

VU Research Portal

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

Vlasblom, J.P.

2015

document version

Publisher's PDF, also known as Version of record

[Link to publication in VU Research Portal](#)

citation for published version (APA)

Vlasblom, J. P. (2015). *Spiritual care by nurses and the role of the chaplaincy in a general hospital*. [PhD-Thesis – Research external, graduation internal, Vrije Universiteit Amsterdam].

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

E-mail address:

vuresearchportal.ub@vu.nl

7

General Discussion



Introduction

The origins of this study lie in the experience of increasing pressure on spiritual care in hospitals. Various developments in healthcare have reduced the length of the average hospital stay (Vandermeulen, 2014). As patients spend less and less time in hospital, many of them, including seriously ill patients, barely have an opportunity to meet with a spiritual caregiver (Bakker, 2000).

At the same time, research has demonstrated a clear relationship between spirituality and health (Handzo & Koenig, 2004; van Leeuwen, 2004). Other studies primarily refer to a relationship between spiritual care and quality of life (Koenig, 2007; van Leeuwen, 2008). We also know that spiritual care is important to many patients (Cavendish et al., 2006; Clark, Drain, & Malone, 2003; Ross, 1997).

This tension between the practical problems confronting spiritual caregiving and the reality of the importance of spiritual care is at the root of this dissertation, which comprises the result of my search for possibilities to improve spiritual care for patients in a general hospital.

The central question for this thesis is: *How can the quality of spiritual care in the context of contemporary developments in health care and in religiosity be maintained and improved?*

Because the spiritual caregiver is no longer able to visit every patient in need of spiritual care, we examined whether others can take over part of this care. Nursing literature shows that spiritual care is viewed as a dimension of nursing care (van Leeuwen, 2008). Against this background it makes sense to examine whether the systematic involvement of nurses in the provision of integrated spiritual care to patients in hospitals is feasible and if so under what conditions.

In Scotland the cultivation of spiritual care has resulted in its implementation in health care as a whole and to systematic attention to the professionalization of spiritual caregivers. Therefore, we have compared major developments of spiritual care in Scotland and the Netherlands in light of the question how spiritual care in the Netherlands could be improved.

Due to the discussion about the significance of the ministerial office and religious endorsement of the spiritual care giver for the quality of spiritual care, we finally considered the value of such endorsement.

Starting from on the above-mentioned central research question these considerations led to the following subquestions:

- 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 or religious institution for spiritual care?

Findings

The paper (Chapter 2) answering subquestion 1: *What are the perspectives of patients and nurses regarding spiritual care?* shows that nurses and patients consider spiritual care to be important. Both also feel that the actual spiritual care did not meet the standard. Of the nurses 40% indicated only few patients receive sufficient attention for their spiritual needs. Patients also noted shortcomings in support and registration of spiritual needs. The main obstacles to providing spiritual care were (experienced) lack of time and lack of training.

The second subquestion we sought to answer was *What are the effects on patients and nurses of a spiritual care training provided to nurses?* The answer is described in chapter 3 that demonstrates that after a spiritual care training, the patients experienced more openness and support for their questions regarding illness and the meaning of life. Following the training nurses saw a larger role for themselves in the provision of spiritual care and acted accordingly. However, due to various causes (lack of time, staff turnover and the multitude of training courses for nurses) the effects of the training were temporary. After a few months the number of requested consultations from the Department of Spiritual and Pastoral Care was back at the pre-training level.

Contrary to reports in the literature and our hopes, a spiritual care training was not a *sufficient* condition for a permanent improvement of spiritual care. However, in line with the literature the training is shown to be *necessary* for nurses to obtain the required competences. Still there are barriers that prevent even the nurses who feel spiritual care is important (Chapter 2) and who are trained (Chapter 3), from providing the level of spiritual care they deem necessary.

