared for at home (as individual preference), or whether they must be cared for at home because of healthcare reorganization (as a result of political, economic drivers), home healthcare services are playing an increasingly important role in healthcare delivery (CHA 2011). Reflecting these dynamics, home healthcare services in Canada increased by 51% between 1997 and 2007, according to the Canadian Home Care Association (2008), a not-for-profit association with representatives from governments, health service providers, and others in the home care sector.

Religious and Ethnic Diversity in Home Health

Our interest is in how diversity, particularly at the intersection of religion and ethnicity, is accommodated in home health, in the context of administrative agendas shaped by current global financial pressures and the social meanings attached to home and home health. This interest stems from a preceding study that examined the negotiation of religious, spiritual, and cultural diversity in hospital settings (Reimer-Kirkham et al. 2012b); participants in the earlier study repeatedly told us that religious and ethnic diversity in home health was an area that required study. Because scholarship has tended to address either ethnic or religious diversity with little consideration of their intersection, the review that follows also addresses religious and ethnic diversity in home health separately. Literature related to ethnic diversity in home health (without explicit attention to religion or spirituality) shows evidence of inequalities in service provision along lines of culture, ethnicity, gender, material resources, geographic location, and language (Davitt et al. 2015; Giesbrecht et al. 2012; Narayan and Scafide 2017; Peckover and Chidlaw 2007; Smith et al. 2015). For example, in a recent systematic review of racial/ethnic outcome disparities in home healthcare, Narayan and Scafide (2017) found strong though limited evidence of disparities for minority patients on health outcomes (e.g. less improvement in mobility and dyspnea, higher likelihood of hospitalization, higher risk of an adverse event, and less satisfied with care). In the USA, Davitt et al. (2015) conducted focus groups with black, Hispanic, and white home healthcare staff to glean their perspectives on contributing factors to racial and ethnic disparities in home healthcare outcomes. The participants identified agency and system factors that contributed to disparities, including preferential treatment by administrative staff (e.g. assignment practices that expected staff of colour to serve predominantly low-income or minority service areas; poor staff coverage in minority

neighbourhoods that decreased the duration and number of visits and disrupted continuity of care; hiring practices that favoured white staff); patient/staff cultural discordance (e.g. agency efforts to match the ethnic identities of staff and clients re-inscribed social patterns of discrimination whereby white clients could refuse care by a staff of colour); and poor access to health and community resources (e.g. clients in low-income neighbourhoods might not be able to access certain medications at their local pharmacy, or might not be able to cover out-of-pocket expenses such as a diabetic diet). Other literature on ethnic diversity in home health focuses specifically on the approaches of care providers. Debesay et al. (2014) in Sweden found uncertainty with intimate care and treatment philosophies, particularly as related to cultural and religious practices of minority patients. In a Canadian study, England and Dyck (2011) uncovered how practices of intimate body care (such as bathing, toileting, and catheter management) demonstrate the diverse dynamics of care work through which caregivers, care recipients and homespace are constituted. Specifically, the ‘dirty work’ of intimate body care is typically assigned to unregulated, lower paid workers who were often from migrant communities (Bourgeault et al. 2010). Other research in Canada shows lower rates of utilization of home health services by immigrant groups, often with families providing more care and with concerns expressed about language barriers and a lack of culturally responsive care (Walsh 2014). Summarizing the literature on ethnicity and home care, the picture is one of the fragility of bodies, the intimacy of care in the home, and gendered and racialized differences that converge; patients from racialized backgrounds may have poorer health outcomes on account of a lesser quality of care and communication difficulties, especially when healthcare providers are not comfortable with difference. Moreover, home care workers from migrant communities may also face linguistic and cultural challenges and are disproportionately represented at the lower echelons of paid work in home settings.

