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## Spiritual care by nurses and the role of the chaplaincy in a general hospital

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# 1

## Introduction





## Introduction

‘Society is changing’ is the title of a 2014 publication of the Dutch Ministry of Health, Welfare and Sport. The subtitle of this brochure is: Will healthcare change correspondingly? [*De maatschappij verandert, verandert de zorg mee?*] (Ministerie van Volksgezondheid, Welzijn en Sport, 2014). The publication is devoted entirely to changes in the health care sector. Technological progress and societal changes are creating a situation in which health care “must run to stay in the same position and sprint to make any headway” (p.59). The relatively new discipline of (professional) spiritual care within the field of healthcare<sup>1</sup> is faced with the challenge of finding an adequate response to those changes (Rebel, 2006, p. 101). With this dissertation I hope to make a contribution to the profession and the quality of spiritual caregiving in a changing society and a perhaps even faster changing field of healthcare. The central question in this study is: How can the quality of spiritual care in the context of contemporary developments in health care and in religiosity be maintained and improved?

Before elaborating on this question, I will first briefly describe the field of spiritual care.

## Developments in Dutch healthcare

In a special issue of *Praktische Theologie* [*Practical Theology*] entitled “Chaplaincy as spiritual caregiving in the general hospital” (2000,4), a contribution by Bakker is dedicated to developments in general hospitals (Bakker, 2000). The turbulent development he writes about in 2000 has continued in full force, partly influenced by market mechanisms. Bakker specifically addresses the changes that have immediate consequences for spiritual care. I will list the most radical changes. Due to ‘*technicization*’ the emphasis has shifted increasingly towards technology and away from caregiving. The hospital has changed from a place of ‘hospital-ity’ to a treatment centre (Bakker, 2000; Querido, 1967). “The term care only resurfaces when technology has reached its limits” (Bakker, 2000). In the practice of technicized care it also becomes less self-evident that spiritual caregivers take initiative to visit patients. Medical specialization means that treatment has become a team effort rather than the work of one doctor. This may result in a discontinuity of care that can have an alienating effect on the patient. Due to ongoing specialization

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<sup>1</sup> In addition to the healthcare sector, spiritual caregivers are also active in fields of the military and justice; in this dissertation we focus on spiritual caregiving in the field of healthcare.

there is a risk of the individual disappearing from sight and of professionals focusing only on the sick organ.

A second important development is the *reduced length of hospital stay and the development of day patient nursing/transmuralization*. In the period 2002-2012 the average hospital stay has decreased from 7.80 days to 5.17 days (Vandermeulen, 2014). This means that the patient spends less time in the hospital, even for major procedures. During his brief stay, which can be very significant for the patient, he is occupied with the primary process of the medical-technical treatment. Not only does the patient spend less and less time in hospital, but also more and more treatments are taking place at the outpatients clinic or the day clinic. This development means that there are fewer opportunities to provide (spiritual) care. At the same time people continue to search for experiences of meaning. However, a shrinking number of people is connected to a religious or worldview organization that can support them in this search. During a crisis, as is often provoked by hospitalisation, a need is felt for support in the search for meaning. The possibilities of the spiritual care giver to provide that support are limited. In the nursing literature it is argued that spiritual care is a dimension of nursing care. Against this background it seems helpful to involve nurses in the spiritual care and to offer them a training in that type of care to enable them to actually provide it. However, it is to be expected that the involvement of nurses in spiritual care and training them to provide it, will only succeed if the institution has a culture and policy that supports it.

## Spiritual care

The profession of spiritual caregiver is relatively new (Kuttschrütter, 1991) although Heitink locates the first roots of spiritual care in antiquity (Heitink, 2006, p. 164). In the Netherlands the profession developed more or less along the same lines as in the United Kingdom (Swift, 2009). In the 1950s the hospital chaplain was not yet considered a professional. Instead he was viewed as a failed minister (Heitink, 2006, p. 163). The rise of Clinical Pastoral Education in the 1960s was the start of the professionalization of the hospital chaplains. Many ministers welcomed the challenge of working in a professional organization (Heitink, 2006, p. 163). In Protestant circles these ministers held a respected position in the hospital, as did the rectors in the Roman-Catholic hospitals. In the non-denominational hospitals pastoral care was provided by local ministers who visited members of their church (Snelder, 2006). Spiritual care was considered a concern of the church (Snelder, 2006). In 1971 the Association of Roman-Catholic hospital chaplains (Vereniging van Rooms- Katholieke Ziekenhuispastores) and the (Protestant) Working group of hospital chaplains (Werkgroep Ziekenhuispredikanten) were founded. They soon