These findings prompted us to look for a simple instrument that could help nurses in their spiritual care. So, our third subquestion was: *Is spiritual assessment a practicable instrument to improve spiritual care?* We tried to introduce spiritual care into the general assessment that is taken of patients on admission to the hospital. This proved more difficult than expected. In the end the proposed spiritual assessment was reduced to a single question: In your present situation do you sense a need of spiritual support?

After implementation of the new assessment tool it turned out that this question was put to less than 11% of the patients. On the whole the patients therefore do not experience any improvement in spiritual care by nurses. However, we did see a significant and apparently lasting increase in the number of consultation requests for the Department of Spiritual and Pastoral Care. Spiritual care is a low priority for the hospital and the nursing staff, which is why the spiritual assessment instrument did not have the effect we had hoped for.

The fourth subquestion was *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?*

In the study of developments within the spiritual care field as discussed in the professional journals in the Netherlands and Scotland (Chapter 5), it became clear that spiritual care occupied a marginal position in Scotland until the National Health Service turned it into a spearhead and it became an important theme in the field of spiritual care. Spiritual care then became a central theme in the Scottish professional journal of healthcare chaplaincy.

In the Netherlands the identity of the spiritual care professional turned out to be the main theme of discussions among the profession of spiritual caregivers. An important subtheme appeared to be the discussion regarding the importance of an official endorsement of a religious or worldview organisation.

In a sense developments in the Netherlands appear to be opposite to the Scottish developments. Due to the influence of the National Health Service (NHS), spiritual care has grown into an important dimension of care as a whole in Scotland. As such spiritual care is increasingly obliged to comply with the relevant healthcare quality requirements.

In the Netherlands spiritual care was regulated in the Care Institutions Quality Act of 1996. With a view to the quality of spiritual care a discussion developed within the profession about official worldview endorsement versus professionalism. For part of the profession this discussion enhanced the experience that endorsement stands in the way of professionalism and hence the quality of care.

This brought us to the fifth subquestion: *What is the value of office with an endorsement of a worldview institution for spiritual care?* The investigation of this question (Chapter 6) shows that lack of clarity about the meaning of the concept of ministry is in part inherent to an ambiguity enclosed in the concept of ministry as defined by theology. The advocates of ‘general’ spiritual care are right in the sense that the functional aspects of spirituality do not require that the spiritual caregiver holds an office. However, some of the tasks definitely require the spiritual caregiver to hold an office. Not only is office a prerequisite for specific religious rituals, the officially endorsed spiritual caregiver also represents a community and

the transcendent, or in other words, the sacred, in a manner that the unaffiliated spiritual caregiver does not.

Summarizing the results of the studies we find:

Patients and nurses consider spiritual care an important aspect of care. A spiritual caregiving training helps the nurse to provide better spiritual care, but this training is not sufficient, especially in the longer term, to bring spiritual care to a higher level. Including a spiritual question in the general history contributes to spiritual care, but is also not sufficient to raise the level of spiritual care. In Scotland, thanks to the efforts of the NHS, spiritual care moved from a marginalized position to the centre of care practice. Especially in relation to the substantial aspects of spiritual care an office has added value. This is among other things related to the observation that a religious office provides a (cross-denominational) representation of ‘the sacred’.

On the basis of these findings regarding the subquestions, we can answer the central research question “How can the quality of spiritual care in the context of the various developments in health care be maintained and improved” as follows: Spiritual care training for nurses and a spiritual assessment administered by nurses are good instruments, but on their own are not sufficient to improve spiritual care. Integration of spiritual care is not a concern for nurses alone; it requires clear and binding policy decisions. The Scottish example shows that an umbrella institution can achieve this, perhaps even better than the individual care organisations with their own preferences could. Furthermore we concluded that the quality of the substantial aspects of spiritual care and the representation of the sacred are enhanced by the office.

Methodological reflections and limitations

The dissertation as a whole is based on mixed-methods research in which the different research methods complemented each other. The connection between the studies (Chapters) is found in the results; the results of one study provided the starting point for answering a next subquestion. 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.