The literature on religious diversity in home health primarily attends to palliative care (e.g. Vallurupalli et al. 2012; Vermandere et al. 2013). Coward, Stajduhar, and Bramadat (2012, 2013) edited two books on what a ‘good death’ looks like in different religious and spiritual traditions. In a systematic literature review of culturally and spiritually sensitive end-of-life care (EoL), Fang et al. (2015) reported numerous barriers, including under-utilization of culturally sensitive models designed to improve EoL care; language barriers; lack of awareness of cultural and religious diversity issues; exclusion of families in the decision-making process; racial and religious discrimination; and lack of culturally tailored EoL information to facilitate decision-making. Another body of the literature related to religious diversity in home health, apart from palliative care, speaks to the role of faith and faith communities in providing social support, meaning and resilience (Gerdner et al. 2007; Taylor 2008; Walsh 2014). For example, in Walsh’s study with Italian Canadians receiving home care, the participants noted the value of care aligned with their spiritual and cultural identities, including ongoing access to a church nearby and connections to their faith communities for social support. Overall, this review of the literature has illuminated certain gaps in the literature in the context of complexity, diversity and inequalities. Notably, the study of religion often does not account for how ‘religion intersects with multiple axes of identity, social location and power relations’ (Sharma and Llewellyn 2016b, p. xviii). How religion is accounted for in home health is not well understood, particularly when separate from end-of-life care, and when intersecting with ethnicity and other axes of social differences.

Purpose and Methods

Purpose and Objectives

The purpose of this ethnographic study was to examine the negotiation of religious, spiritual and ethnic plurality in the provision of healthcare services in the home, and the social, gendered, economic, and political contexts that shape these dynamics. Objectives were to: (1) explore how caregiver/recipient identities are constructed in home health settings; (2) describe how religious, spiritual, and ethnic plurality is negotiated in caregiver/recipient encounters in home settings; (3) examine how home health services shape how religious, spiritual, and ethnic are negotiated; and (4) analyse how societal contexts shape the negotiation of religious, spiritual, and ethnic plurality in the provision of home health services.

Data Collection

The study was conducted out of six home health offices under the auspices of a large regional health authority in the province of British Columbia. The districts served by these six home health offices varied in size and demographics from a smaller, rural community to diverse urban cities. Percentages of newcomers to Canada (foreign born) were just under 40% in two cities, with 22% of the population in one city not speaking English at home. Study brochures were distributed to the home health offices and short presentations were made at staff meetings, inviting home healthcare providers (HCPs) and administrators to participate. Participants (HCPs and administrators) enrolled in the study were asked to suggest possible clients and families to interview, and also distribute study brochures to them. Clients then contacted the research office directly if they were interested in participating.

Data collection involved interviews and focus groups, and was conducted by the principal investigator and the research team, who represented the disciplines of nursing and sociology. In addition, fieldwork involved participant observation during home health visits with five HCPs. Interview and participant observation guides provided prompts for the researchers and ensured consistency in data collected. The variety of data collection methods and sources resulted in a rich, triangulated dataset. Ethical approval was obtained from the two universities represented by the investigators and from the regional health authority. Informed consent was obtained prior to each interview or participant observation period, and all participants were assured anonymity and confidentiality. Interviews took place at a time and place preferred by the participant, and all interviews were recorded with participants' permission. The final sample ($n = 46$) consisted of 27 healthcare providers (of which 3 were unregulated 'aides'), 10 administrators, and 9 clients (with another 11 clients who were observed during home health visits). Given our interest in the negotiation of diversity, we sought a range of religious and ethnic diversity represented in our sample. Participants self-reported religious affiliation as Christian (with considerable self-reported intragroup variation that included Evangelical, Lutheran, Protestant, Pentecostal, Anglican, Roman Catholic, Presbyterian, Mennonite, United Church, and Greek Orthodox), Sikh, Buddhist, Muslim, and Bahai. Of the 46 participants, 12 were non-affiliated (26%), though most of them rated spirituality as very important. The following countries of birth were given: Canada, Britain, India, USA, Poland, Korea, Australia, Romania, Ireland, Albania, and Iran. Further diversity was present among those who were Canadian born, with the

