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8

Summaries in English and Dutch



Summary

The starting point for this thesis was the ambition to achieve better spiritual care in a general hospital. The concept of “spiritual care” is easily misunderstood in the Netherlands. Spirituality is associated with “vague”, “for dreamers”, “unchristian”, or even “occult”. Instead of using the term “spiritual care” we could also say: “dealing with existential questions” or “support in giving meaning to life”. In line with the literature worldwide we choose to employ the term “spiritual care”. The focus is not on the substance (substantial approach) of spirituality (what a person believes), but rather on its function. In this approach spirituality is understood as a dimension of being human, with the implication that every person is a spiritual being. A definition based on this functional approach of spirituality is: “Spirituality is the religious or existential mode of human functioning, including experiences and questions of meaning and purpose”. One advantage of this functional approach is its universal applicability.

Chapter 2 reports on a study conducted in 2007 of the experiences of nurses and patients regarding the spiritual care they respectively provided and received. The study among nurses consists of a qualitative and a quantitative part. For the quantitative part 51 nurses on five wards in a general hospital completed a questionnaire. It examined their ideas on patient wishes with regard to spiritual care, the practice of spiritual care and their evaluation of the spiritual care they provide. In the qualitative part of the study eight nurses were asked, using a semi-structured interview, about their ideas on spiritual care and what they see as barriers or facilitating factors in providing spiritual care.

75 patients who were cared for by these nurses completed a questionnaire about their experiences with the spiritual care provided by the nurses and about their satisfaction with the information on spiritual care. The research showed that both patients and nurses consider spiritual care to be an important element of care *and* that patients and nurses feel improvement in the provision of spiritual care is necessary. Of the nurses, 40% indicated that only few patients receive sufficient attention for their spiritual needs. Patients also noticed shortcomings in the support and registration of spiritual needs. For example, 57% of patients considered a minimum registration of spiritual background on admission to the hospital to be important. In practice, spiritual background was registered for only 41% of the patients. The main obstacle to providing spiritual care was lack of time. Lack of training was also mentioned as a barrier. Several studies have shown that spiritual care training helps nurses in providing spiritual care.

In Chapter 3 we describe a spiritual care training, which we organized for nurses, and we present the results of the quantitative study of the effects of this training.

Apart from the effects on the nurses and their actions, we first examined the effects of the training on the spiritual care as experienced by the patients. After the training the patients on the intervention wards (81 after and 51 before the training) experienced more room and support for their questions regarding illness and meaning. The nurses (44 before and 31 after the training) not only saw a larger role for themselves in spiritual caregiving to patients, there was also change in the spiritual care they actually provided. For example, after the training the nurses indicated doing more to find out what spiritual questions patients had. They also checked the medical files more frequently for possible spiritual needs. Patients were asked more often whether they wanted to visit the chapel, the meditation room, or the drop-in centre. More about spiritual questions and/or needs was reported in the patient files. Furthermore, job satisfaction among nurses increased and they referred more patients to the spiritual caregivers after the training. Several months after the training and the effect study, the number of consultation requests for the spiritual caregivers was back to the pre-training level. The impression gained from personal observations and conversations with team leaders on nursing wards is that the effects of the training were temporary due to time constraints, turnover of personnel and the multitude of training courses for nurses. We consequently searched for a method to safeguard spiritual care in hospital practice. A fairly simple instrument was found in a spiritual needs assessment. Chapter 4 describes the implementation of a spiritual needs assessment in a general hospital and its effects on the patients. The main effect, that remains unchanged one year later, is the number of consultation requests for the Department of Spiritual and Pastoral Care. At baseline, three months before the implementation of the spiritual needs assessment, nurses requested 2 consultations from the Department of Spiritual and Pastoral Care. During the effect measurement 3 months after implementation the Department of Spiritual and Pastoral Care received 9 consultation requests from nurses, plus an additional 24 requests were made via the digital general medical assessment programme. A second intended effect, i.e. patients experiencing an increase in spiritual care provided by nurses, did not materialize. Indeed, after the implementation of the spiritual needs assessment patients experienced less spiritual care from the nurses. One explanation is that the nurses no longer felt required to provide spiritual care because the increased number of consultations for the Department of Spiritual and Pastoral Care meant that the spiritual caregivers would take care of it.