A limitation is that the studies described in Chapters 2, 3 and 4 were conducted in a single hospital, a hospital with a Christian identity. Due to this identity the percentage of nurses with a Christian background was relatively high compared

to most other hospitals. How this affected our findings is difficult to assess. The Christian identity of the hospital was one of the reasons that hospital management agreed to the spiritual care training described in Chapter 3. At the same time this identity generated resistance to the training among a number of participants. Some Christian nurses had their doubts about the content of the training, which for them was not Christian enough and too vague. They had difficulty understanding what spiritual care entails because of their strong focus on content, based on their own spirituality. Others, who were not religious or adhered to a different worldview, rejected the training out of hand because they feared an overly Christian focus. For both groups it seemed difficult to appreciate the functional aspects of spiritual care apart from the substantial aspects that regard the content of spirituality. The difficulty may have been influenced by the fact that the hospital not only has a Christian identity, but that both of the spiritual caregivers are endorsed Protestant ministers. The impression may have been that a training in spiritual care coming from the spiritual care department would or should have a Christian content.

Despite training and discussions a common assumption seemed to be that spiritual care is only for religious Christian patients who struggle with their faith. This possibly also affected the willingness to complete the spiritual question in the general history.

In view of this limitation the size of the samples of nurses and patients are large enough to ensure outcomes that have considerable statistical power. In the qualitative study among nurses saturation was reached after interviewing 8 nurses.

A limitation of the study into the spiritual needs assessment (Chapter 4) is that we used a less than ideal assessment because of restrictions imposed by the organisation. The question that was finally used “In your present situation do you sense a need of spiritual support?” is a minimal form of a spiritual assessment. However, a question regarding the need for spiritual support is possibly easier to ask than more difficult questions about the meaning of life.

For the analysis of the two journals of the leading professional associations in the Netherlands and Scotland (Chapter 5) I used the method of content analysis.

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

Discussion

One of the things I examine in this thesis is the role of the nurse in providing spiritual care to patients in a general hospital. The findings lead to the following reflections.

Time

Although nurses consider spiritual care important, they are often unable to provide it at a sufficient level. The main obstacles mentioned by the nurses are lack of time and lack of education/training. As we expected, spiritual care does improve after training. However, several months after the training the situation is back to pre-training levels. As some of the interviewed team leaders indicate, this is partly due to staff turnover and the multitude of training courses. Still, the question arises whether other factors can be identified that undo the effects of a – quite successful – training.

This question becomes even more significant after the difficult process of implementing the spiritual assessment. After much discussion it is finally decided to add one spiritual question to the general history, a question that, after implementation, is only put to one in ten patients. My (informal) conversations with various nurses lead me to the conclusion that the perceived lack of time and prioritizing the multitude of tasks are the main problems. As regards the spiritual assessment it appears to be mainly a question of priorities, as our assessment requires only a limited time investment. This also appears to be consistent with the problems management had with the implementation of this instrument. Spiritual care is an aspect of care with a relatively low priority compared to ‘competing’ care aspects. Precedence seems to be given to the “hard” indicators of the Inspectorate and health insurers.

Relationship between nurse and spiritual caregiver

Different professional nursing codes view spiritual care as one the nursing tasks (ANA, 2010; ICN, 2012; Leistra, Liefhebber, Geomini, & Hens, 1999), and the nurses from the study described in Chapter 2 also consider spiritual care to be one of their tasks. Whereas spiritual care is one of many tasks for the nurse, for the spiritual caregiver it is the core task. This also defines the relationship between the two disciplines. It is the nurse’s job to notice spiritual needs and problems and provide ‘primary care’, which will focus predominantly on functional aspects of spirituality. In contrast the discipline of the spiritual caregiver is characterized by the focus on meaning (Kuin, 2009). Only the discipline of the spiritual caregiver focuses on attributing meaning to problems instead of solving them (Kuin, 2009, p. 25). This means the spiritual caregiver looks at the individual as a person rather than focusing on one aspect of this individual (Velkamp, 2006, p.157). Spiritual care not only concerns functional aspects of spirituality, but also substantial aspects of the patient’s spirituality. In this context it makes little difference whether the source of this meaning for the patient is traditionally religious or not. For those substantial aspects in particular the office of the spiritual caregiver can

have added value, because the bearer of an office within a religion is viewed as a representative of the sacred.