following ethnic heritages named: Italian, German, Metis, Scottish, First Nations, Ukrainian, and Scandinavian. Despite this diversity, several limitations remain in the representativeness of the sample. First, the study is limited by its location in one health region in one province in Canada. While this site offered wide ethnic and religious diversity among the clients, only one (albeit large) health organization is represented in this study; another organizational context might result in different findings. Second, few non-English speakers were included because few volunteered to participate, despite the availability of translators as part of the research design. Finally, those sympathetic to religion were probably more likely to volunteer. Nonetheless, the study offers much needed insight into the negotiation of religious, spiritual, and cultural plurality in home healthcare because of its robust design, including the degree of diversity represented in the sample, the rich data generated, and the analysis grounded in critical social theories.

Data Analysis

Data were transcribed and entered into NVivoTM, a qualitative data analysis program, and data analysis occurred concurrently with data collection. An initial codebook with broad ‘bucket’ codes was developed based on the research objectives and coding of the first two interviews by the entire team. We closely read each transcript, jotting notes and discussing what codes would be assigned to specific meaning units (Thorne 2016). Early codes included: difference, home health context, health-illness experience, relationship, social network, and spiritual care/spirituality/religion. As data collection and analysis progressed, the bucket codes were re-analysed with a second level of coding to identify cross-cutting themes. Memos were written with deeper analysis of data, and code summaries were generated for the main themes. NVivoTM facilitated the creation of various matrices for further analysis of the data (e.g. comparing views on religion by gender and class). Regular team meetings to discuss the emerging findings added further depth to the analysis. Thus, several strategies were employed to ensure analytic rigour, including triangulation of data collection methods and researchers, inter-rater reliability in the form of comparing coded transcripts and discussing variations in coding, and expert checking in discussing emerging findings with a Think Tank of guest scholars, including sociologists and anthropologists of religion, and a geographer. Reflexivity was encouraged throughout, with researchers writing detailed field notes that included reflection on their own spiritual and cultural viewpoints.

Findings

The data generated in this study—presented here through the viewpoints of administrators, clients, and healthcare providers³—traced a pattern of *noticing and managing difference* in the provision of home health. These viewpoints were mediated by commonplace constructions of religion and ethnicity in Canadian society, and the political economy of home health.

³ In other publications, we have presented findings from this study in regard to religious practices in healthcare—specifically the practice of prayer (Sharma et al. 2012); spirituality and nursing leadership (Reimer-Kirkham et al. 2012a); a historical analysis of spirituality in home health (Grypma et al. 2012); and religious accommodation in healthcare organizations (Reimer-Kirkham and Cochrane 2016).

Administrators' Cautions: Religion as '*The Elephant on The Table*'

The home health administrators were careful in their descriptions of how diversity was approached. They spoke of the diverse clientele they served, acknowledged the relevance of religion to many home health clients, and recognized the deficiencies of programmatic approaches to accommodating religion. The first administrator we interviewed used a telling phrase—'*the elephant on the table*'—to reference the strong influence of religion and the concurrent and paradoxical lack of attention to religion in home health, adding: 'It is an area that is under supported'.

The plurality of the populations served was frequently emphasized, and religious diversity was situated within this broader context. One administrator referred to this diversity as 'not cookie cutter'; another said, 'it's not all vanilla'. An administrator in a particularly diverse community said: 'I think that we try. But truthfully we're not serving the needs of those from different ethnic backgrounds and certainly not of those from a gay orientation'. This administrator, like others, explained that the workforce was also diverse, noting, '50% of our staff are South Asian'. Another administrator observed that 'we live in a very secular society', signalling not the irrelevance of religion, but rather the need to move towards inclusive policies and practices, including those who are non-religious.

When asked how important religion/spirituality were to the provision of health services, most asserted they were very important. One administrator explained the significance of faith communities to immigrants or newcomers

Involvement in a faith community not only gives you connection with God or a higher power, it gives you an instant community who understands you. You then feel you belong as a new person in Canada. We underestimate the value of faith communities around the cultural connection and maintaining those traditions for people and that sense of identity. It becomes that one thing that is timely and timeless within the context of massive transition.