merged and formed the two autonomous sectors of the Association of Spiritual Caregivers in Hospitals, [*Vereniging Geestelijk Verzorgers in Ziekenhuizen*] VGVZ (Kuttschrütter, 1991). Following an appeal inviting hospital chaplains to join, this new association's membership quickly increased to 255 (Snelder, 2006). Soon thereafter humanist spiritual caregivers were welcomed as members. In 1976 a new *non-religious* sector was established. Apart from the association's strong focus on professionalization of the profession, the churches paid little attention to the spiritual caregivers. This led to the latter to increasingly perceive themselves as professionals within the healthcare institution and less as representatives of the church (Heitink, 2006, p. 163).

In 1972 the National Hospitals Council of the Netherlands (NZR) determined that spiritual caregiving is a part of healthcare practice. In 1988 the Advisory Committee for the Provision of Support for (Church) Communities [*Commissie van advies inzake de criteria voor steunverlening aan kerkgenootschappen en andere genootschappen op geestelijke grondslag*], also known as the Hirsch Ballin Committee reached a consensus based mainly on article 6 of the Constitution of the Netherlands. According to this article: "Everyone shall have the right to profess freely his religion or belief, either individually or in community with others, without prejudice to his responsibility under the law" ("The Constitution of the Kingdom of the Netherlands," 2008). Following a lengthy process the Dutch Care Institutions Quality Act [*Kwaliteitswet Zorginstellingen*] went into effect on 1 April 1996. In Article 3 we read: Regarding the care provided for the stay of the patient or client in the institution during a period of at least 24 hours, the care provider also ensures the availability in the institution of spiritual care corresponding as much as possible with the religious or worldview tradition of the patients or clients. As a result spiritual care is not just a concern of the church and religious professionals, but is taken to be integral to quality of care.

In 1994 the name of the Association of Spiritual Caregivers in Hospitals was changed to Association of Spiritual Caregivers in *Healthcare institutions* (Zorginstellingen). Today, in addition to the general hospital setting, the association includes five other fields of work: nursing and elderly care homes, psychiatry, youth care, care for the mentally disabled, and rehabilitation. With the addition of the Sector Not Formally Affiliated [*Institutioneel Niet Gezondenen*, (SING)], the number of sectors has been expanded to seven. Apart from the original Roman-Catholic, Protestant, and Humanist sectors, there are also sectors of Jewish, Islamic, and Hindu spiritual caregivers.

## Definition of spiritual care in the Netherlands

We find the first definition of spiritual care in the 1976 report *Identity and necessity of spiritual care [Identiteit en noodzaak geestelijke verzorging]* by the Spiritual Care Committee of the National Hospitals Council of the Netherlands [Nederlandse Ziekenhuis Raad NZR]. The definition was: “Professional support and guidance of people in fundamental questions regarding life, illness, and death, offered through and based on a religious or worldview belief system” (Snelder, 1996). Over time the definition has been modified several times. In 2002 the Professional Standard for spiritual caregivers in care institutions [*Beroepsstandaard voor de geestelijk verzorger in zorginstellingen*] (GVVZ, 2002) defined spiritual care as:

- *the professional and official guidance of and assistance for people with regard to meaning and spirituality\*, from and on the basis of faith and life convictions,*
- *and professional consultation in ethical and life view aspects<sup>2</sup> of care provision and policy making (GVVZ, 2005).*

\*The term spirituality was added by the General Assembly in 2010.

## The domain of spiritual care

It proved quite difficult to capture the domain of spiritual care in one term; in 2002 the term “meaning” (*zingeving*<sup>3</sup>) was selected. Other terms had also been discussed, and rejected. For example “life view” (or “worldview”), which referred too much to institutionalized religion, and “spirituality” that was rejected because (in the Dutch terminology) it might evoke associations with “mental healthcare”. The decision in favour of meaning was in part the result of the fact that the term implies a process (Hekking, 2003a, 2003b; Veltkamp, 2006).