After the implementation of the spiritual question, patients experience the spiritual care by nurses as poorer instead of better. One explanation may be that nurses feel that the patients in need of care will now ‘automatically’ receive this care from the spiritual caregivers and it therefore is no longer part of the nurses’ tasks. Further research can determine whether this is a valid explanation.

The argument in favour of official endorsement by a religious or worldview organisation seems contrary to the social and religious developments that have taken place in the Netherlands over the past decades, which are commonly summarized in the term secularization. However, as various contributions in the report *Faith in the public domain. Investigation of a dual transformation [Geloven in het publieke domein. Verkenningen van een dubbele transformatie]* (van de Donk, Jonkers, Kronjee, & Plum, 2006) show, secularization does not mean that people are less religious or less in search of meaning. It means they may search outside the context of traditional religious or worldview institutions. If it ever was, the goal of the officially endorsed spiritual caregiver today is definitely not/no longer to ‘sell’ the doctrine of his institution. This means that as the bearer of an archetypal office he can use his, as Kennedy and Valenta call it, ‘fluid religiosity’ (2006) to support (post)modern man in his search for meaning.

Recommendations for practice and policy

As long as there is no obligation to devote attention to spiritual care this is granted no more than a marginal position in the hospital setting. “Spiritual care is important”, to quote a manager from a healthcare institution who hinted at a famous statement of Huxley in *Animal Farm*, “but some types of care are more important than others.” Apparently an external enforcement is necessary for spiritual care to obtain the position it deserves. Similar to the many quality indicators for other care elements, there should also be quality indicators for spiritual care. In the Netherlands this could be a task for the Health Care Inspectorate [*Inspectie voor de GezondheidsZorg (IGZ)*]. The Inspectorate is required by law to monitor that care providers in the Netherlands provide high-quality and safe care (IGZ, n.d.). Since there is evidence now that spiritual care is essential for quality of care, in our view the Inspectorate should begin to focus on spiritual care. For spiritual care, like for other important elements of care, quality indicators should be formulated to which healthcare institutions are obliged to comply. With these quality indicators

the Inspectorate would be able to check whether spiritual care is safeguarded in the institutions.

Spiritual Caregivers are the professionals in the field of spiritual care. Not only in the care for individual patients, as they have always been, but also within the healthcare organisation as a whole. To this end the spiritual care profession requires further professionalization and, like all disciplines in the healthcare field, should find its own evidence-based way of working.

The spiritual care profession has to communicate clearly internally and externally what are the competencies of both the non-institutionally endorsed spiritual carer and the spiritual carer who has an official endorsement. To safeguard the quality of spiritual care, guidelines should be developed on the way in which the non-institutionally endorsed caregivers may ensure that ministerial religious acts can be performed in their healthcare organisation.

Recommendation for future research

For the study of the spiritual needs assessment (Chapter 4) we used a less than ideal assessment tool because of restrictions imposed by the organisation. A different assessment instrument may yield better results. Further research into a spiritual needs assessment that can be implemented within existing general assessment instruments is therefore recommended.

With a view to a desired guiding role of the IGZ, further research into indicators measuring spiritual care in healthcare institutions is recommended. The effects of compulsory accountability of institutions regarding the application of these indicators should be investigated in follow-up research.

Research has shown that nurses view spiritual care as one of the tasks of nursing practice. The priorities of the nurses are determined to a significant degree by the managers inside (and outside) the hospital. Research into how these policymakers value spiritual care is urgently needed.

To date little or no research has been done into best practices for spiritual care. One of the things that need to be investigated in the required process of professionalization of spiritual care is what best practices for spiritual care look like.