Commendable here is the administrator's recognition of the salience a transnational faith community might have to support relocation to a new country.

We asked administrators how religious plurality was accommodated in their organization, and how spiritual care might be offered to home care clients. The majority of them responded that spiritual care was not directly or intentionally addressed in home health, or that it was 'not done very well'. One senior administrator was resistant to the question, responding:

I would say I have no clue what that means. Like what is spiritual care? Are you talking cultural care? Or are you talking ethnicity? Or are you talking diversity? I do yoga. Are you talking yoga? I'm more of a champion for cultural care; if I had a choice between spiritual care and cultural care I would absolutely say cultural is more important. I would actually be fairly offended if somebody sent me, if I was dying, a spiritual care practitioner.

With this assertion, we see the administrator drawing on their personal views to deduce what an organizational response to diversity, and in particular religion, should be.

The administrators could identify few policies or resources specific to the integration of spiritual care into home health, but did not identify this as a serious gap. It was inferred that formal spiritual care services were more important to hospital-based care, but less so for community-based care, because it was assumed that clients would access their community

clergy or faith communities for spiritual support and that any spiritual practices or religious rituals would continue as per usual, in their homes. The exception was palliative care services provided in the home. Spiritual care practitioners (i.e. paid chaplains with formal spiritual care training) were active in the palliative team, providing staff education and support to clients and families, as reflected in this comment: ‘Our spiritual care practitioner is well embedded into the home health palliative rounds and attends rounds with the team’. However, this type of integration into other aspects of home health (e.g. chronic disease management, acute rehabilitation) was missing in the jurisdiction where this research was conducted.

In the light of the lack of dedicated spiritual care resources and policies, several ‘stop gaps’ were identified by administrators as ways to manage religious diversity and provide spiritual care. These solutions mapped on to the common administrative discourses such as person-centred care, risk management, self-management, and interprofessional practice. A senior administrator explained: ‘policy isn’t written about spiritual care—I guess that gets to the nuts and bolts around the research—but there are big policy statements that I hope have removed some barriers for us being more holistic and person-centred, which would bring in a whole piece of spirituality.’ The expectation was that a client’s spiritual needs would be met through their faith communities, as asserted by one administrator: ‘We ask, ‘what does your network of strength look like?’ They often say ‘my community, my church, my pastor’. Then we would mobilize that with the client.’ Where a client was not connected to a faith community, administrators noted that interprofessional practice could fill the gap, ‘There are times when it would be helpful to have a spiritual care practitioner involved in care, but a staff person—a nurse, doctor, physiotherapist or whomever—can offer spiritual care’. In sum, the viewpoints of the administrators revealed ambivalence about the role of home health in accommodating religious diversity and the lack of resources or policies for spiritual care. To address this gap, administrators posited that religious diversity and spiritual care needs be addressed through somewhat related policies and care priorities already in place (i.e. person-centred care, risk management, self-management interprofessional practice). Thus, the lack of attention to religion played out in the overlapping areas of managing diversity and providing spiritual care, a point we return to in our discussion.

Clients’ Considerations: ‘The World Comes to My Home’

In contrast to the administrative arms-length management of diversity, clients lived the intimacies of navigating difference while receiving care in their homes in a first-hand way. The viewpoint of clients revealed the intimacies—imbued with frailties and resistances—that are part of receiving healthcare services at home. Our interest was in how these intimacies played out in social relations of difference, which could lead to connection and/or distance. The clients represented a range of religious identities and likewise reflected on the diversity represented by HCPs, as evident in one woman’s remark: ‘the world comes to my home’. Another client said:

We’ve never met and suddenly this person is coming in, they stripped me off stark naked and they bathed me. But she’s [healthcare provider] in the same predicament. If you think about it, they’re mostly women, they’re mostly physically tiny, and they go into these houses and it’s not really the safest situation. They’ve got a hard job because they come into the home and the home is sacrosanct in a lot of cultures.