The General Assembly of 2010 determines that the term meaning refers to: “the continuous process in which each individual, in interaction with his environment gives meaning to (his own) life. In the individual process of giving and experiencing meaning, religions and world views can play an essential role.” Meaning can therefore be religious as well as non-religious. The process of giving meaning includes rational, emotional, behavioural, and spiritual levels (Veltkamp, 2006, p. 152), not separately, but in relation to the totality of the individual. In the statement

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<sup>2</sup> Translator’s note: The term ‘life view’ is a literal rendering of the Dutch ‘levensbeschouwing’ (or the adjective form: ‘levensbeschouwelijk’) which is a collective term for various religions and spiritualities, philosophical and humanistic positions, art of life views, etc., whether on the level of practical understandings and/or as more developed, traditional viewpoints.

<sup>3</sup> Literally: the giving or attribution of meaning, the implication being ‘meaning in life’.

accompanying the modification of the Professional Standard in 2010 that added spirituality to the core definition of spiritual care, the fourth level is renamed the symbolic level.

## The (changing) significance of religion

Since the foundation of the VGVZ in 1971, the influence of the churches has diminished rapidly. In 1970, for example, 60% of the population belonged to a church community; in 2012 this was only 30%. The percentage of regular churchgoers among members of the church dropped from 67% in 1970, to 50% in 1980, to 42% in 2012. There is a steady decline in terms of membership numbers, church attendance, participation in church rituals, the number of church buildings and church communities, the recruitment of professionals (de Hart, 2014). Of the adult Dutch population a small majority of 54 per cent indicated being religious in 2012, compared to 60 per cent in 1999 (CBS, 2013).

The publication *Faith in the public domain. Investigation of a dual transformation [Geloven in het publieke domein. Verkenningen van een dubbele transformatie]* by the Dutch Scientific Council for Government Policy [*Wetenschappelijke Raad voor het Regeringsbeleid*] (Van de Donk, Jonkers, Kronjee, & Plum, 2006) describes how the presence of new forms of spirituality has increased in recent decades, but also how those new forms are a far cry from the older forms of spirituality. Kronjee (2006) speaks in this context of religious transformation. In the new forms of spirituality self-fulfilment seems to be the key, without any significant input from religious institutions (van de Donk et al., 2006, p. 14). Secularization should therefore be interpreted primarily as deinstitutionalization (van de Donk & Plum, 2006, p. 33). Even if they are no longer affiliated with a religious or worldview institution, people are not less religious, but rather differently religious. Religiousness is less defined and more fluid (Kennedy & Valenta, 2006).

## Spirituality in care practice

Reflecting on spiritual care within healthcare practice, it is important to realize that spirituality and spiritual care have been a subject for reflection not only within the field of chaplaincy but in other fields as well. Starting mainly in the field of palliative care health sciences have given considerable attention to the spirituality of the patient and to the provision of spiritual care. The connection between health and spirituality has been demonstrated by many authors (Handzo & Koenig, 2004; van Leeuwen, Tiesinga, Jochemsen, & Post, 2004; Puchalski, 2013). The World Health Organisation and the International Council of Nurses consider



spiritual care an essential element of healthcare practice (ICN, 2012; WHOQOL Group, 1996; WHOQOL SRPB Group & Saxena, 2006). Spiritual care has become a part of many nursing codes. So there is a broad consensus about the need to integrate spiritual care in healthcare practice. Spiritual care is not an additional element only to be dealt with in exceptional cases but a vital element of health care practice (Baldacchino, 2008; McSherry, 2006; NHS Education for Scotland, 2009; Stirling, 2012; Vandenhoeck, 2013) and there is growing evidence of its effectiveness (Kalish, 2012). Clearly spiritual care has acquired a recognized position in healthcare practice.

## Definition of the concept of spirituality

As a result of extensive worldwide attention by different disciplines, spiritual care has become a catch-all term, that is defined in a number of different ways (Christensen & Turner, 2008; McSherry, Cash, & Ross, 2004; NHS Education for Scotland, 2009; Ross, 2006). However, in the variety of definitions two broad approaches to spirituality can be distinguished: a substantial and a functional approach (van Leeuwen, Schep-Akerman, & van Laarhoven, 2013).