A frequently presented argument in the reflection on the value of the office of ministry is that increasing numbers of patients want neutral spiritual care. However, to my knowledge there has been no research among patients to support this argument. Research into the opinions of patients about the value of the office is urgently needed and fits in the recommended evidence-based practice for spiritual care.

Conclusion

The central question of 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?

We found that patients and nurses consider spiritual care as an important aspect of care. Patients and nurses believe that spiritual care can and should be improved. A spiritual care training for nurses and a spiritual assessment administered by nurses are helpful instruments, but in themselves insufficient to sustainably improve spiritual care. Integration of spiritual care cannot be a concern for nurses alone; it requires clear and binding policy decisions. Furthermore, we concluded that the quality of the substantial aspects of spiritual care and the representation of the sacred are enhanced by the endorsement of the ministerial office.

References

- ANA. (2010). *Code of Ethics for Nurses With Interpretive Statements*.
- Bakker, D. J. (2000). Het algemene ziekenhuis van onze tijd. *Praktische Theologie*, 27(4), 365-374.
- Cavendish, R., Konecny, L., Naradovy, L., Luise, B. K., Como, J., Okumakpeyi, P., ... Lanza, M. (2006). Patients' perceptions of spirituality and the nurse as a spiritual care provider. *Holistic Nursing Practice*, 20, 41-47. <http://doi.org/00004650-200601000-00010> [pii]
- Clark, P. A., Drain, M., & Malone, M. P. (2003). Addressing patients' emotional and spiritual needs. *Joint Commission Journal on Quality and Safety*, 29(12), 659-670.
- Donk van de, W. B. H. J., Jonkers, A. P., Kronjee, G. J., & Plum, R. J. J. (2006). *Geloven in het publieke domein. Verkenningen van een dubbele transformatie*. Amsterdam.
- Handzo, G., & Koenig, H. G. (2004). Spiritual care: whose job is it anyway? *Southern Medical Journal*, 97(12), 1242-1244.
- ICN. (2012). *The ICN code of ethics for nurses*. Geneva.
- IGZ. (n.d.). Incidententoezicht. Retrieved from http://www.igz.nl/onderwerpen/handhaving_en_toezicht/incidententoezicht/melden/index.aspx
- Kennedy, J., & Valenta, M. (2006). Religious pluralism and the Dutch state: reflections on the future of Article 23. In W. B. H. J. Donk van de, A. P. Jonkers, G. J. Kronjee, & R. J. J. Plum (Eds.), *Geloven in het publiek domein: verkenningen van een dubbele transformatie* (pp. 337-351). Amsterdam.
- Koenig, H. (2007). *Spirituality in patient care: Why, how, when, and what* (2nd ed.). Philadelphia: templeton foundation press.
- Kuin, A. (2009). *Competenties voor het bieden van spirituele zorg aan patiënten in de palliatieve fase en hun naasten*.
- Leeuwen van, R. (2008). *Towards Nursing Competencies in Spiritual Care*. Rijksuniversiteit Groningen.
- Leeuwen van, R. R. (2004). De samenhang tussen spiritualiteit en gezondheid bij patiënten met lichamelijke aandoeningen; een analyse van geneeskundige en verpleegkundige studies. *Tijdschrift Voor Gezondheidswetenschappen*, 82, 307-316.
- Leistra, E., Liefhebber, S., Geomini, M., & Hens, H. (1999). Beroepsprofiel van de verpleegkundige (Nursing Profile).
- Ross, L. A. (1997). Elderly patients' perceptions of their spiritual needs and care: a pilot study. *Journal of Advanced Nursing*, 26, 710-715.
- Vandermeulen, L. (2014). Ligduur in ziekenhuizen daalt minder sterk. *Zorgvisie Executive*, 8, 2.
- Veltkamp, H. (2006). Domein, identiteit en passie van de geestelijke verzorging. In J. Doolgaard (Ed.), *Handboek geestelijke verzorging*. Kampen: Kok.