In this quote, the participant elucidates the vulnerability of both the recipient and provider of personal care, and references Filipina migrant healthcare providers.

Some clients made deliberate effort to create an interpersonal space that would diminish the awkwardness of the personal care they were requiring, challenging traditional views represented in the literature that HCPs are responsible for establishing therapeutic relationships (see for example, Guttman 2013; Williams and Davis 2005). For some clients, this connection came through shared religious affiliations, as articulated by this Italian-Catholic woman:

I'm actually more comfortable around the ones who have a similar upbringing. I was raised as a Catholic, and most of the care aids were raised Catholic. The lady who wasn't raised in the Catholic faith just had such a totally different upbringing it's very hard to find a common ground. You're more comfortable when you have someone who has more similar background.

A Punjabi-speaking woman, through an interpreter, had a similar observation: 'When the other nurses come they aren't speaking Punjabi so they just come and do the work and go. I don't really feel comfortable because they can't really understand me and I can't understand them'. Another client, a Christian woman, sought connection through the practice of prayer, even when not sharing the same religious affiliation: 'I found that when working with Muslims and Sikhs, prayer is a good bridge because prayer is very important in their religion'. In another case, a family who was grateful for the help they received realized the HCP, a newcomer from Latin America, shared the same religion and was working hard to make ends meet as a single parent. The client helped the HCP by offering her lunch and the use of their laundry machines as a way to make her life easier and ensure that she continued to come. The client reflected: 'she was always saying, "I love to come to you guys' place"'. As such, connections based on shared faith and religious practices such as prayer were enacted to buffer the intimacy of receiving personal care and to bridge social differences.

Power relations can be more fluid in home healthcare compared to hospitals, such that clients can create a social climate that places the caregiver in a vulnerable situation and that is reinforced by the common home health philosophy of 'being guests' in clients' home. One client discussed how she 'witnessed' or shared her faith perspectives with the aim of proselytizing: 'I try to witness about the Lord. When it comes Easter time and Christmas time, I try to share my beliefs particularly about the resurrection of Jesus and they usually don't say anything, they just listen but don't make any comment'. While the client derived meaning from speaking about her faith, it appeared that the caregivers who did not share her faith, particularly those who were newcomers to Canada and could be made to feel uncomfortable, remained silent. Although proselytizing by a client could also occur in a hospital, the intimacy of the home setting and the social obligations associated with being a guest arguably make the caregiver more vulnerable, particularly when the client is affiliated with a majoritarian religion (i.e. Christianity in this case) and the caregiver with a minority religion (e.g. Sikhism in this case). Racialized social discourses drawing on the religious motif of 'service' were offered by one participant as explanation for the number of migrant care providers. A Christian woman quoted her white pastor:

Our pastor said Filipinos have a gift for service. I have that in my mind. A lot of Filipinos go into that type of work and a lot of it is because, let's face it, a lot of white people won't do it (chuckle), not to be prejudiced or class conscious but, you know. So I wasn't that surprised when they were mostly Filipino.

In this comment and some of the other reflections that clients made about the diverse home health workforce, we see the reality of global patterns of labour flows and the generalizations such as a propensity for service that are mobilized to explain a stratified workforce. Domestic migrant workers, including those who care for the elderly, often face precarious working conditions while providing caring work that involves emotional labour and body work with close and intimate physical contact with those they care for (Dyer et al. 2008). They do so as ‘servants of globalization’ (Parreñas 2015) in low paid jobs that support neoliberal strategies of the global movement of workers, and the marketization and privatization of public goods and services for the goals of corporate profit and managerial efficiencies (Bryant 2016). The attribution of divine giftedness in this quote obscures the racialized, gendered, and classed nature of this commodified care work.

In summary, the accounts of clients and our observations of caregiving encounters in homes reveal intimate exchanges whereby care recipients and caregivers alike navigated the complex terrain of diversity. In some situations, shared religious identity could bring connection and comfort, in other cases religious identities intersected with racialized and classed identities to re-inscribe societal patterns of advantage and disadvantage.

