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## Learning spiritual care in Dutch hospitals

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## Summary



## Summary

### Background

After the decline of the pillarization of Dutch society, a period in which healthcare was organized along confessional/denominational lines, spirituality became neglected or implicit for decades in the Dutch healthcare system. During the modernisation of healthcare in the 1960s, the development of professional language concerning chaplaincy and psychosocial care in a secularising society created a blind spot for this fundamental dimension of care. In the Netherlands, palliative care was boosted by a national programme challenging healthcare providers, policymakers and researchers to reassess and allocate the spiritual dimension to the biopsychosocial model in health care. Inspired by this national policy and personal leadership the Agora Taskforce on ethics and spiritual care initiated the development of the first Dutch, consensus-based national guideline for multidisciplinary spiritual care as part of palliative care, the Guideline Spiritual care in palliative care (*Richtlijn Spirituele zorg*), summarized in Chapter 1. The publication of this guideline led to the adjustment of the professional standard of healthcare chaplaincy in the Netherlands, including the concept of spirituality in medical care, which was not used before in this standard. It also inspired the authors to invite experts on spiritual care in palliative care from different countries to join the initiative for a European Taskforce on Spiritual Care, as described in Chapter 2.

The combination of specific educational programs on the spiritual dimension in health care and broad international contacts inspired the author to undertake an action-research study to explore possibilities for health care chaplains in Dutch general hospitals to contribute to palliative care improvement programmes. This thesis reports the results of this mixed-methods study using quantitative and qualitative methods, in which a pilot training on spiritual care in palliative care was tested by trained hospital chaplains in eight Dutch non-university teaching hospitals. The effects on patients and health

care professionals (physicians and nurses) was measured via questionnaires followed by quantitative analysis. Semi-structured interviews were held with the hospital chaplains who performed the intervention in order to analyse their experiences.

### **Research questions**

The main research question as described in Chapter 1 was: ‘What is necessary for training primary health care professionals (physicians, nurses) in the hermeneutical use of diagnostic tools for multidisciplinary spiritual care, so that they can integrate this into their professional practice with the expert support of health care chaplains?’

Secondary research questions were:

1. What is the baseline situation for the development of multidisciplinary spiritual care in palliative care in the Netherlands in the year 2012?
2. How have teaching hospitals in the Netherland structured and organized palliative care, and spiritual care as part of that, for inpatients?
3. Which diagnostic tools for spiritual care
  - a. theoretically correspond to the multidisciplinary guideline,
  - b. correspond with the needs of patients and proxies,
  - c. correspond with the needs of health care professionals and their professional tasks and standards,
  - d. are, from the primary health care professionals’ perspective, suitable for practical application?
4. How are chaplains able to concretise spiritual care training for primary caregivers in clinical practice?
5. What is the effect of this training on:
  - a. patients?
  - b. participating health care professionals?
  - c. chaplains?

### **Context and set-up**

In Chapter 2 we describe the context for the development of multi-disciplinary spiritual care in the Netherlands in 2012, at the start of this research project. The conclusion is that in the Dutch health care system at the time a specific infrastructure for the development of spiritual care was almost complete. Groups of dedicated chaplains in the Netherlands, motivated to engage in local and national development of spiritual care, had from 2007 onwards been trained in the 'Masterclass on spirituality and health care chaplaincy in palliative care'. Other health care professionals, such as nurses, physicians, art and music therapists, also started to attend the masterclass, which developed the programme for multidisciplinary groups and in 2012 changed its name to 'Masterclass on spirituality in palliative care'. The need for training and implementation methods discussed in these groups, combined with personal experience as a project leader pioneering and searching for structure and organization of hospital palliative care in a teaching hospital, inspired the author to develop a multicenter action research project in teaching hospitals in the Netherlands.

At the start of the project, 10 out of the 28 teaching hospitals in the Netherlands showed interest in participating, and met the inclusion criterion of having some form of palliative care improvement programme or Palliative Consultation Team.