In order to gain insight into the role of spiritual caregivers in the whole of spiritual care practice in a general hospital, we examined, by means of a literature review, to determine how spiritual care is organized and functions in Scotland, where spiritual care is viewed as an integral element of medical care. Chapter 5 analyses

the main themes in the professional journals of the main associations of spiritual caregivers in Scotland and the Netherlands. This analysis shows that spiritual care in Scotland changed in a short period of time after the publication of the 2002 report “Spiritual Care in NHS Scotland”. It transformed from a task for the spiritual caregiver on the sideline into an integrated element of care that involves all caregivers. It is therefore no surprise that “spiritual care” is the main theme in the Scottish Journal of Healthcare Chaplaincy. A second theme often addressed in this journal is “professionalization” and in connection with this “research”. It is clear that the National Health Service plays a central role in the development of spiritual care in Scotland. In the journal *Tijdschrift Geestelijke Verzorging* of the Dutch Association of Spiritual Caregivers in Healthcare Institutions (VGVZ), the most important theme was the identity of the spiritual care professional, and the main subtheme was the official endorsement of the spiritual caregiver. In other words, the main focus of spiritual care in the Netherlands was directed inward, lagging behind the colleagues in Scotland.

Until recently spiritual caregivers needed endorsement from a church or the Humanist Society, which meant they were officially affiliated with their religious or worldview organization. In Chapter 6 we examine whether the ministerial office, which has been an important theme in Dutch spiritual care for a long time, can play a role in making spiritual care a priority and also in the actual practice of spiritual care. In recent decades the Association of Spiritual Caregivers in Healthcare Institutions (VGVZ) has become divided on the importance of the office and official endorsement. This divide is closely linked to the definition of spiritual care as it was formulated in 1987 by the Spiritual Care Committee of the National Hospitals Council [Nationale Ziekenhuis Raad (NZR)]. “The professional and ministerial (i.e. endorsed) guidance and support of people from and on the basis of a religious or worldview belief system”. Over time professionalism and ministry came to be regarded increasingly as rival poles. In 2013 the decision was made that official endorsement, which had been a condition for membership of the VGVZ and admission to the professional register, is no longer a requirement. A reviewing board for the non-endorsed spiritual carers [Raad voor institutioneel-niet-gezonden Geestelijk Verzorger (RING-GV)] was constituted for the non-endorsed spiritual caregivers. Instead of the endorsement by a religious or worldview organization this board can grant authorization for membership and register.

An historical outline reveals that the discussion about the position of the office in the VGVZ ran almost parallel to discussions within theology and church about the meaning of the office of ministry. These discussions addressed the question whether office is more than just a particular type of function. Our analysis shows that the office has, as Noordmans calls it, a ‘mystical element’. In other words,

a reference to the sacred or to God. And so the office also entails several notions that are important to spiritual care.

I propose a variation on the triangle designed by Hanrath to depict the professional identity of the spiritual caregiver (figure 1). In this new version calling is placed at the top and charismata and function at the two remaining vertices. The sides are formed by professionalism and religious or worldview tradition. The base is formed by the person of the spiritual caregiver.

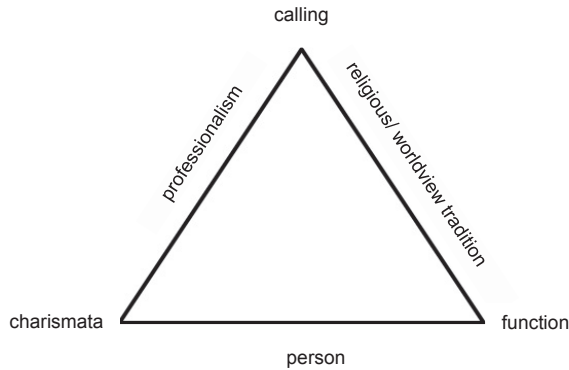


Figure 1 Office triangle

Finally, several recommendations are offered for needed reflection on the relationship between officially affiliated and ‘free’ spiritual caregiving.