Healthcare Providers’ Capacities in Tending to Religion: ‘When you cross the threshold’

Healthcare providers, whether regulated professionals or non-regulated, were by and large exemplary in the respect, compassion and kindness shown to clients. HCPs described how they ‘read difference’ at the threshold or doorway, even before they entered the home:

The beauty of working in the community is that you are in their setting. I can walk into someone’s house and see important scripture, you know, a frame that’s written on the wall or I can see a crucifix or I can see a Buddha. There are so many visual things in someone’s home of what’s important for them, where in the hospital you don’t always see that.

Reading difference was vital in the face of the diversity represented among the clients, who like the healthcare professionals varied in their religious identities (devout religious, spiritual but not religious, agnostic, atheist), and also varied in the extent to which they were reflexive about the influence of their own identity. When we asked participants to give examples of providing care in situations of ‘difference’, they noted along with religious diversity (e.g. Sikh, Buddhist, and Jehovah’s Witness) intersecting sources of diversity such as economic deprivation and criminal involvement, particularly in some of the lower resource neighbourhoods within the catchment area of the home health office. A passing comment—‘I never met a drug dealer who prayed’—reflected a social distancing and an assumption about religiosity, but also the conditions and workplaces of home health.

Similar to administrators and clients, HCPs varied in their capacity and propensity to tend to religion, influenced by their personal valuing of religion, educational preparation, and the lack of clear policies. Some went out of their way to incorporate religious views and practices (e.g. organizing care around prayer times, or church attendance), others were uncertain about whether this was allowed, and yet others were careful not to make any reference to religion, seeing it as irrelevant or off limits. Participants who volunteered for this study were mainly attuned to religion as relevant to home health, and one exchange exemplified the influence of this personal interest:

Researcher: It seems like you go out of your way to take care of people's religious preferences.

HCP: Yeah, but it's not because of any support or training. It's just my own interest in the wellbeing of someone or if they have questions.

A nurse noted that because the detailed 19-page home health admission assessment form did not include any questions about spirituality, she created a workaround to this institutional barrier by incorporating spirituality into questions on social support because she saw the merit of integrating related assessment data. Another HCP acknowledged her uncertainty and wished for training in this regard:

There is always a wariness to talk about your own spirituality or your own thoughts on the matter because you do not want to compromise. You know this is such a delicate matter, it happens to me quite a bit. And I would really, really like spiritual training on how to deal with this situation when it comes up.

In contrast, another HCP explained in some detail:

I will never talk religiously to my clients; it [religion] does not apply to my work. Rather, I am very kind and approach them appropriately, I am respectful. We've been taught that we are not able to discuss anything political or religious with clients. Clients can be Hindu, they can believe in Buddha, I will not discuss. They might have religious pictures in the house, but I will never talk about religious beliefs or practices.

This HCP emphasized that rather than individualizing care through the integration of spiritual beliefs or practices, she focused on providing the best care she could 'based on what I was trained in school'. Here, we see personal valuing together with education and her position as care aid resulted in her distancing herself from responding to religion in any form. This approach was in keeping with her country of origin, a former Soviet state, where atheism was the official government stance. In a more overt case of resistance to the integration of religion into home health, a nurse told of a situation in which she had prayed with a home health client and family at their request, but that a colleague had scolded her with 'we don't pay you to pray'.

Several stories stood out as exemplars of responsiveness to clients' religious identities.

In one case, a nurse described how services were arranged to allow a woman to go to the temple:

With a client being unable to go to the temple because of incontinence, we increased her personal care help so that she was getting more personal care, showering and bathing, and made sure that we did it the day before or the morning of the temple visit.

In another case, a HCP came to realize how important attendance at mass was for a housebound client. She made arrangements for the priest to visit, who subsequently arranged for volunteer to pray the rosary for her weekly. While there might be questions about whether making such arrangements are the role of home health, the participant marvelled that the client's outlook and health improved remarkably after these visits began. Along with facilitating religious practices, some HCPs expressed a more

comprehensive view of tending to the spiritual that reflected concepts of dignity, compassion, and person-centredness:

I think that the way you touch the client, the personal care that you give, if it's a sponge bath, to give them respect for their bravery, the courage they have to face what they're going through, I always try and do that. I think that is part of spirituality too, because you're looking at the whole person from a holistic point of view.