Although in the international research literature there were more tools available that theoretically correspond to the Guideline spiritual care in palliative care (further: the Guideline), the experts in an invitational research conference in 2013 limited the models to be trained in the pilots to: a) symbolic listening according to Erhard Weiher, b) the translation of the three screening questions developed by the Mount Vernon Cancer Network (MVCN), and c) the Dutch *Ars Moriendi* spiritual care model developed by Carlo Leget. This selection corresponded to the three models included and translated in the Guideline. At this conference further requirements for the pilot training in spiritual care in palliative care were discussed. The

target group had to consist of multidisciplinary clinical teams of departments where patients in both palliative and curative trajectories are treated. The main competencies to be trained were: recognizing, referring, self-reflexivity, and open attitude toward patient spirituality, in two lessons of 90-120 minutes.

### **Systematic review**

Chapter 3, reports of a systematic review of the literature on spiritual care training methods, and their effects on patients and health care professionals, we found a diversity in outcome measures, with a tendency towards competence-based measures. On the basis of the qualitative synthesis we conclude that improving spiritual care, or implementing a spiritual care standard, is optimal when it is designed as a quality improvement project.

### **Intervention, participants and measures**

The spiritual care training intervention was delivered nine times in seven hospitals from February 2014 to February 2015, and 374 healthcare professionals were scheduled in groups for one or two lessons during working hours given by the healthcare chaplains, using standard slides for presentation and selected teaching methods. In accordance with the action research approach, there were local variations in the training within the preliminary set of requirements of the study protocol as described in Chapter 4.

The aim of the intervention was a) to improve healthcare professionals' attention to patients' expressions of spiritual needs, and not to implement one specific tool for spiritual interventions but to raise healthcare professionals' competencies in supporting patients on this dimension, b) to raise the quality of care as perceived by palliative patients on the wards that participated in the training, and c) to gain practical knowledge about the barriers to and critical success factors for training spiritual care and the implementation of the spiritual care guideline. The core skills for doctors and nurses to be trained were: screening/assessing spiritual needs, counselling pa-

tients (matching their own professional role), and referring patients to specialists in cases of crisis. Multidisciplinary training was mandatory.

The hospitals were selected on the basis of three inclusion criteria: being a member of the association of tertiary medical teaching hospitals (*Stichting Topklinische Ziekenhuizen*), being actively involved in advancing palliative care by having a specialist consultation team or implementing palliative care quality improvement programmes, and having a dedicated trained healthcare chaplain specialized in spiritual care in palliative care.

The intervention and control wards were selected by the local co-researchers, i.e., the dedicated chaplains; as the instructors, the chaplains were responsible for the spiritual care training for palliative care. The criteria for the intervention wards required the chaplain to be connected to the ward, the ward to be willing to facilitate and encourage staff to follow the training, and to be willing to facilitate patient interviews.

The physician responsible for each patient was asked to assess the patients' advanced clinical conditions as well as the indicators for supportive or palliative care. The physicians were asked, "Would it surprise you if this patient died in the next 12 months?". When the answer was negative, the patient was asked to participate, was given written information about the study, and was included in the study after giving informed consent in writing. The patients included were asked to complete the questionnaire independently. If necessary, the questionnaire was read at their bedside by a specialist palliative care nurse or a ward nurse from another department with additional palliative care training.

As co-researchers the participating chaplains were responsible for conducting the study locally according to the protocol: planning and carrying out the training in the intervention wards of the participating hospitals, including the participating health care professionals in the study of the effects on barriers and competencies regarding spiritual care, selecting control wards, and - in cooperation

with the local spiritual care consultation teams - organizing the process of selecting palliative patients for the purpose of studying the effects of the training on the quality of care. To assess the acquired practical knowledge of the co-researchers, 20 semi-structured interviews were conducted during the project: nine interviews at eight sites before the training (at one site, two separate pilots were conducted with different chaplains as the trainers) between 9 December 2013, and 18 March 2015 (duration 50-85", average 55"). The participants received the questions beforehand.

