Amid the workings of modern hospitals, which are characterized by high acuity, technology and managerialism, prayer, often presumed private, is also performed in public, as in hospital chapels, at a patient's bedside, or in a corridor with family (Reimer-Kirkham and Sharma et al. 2011). Healthcare staff and volunteers are increasingly asked to accommodate spiritual and religious diversity, which is embraced and avoided due to different beliefs, no belief, or other priorities. Thus, prayer in addition to involving the sacred, making meaning, seeking divine support, and not being fixed to a particular religious tradition, can also be perceived a transgressive act that accommodates and resists social and institutional norms and structures in healthcare settings. Prayer has the capacity to ‘transgress’ limits and conventions, to deny and affirm difference, and move against and beyond boundaries (Ooks 1994; Jenks 2003).

In this paper, we explore such transgression, drawing on selected findings from a program of research that examines the negotiation of religious and spiritual pluralism in Canadian hospitals and home health. Our focus is on the various and contested ways that patients, volunteers, and staff approach prayer. We address three overlapping areas. First, prayer by patients, volunteers, and staff both supported and challenged normative western Christian practices and secularity often associated with healthcare. Second, acts of prayer had the capacity to bridge and reinforce religious differences between individuals and groups. Third, because meeting needs for prayer had the capacity to disrupt institutionalized schedules in a taxing and high-paced environment, some staff were wary of transgressing healthcare routines in the everyday. As we examine these areas, we draw on sociologists and feminist postcolonial theorists to conceptualize our understandings of the everyday practices and power of prayer, arguing that prayer, when accommodated and resisted, can transgress and thereby reinforce and bridge unlikely boundaries.
Where Do the Stories Come From? Overview of Research Program

The stories that form the foundation of this paper were generated during a critical ethnographic study, conducted in nine Canadian hospitals, that examined the negotiation of religious, spiritual, and cultural plurality. Utilizing interviews and participant observation, 69 healthcare professionals (nurses, doctors, and allied health care professionals), spiritual care practitioners (professional and volunteer), patients and families, and decision-makers participated in the study. Data were analyzed through thematic coding analysis. Findings demonstrated how religion is ‘lived’ in the everyday (McGuire 2008; Reimer-Kirkham 2009), how religious and spiritual plurality is negotiated in clinical encounters (see Pesut and Reimer-Kirkham 2010; Pesut, Reimer-Kirkham et al. 2010), and how institutional and social contexts (Reimer-Kirkham and Sharma 2011) shape these encounters. A theme that emerged to tie the personal, interpersonal, organizational and social dimensions together was that of sacred space. Analysis revealed how sacred spaces, whether designated or informal, were shared, blurred, and were sites of the negotiation of identity and power (Reimer-Kirkham and Sharma et al. 2011).

The context of the study is western Canada, which is important. Canada, particularly in its major cities, represents a remarkable mix of ethnic, religious, and national backgrounds. Along with its indigenous peoples (Aboriginal, Metis, and Inuit) (Ralston Saul 2008; Todd 2008) and founding settler Canadians (English and French), it has in more recent years seen a steady influx of immigrants from non-European countries (Statistics Canada 2008). Although seven out of ten Canadians self-identify as Roman Catholic or Protestant, much of the shift in Canada’s religious profile is the result of this migration. In the past decade, Buddhism, Hinduism, Islam, and Sikhism have increased substantially in their number of adherents. At the same time, the percentage of Canadians indicating ‘no religion’ on census surveys has risen (Clark and Schellenberg 2006), including those who identify as atheist. Also in this category of ‘no religion’ are those who represent emergent non-religious spiritualities, the growing phenomenon in modern western society of the sacralization of nature, the self, and everyday life (Lynch 2007; Sharma, Reimer-Kirkham et al. 2012).

Since the 1970s, Canadian hospitals, formerly administered by such religious groups as the Catholic Church and the Salvation Army, have transitioned to government oversight with chaplaincy services and other expressions of religion and spirituality largely side-lined from the hospital operations. However, amid social change and increased spiritual