The substantial approach to spirituality concentrates on the *content* of the concept. This may be a traditional doctrine (Christian, Muslim), but it can also be a less clearly defined faith people may have in our postmodern age. In such a substantial approach the spirituality of a particular religious community can be studied. The question asked by many nurses: ‘how do we deal with the religious beliefs and customs of Muslims?’ pertains to this substantial approach.

The functional approach, instead of looking at content, looks at the *function* of spirituality in the life of the person. This approach departs from the premise that spirituality is a dimension of being human and that every human individual is (therefore) a spiritual being.

In the work for this thesis the focus has not been on the content of what people believe, but on the function of their beliefs in their lives, recognising the increasing plurality of religions and world views in our society. Against this background a functional approach to spirituality will be followed in this study. This approach concentrates on the meaning of peoples beliefs irrespective of the contents of those beliefs. Hence, I use the following definition of spirituality:

“Spirituality means the religious or existential mode of human functioning, including experiences and questions of meaning and purpose” (Jochemsen, Klaasse-Carpentier, Cusveller, van de Scheur, & Bouwer, 2008; van Leeuwen, 2008).

## Subquestions

In considering the question how to maintain and improve the quality of spiritual care in the changing field of healthcare, I have outlined a few developments that affect the provision of spiritual care. From these considerations I distil the following points:

- The length of patients' stay in the technology-focused hospital decreases.
- The role of religious or worldview institutions is diminishing, but people are searching for meaning in their own way.
- The domain of spiritual caregiving is (experiencing) meaning in life.
- Spiritual care not only receives attention by professional spiritual caregivers (formerly, and in some contexts still today, called chaplains), but is considered an essential element of healthcare in general.
- The opportunities of spiritual caregivers to provide spiritual care has diminished
- Giving attention to the spiritual dimension of patients is considered to be a dimension of the nursing care.

In this context it makes sense to examine whether nurses can be involved systematically in the spiritual care for patients in care institutions. Considering this the question rises whether nurses feel competent to provide such care or would need a training for it. Another question is how patients experience the attention given to their spiritual needs. Based on the general research question: How can the quality of spiritual care in the context of contemporary developments in health care and in religiosity be maintained and improved? The following two subquestions were formulated:

- What are the perspectives of patients and nurses regarding spiritual care in a hospital?
- What are the effects on patients and nurses of a spiritual care training provided to nurses?

Since more and more protocols are used to support the quality of care we examined whether also spiritual care could be improved by a kind of protocol. A fairly simple instrument in this regard is a brief spiritual assessment. This led to the third subquestion:

- Is a spiritual assessment a practicable instrument to improve spiritual care?

Spiritual care training for nurses and a spiritual assessment administered by nurses seem good instruments, but insufficient in themselves to improve spiritual care. Integration of spiritual care is not a concern for nurses (and professional spiritual caregivers) alone; it requires clear and binding policy decisions in the healthcare institutions. A quick orientation of the situation in other countries brought to light

that this integration had been realized in Scotland. This finding led to the fourth research question:

- What can developments with respect to spiritual care field in the Netherlands and Scotland – as identified in spiritual care journals – teach us about improving (the quality of) spiritual care in the Netherlands?

In Scotland a lot of attention was given to the integration of spiritual care in health care as a whole and to its professionalization. In the Netherlands the central theme has been the significance of the endorsement of the ministerial office for spiritual caregiving. This raises the question whether the holding of an official office and receiving endorsement from a religious (or world view) community contributes to the quality of the spiritual care. Thus the fifth subquestion is:

- What is the value of office with an endorsement of a worldview institution for spiritual care?

In summary the five subquestions of this study are:

- 1) What are the perspectives of patients and nurses regarding spiritual care?
- 2) What are the effects on patients and nurses of a spiritual care training provided to nurses?
- 3) Is spiritual assessment a practicable instrument to improve spiritual care?
- 4) What can developments within the spiritual care field in the Netherlands and Scotland – as identified in spiritual care journals – teach us about improving (the quality of) spiritual care in the Netherlands?
- 5) What is the value of office with an endorsement of a worldview institution for spiritual care?