### **Findings**

In Chapters 5 and 6 we report the effects of the spiritual care training on patient reported outcomes and health care professionals' competencies. The findings suggest that within the limited time available in hospitals for training health care professionals, it is possible to lower barriers to spiritual care, enhance physicians' and nurses' spiritual care competencies, and improve the quality of care as perceived by patients in palliative trajectories. Measuring the effects of spiritual care training for multidisciplinary teams by means of the Spiritual Care Competence Scale (SCCS) was successful in that it enabled us to measure differences in time and between groups.

We found a sustainable effect (after 1 and 6 months) on nurses, but a lower impact of the training on physicians. This may be explained by the fact that as trainers/co-researchers the health care chaplains are more familiar with nursing practice than with the daily practice of physicians, and hence were less able to adjust their training methods to physicians' training needs.

In Chapter 7 we report the findings of our qualitative study concerning the research question 'how can chaplains concretise spiritual care training for primary caregivers in clinical practice?', on the basis of the semi-structured interviews with the health care chaplains. The conclusion is that the implementation of spiritual care in hospitals can be expected to be successful if it is based on two training sessions in multidisciplinary groups of 90 minutes each (group size 8-20),



with participants' detailed personal case descriptions used in the second session to illustrate and practice the models and diagnostic tools trained, in multidisciplinary groups.

Monodisciplinary training seems more practical, or easier to organize, and adjustable to specific learning needs. However, the advantages of multidisciplinary training tip the balance: co-researchers reported that the quality of the training was improved by the participation of physicians in trainings for nurses and vice versa, as this helped eliminating of mutual stereotypes, and provided opportunities for influencing working processes. Furthermore, in multidisciplinary staff training it is possible to make joint choices about the implementation of specific models/diagnostic tools for referral, and about multidisciplinary communication in patients' reports.

Our findings indicate that for adequate training more notice should be taken of physicians' training needs, which means that health care chaplains need to familiarize themselves more with physicians' daily practice. Further, reflection on one's own spirituality or confrontation with end-of-life-care is hardly possible within the limited time available for training professionals in hospitals.

Our qualitative study has shown four main effects on the chaplains: a) new knowledge about and experience with research in an action-research approach, b) improved understanding of the professional practice of nurses and physicians, c) renewed self-consciousness, and d) a better profile of chaplaincy in the participating hospitals.

The co-researchers in the participating hospitals reported a large variation in staffing, set-up, structure, and financial support of palliative care consultation teams, and four out of eight chaplains were able to build a fruitful cooperation with these teams in performing the study according to the study protocol. They observed a predominantly curative attitude among health care professionals in their hospitals, combined with a lack of knowledge about palliative care, which resulted in often failing to recognize patients' being in the beginning of the palliative or even dying phase. In those hospitals

no diagnostic tools for spiritual care were used, and only three out of eight co-researchers reported the use of the ‘distress thermometer’ for the detection of psychosocial distress. We conclude that at this moment diagnostic tools for spiritual care have not structurally been implemented in Dutch health care.

### **Conclusion**

In Chapter 8 the main research question is answered. The conclusion is that concise training programs for spiritual care in palliative care are effective in improving quality of care in hospitals, decreasing spiritual care barriers, having positive effects on spiritual care competencies, improving multidisciplinary working, and enhancing the profile of chaplains.

We consider the following critical success factors essential for a successful implementation of the spiritual care guideline.

First: at the local level, the availability of at least one (preferably two, depending on the staffing of the chaplaincy team) dedicated chaplain with additional training in spiritual care, and a clear mandate from the supervising physician, nursing director, and management concerning responsibility for the spiritual care policy of the organization.

Second: preferably at national level, the availability of an e-learning module or interactive learning environment for the theory of spiritual care based on the Guideline.

Third: simply some room in hospitals’ education plans for wards where patients are treated in curative as well as palliative trajectories. Our findings suggest that with two sessions of 90 minutes each (or three 60’ sessions) significant improvement in the quality of care may be expected. Since our findings indicate that chaplains’ knowledge of physicians’ practice is too limited to have a significant effect on physicians, we suggest performing these trainings in pairs: a chaplain together with a dedicated physician or nurse.