Thus, there was inconsistency among HCPs as to whether they saw religion as relevant to home care, a reality consistent with the lack of policies, resources, and administrative support. When the viewpoints of administrators, clients, and HCPs are taken together, the findings of this study show how religious diversity was worked out in the day-to-day in the proximity and intimacy of body care in homes. Whether administrator, care recipient, or caregiver, the social gradient of power favoured those who were EuroCanadian and affiliated with Christianity, which resulted at times in the paradoxical situation in which a client could hold considerable advantage over a caregiver. Managing diversity and spiritual care were in large part left to individual HCPs under the auspices of other policies such as person-centred care and interprofessional practice. Indeed, many participants voiced ambivalence about whether religious practices and spiritual care were to be facilitated in publicly funded healthcare. In these ways, the narratives of the administrators, clients, and HCPs took place against the backdrop of the political economy of home health which is reliant upon a gendered, migrant workforce; intersecting social relations of advantage and disadvantage; and views about the role of religion in the public sphere of healthcare.

Discussion

The data generated in this study, captured in the comment of *'the elephant on the table'*, signal the contested, troublesome, and yet often overlooked presence of religion in home health. Research on home health is relatively sparse compared to other areas of health services, and the void is even greater when looking at religious diversity. However, this study has revealed the real presence—whether welcomed, ignored, or contested—of religion as an influence on the provision of home healthcare, often intersecting with other social forms of difference. These findings align with sociologist of religion, Grace Davie's (2013, p. 1) assertion: 'Religion is not something that can be safely or sensibly relegated either to the past or to the edge'.

The findings of this study show an overlap in the mandates of managing diversity and providing spiritual care, perhaps because of the lack of attention to both and because both are required to fulfil human rights and multiculturalism policy obligations. Organizational support, especially in the form of resource allocation, for the integration of spiritual care services and religious accommodation is inconsistent in Canada. We have found in our work a continuum of religious accommodation ranging from resistant to responsible across micro-, meso-, and macro-levels (Reimer-Kirkham and Cochrane 2016). This variation must be read against the larger social debate on the role of religion in the public sphere. While the influence of institutional religion has declined significantly in Canada, there has been a greater presence of religiously orthodox individuals, due in large part to global migration (Lefebvre and Beaman 2014). At the same time, the number of Canadians who are not religiously affiliated is also rising. As official state policy, the Charter of Rights and Freedoms (1982) and the Multiculturalism Act (1988) have ostensibly created space for

multiple ethnic and religious expressions of identities, and yet the concurrent commitment to secularism can leave the impression that ethnic identities are more welcome than religious identities. Multiculturalism has been criticized as maintaining a dominant French-Anglo Canada that allows for some newcomers on the margins, and Canada's secularism likewise has been characterized as allowing an unspoken Christian hegemonic centre while negating the influence of other religions (Haque 2010).

The challenge in home health is to create the conditions for responsible pluralism (Reimer-Kirkham and Cochrane 2016; Thaler 2009), where there is respectful, welcoming space for clients and, paradoxically, for those who care for them. HCPs were left with the challenge of filling in gaps in organizational resources and policies as they transformed 'neutral' or secular assumptions of institutionalized 'public' care into responsible accommodation of religion at the individual level. For example, in the absence of spiritual care services, some HCPs went to considerable length to make connections to community faith leaders for their clients, and in one case, that faith community declined involvement. Debesay et al. (2014) point to the importance of contextualizing the experience of individual care providers to the institutional and social context in which they operate. They found that home health services were making only minor adjustments to accommodate a much more diverse population and this could result in nurses at the point of care constructing these patients as 'difficult' when the problem was indeed lack of organizational support. In our study, what could be understood as inequalities in service provision to religious and ethnic minorities at the organizational level were ameliorated or reinforced by individual care providers in an *ad hoc* fashion, depending on the propensity of the HCP.