## Methods

Various methods have been used in the research reported in this thesis, related to the various approaches that were followed to find answers to the research questions and through them to the main question of this study.

The studies on perspectives and experiences of patients regarding spiritual care were based on quantitative research methods (Chapters 2, 3, and 4). For reasons of triangulation, credibility and completeness as well as enhanced opportunities for explanation and illustration (Bryman, 2006) a mixed-method design with quantitative and qualitative research was used in the study of nurses' perspectives on spiritual care (Chapter 2). The studies into the effects of a spiritual care training (Chapter 3) and the implementation of a spiritual assessment on the nurses

(Chapter 4) were based on a quantitative research design using standard statistical methods and analyses.

For the analysis of the two journals of the leading professional associations in the Netherlands and Scotland (Chapter 5) I used content analysis. This study focuses on developments in the field of spiritual care.

Reflection on ministry and endorsement within the field of spiritual care in Chapter 6 is based on a review of the literature regarding ministerial theology and spiritual care.

In summary, the dissertation as a whole is based on mixed-methods research according to the different parts of the study that tried to find answers to different (types of) question. For each subquestion we used the methods that were most appropriate for that particular type of research. Hence, this dissertation is the result of research based on methods and insights from a number of disciplines, viz. nursing studies, social-scientific studies, spirituality studies and (practical) theology.

## Reader's guide

Chapter 2, 'Spiritual care in a hospital setting: nurses' and patients' perspectives', is, as far as we know, the first study to examine how both nurses and patients experience the care provided or received. The study among nurses includes a quantitative and a qualitative section. This study shows that patients as well as nurses consider spiritual care an important element in care practice *and* that patients and nurses are of the opinion that spiritual care provision should be improved.

One of the obstacles to providing spiritual care that we found in this study and in the literature, is the lack of training (Cavendish et al., 2004; Edwards, Pang, Shiu, & Chan, 2010; Lind, Sendelbach, & Steen, 2011; NHS Education for Scotland, 2009).

In Chapter 3, 'Effects of spiritual care training for nurses', we describe a spiritual care training of nurses, and we present the results of the quantitative study into the effects of this training. We were the first to include the effect of the training on spiritual care as experienced by the patients in our study.

The training proves, in accordance with earlier research, to have an effect on the attitude of the nurses. In addition, effects were also found on the care as it is experienced by patients. However, after several months the number of consultations of the spiritual caregivers dropped back to the pre-training level. Personal observations and discussions with team leaders on the nursing wards suggest that, due to time constraints, staff turnover, and the multitude of training courses for nurses, the effects of spiritual care training were only temporary. The question

becomes how to permanently safeguard spiritual caregiving in a general hospital. A fairly simple instrument is the spiritual assessment.

Chapter 4 'Effects of nurses' screening of spiritual needs of hospitalized patients on consultation and perceived nurses' support and patients' spiritual well-being', describes the implementation of the spiritual assessment in a general hospital and its effects on the patient.

Chapter 5, 'Developments in Healthcare chaplaincy in the Netherlands and Scotland. A content analysis of professional journals' analyses the most important themes in the journals of the major professional associations of spiritual caregivers in Scotland and the Netherlands. We found that the most important theme in the Scottish Journal of Healthcare Chaplaincy, the journal of the Scottish professional association, was 'spiritual care'. In Tijdschrift Geestelijke Verzorging, the journal of the Dutch professional association of spiritual caregivers (VGVZ), the most important theme turned out to be the identity of the spiritual caregiver, and a major subtheme the official endorsement of the spiritual caregiver.

In Chapter 6, 'The meaning of (ministerial) office in spiritual care practice', we examine whether office, which has been an important theme in Dutch spiritual care practice for quite some time, plays a role in spiritual care. Along with a historical outline of the development of thinking on ministerial endorsement, several theological lines are highlighted in this chapter. The concept of office/ministry proves to contain some vital notions regarding spiritual care.

In Chapter 7 'General Discussion' we reflect on our findings

Finally, in Chapter 8 we present an English and Dutch Summary.

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