Interviews and observations with participants revealed the intimacy and proximity of care provided in home settings. We found that social relations between caregivers and recipients of care in home health settings—and the negotiation of religious and ethnic plurality—took shape differently than in hospital settings. Common accommodations (e.g. religious preferences re: food, prayer, role of family) that can be problematic in the hospital were already present in the home. By and large, personal and professional boundaries were more porous in home settings, where HCPs and clients might share their religious views openly. Indeed, within our data there was evidence that clients sought to engage with HCPs around religious views and practices with clear goals in mind. In some ways, this reverses the dynamics of power that occur in institutional settings. HCPs could become the focus or recipient of religious intervention. The home as a place of intimate labour meant personal and social boundaries were constantly blurred, as HCPs prepared food, folded laundry, and provided personal care. The narratives of intimate labour in this study can be better understood when viewed as 'body work'. England and Dyck (2011) describe body work as 'employment that takes the body as its immediate site of labour, involving intimate, messy contact with the body, its orifices or products through close proximity' (p. 207). Body work in the home can carry an intensified sense of intimacy, a revealing of one's self in their private spaces, complete with the intimacy of religious/spiritual symbols and artefacts. For some, body work in the home included a spiritual dimension. McGuire (2008) makes the link between spirituality and the body, saying:

Spirituality fully involves people's material bodies, not just their minds or spirits. The key connection here is not ideas about the body, or simply moral control of the body and its impulses. Rather spirituality is closely linked with material human bodies—and not just bodies in the abstract. I mean real bodies—arthritic bodies, pregnant bodies, malnourished bodies, healthy bodies, and suffering bodies. I mean human bodies that labor and rest, bodies that create and destroy. (p. 97)

One wonders how home health would be enhanced if more HCPs viewed bodywork as sacred or spiritual. The risk in such an emphasis, of course, is the further subordination of women, many of them migrant, doing this work, where their efforts are deemed ‘service’ and ‘spiritual’ as reflected in the comments of the Christian pastor to say Filipinas are meant to care. Such a construction takes little account of the global patterns of transnational labour operating in the background to support the political economy of healthcare. Our entrée of religious diversity in this study ultimately mapped on to gender, race, and economy to elucidate experiences of inclusion and exclusion (Sharma and Reimer-Kirkham 2015). For this reason, intersectionality serves us well to move past the essentializing tendencies of focusing on the values, beliefs, or practices of ethnic or religious groups to a more fruitful exploration of the ways in which individuals and groups are socially located to be either advantaged or disadvantaged and how these social locations affect health status (Reimer-Kirkham and Sharma 2011; Sharma and Llewellyn 2016a).

Conclusion and Implications

In addition to contributing to theoretical scholarship in religion, ethnicity, and health, our discussion carries several implications for home health service delivery. Our findings make visible the importance of organizational resources to support religious and ethnic diversity. While current administrative discourses of person-centredness, risk management, self-management, and interprofessional practice can all be operationalized to support diversity management, dedicated resources will be needed in order to accomplish responsible pluralism. These resources could include spiritual care practitioners, diversity brokers, and ethicists as part of clinical teams. Clear policies should be established to guide staff in navigating diversity. Education of HCPs, both continuing interprofessional education and undergraduate education, is needed to advance religious literacy (Dinham and Francis 2015).

The ambivalences made evident in this study are embedded in broader Canadian discourses about the role of religion in public service institutions. Given the diversity of Canada’s population along the lines of religion, ethnicity and race, class and gender, this study alerts us to the importance of identifying what contributes meaning and support to those requiring home health services, and of clearer policies regarding how religion might be integrated into home health. As long as religion persists as ‘*the elephant on the table*’, the negotiation of religious and ethnic diversity will remain contested and clients and healthcare providers will continue to be at risk for marginalizing practices.

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Compliance with Ethical Standards

Conflict of interest The authors have no conflicts of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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