Improving Spiritual Care in Hospitals in the Netherlands: What Do Health Care Chaplains Involved in an Action-Research Study Report?

Joep van de Geer, Chaplaincy Department, Medical Centre Leeuwarden, Netherlands
Anja Visser, Faculty of Theology and Religious Studies, University of Groningen, Netherlands
Hetty Zock, Faculty of Theology and Religious Studies, University of Groningen, Netherlands
Carlo Leget, Department of Care Ethics, University of Humanistic Studies, Utrecht, Netherlands
Jelle Prins, MCL-Academy, Medical Centre Leeuwarden, Netherlands
Kris Vissers, Department of Anesthesiology, Pain- and Palliative Medicine, Radboud UMC, Netherlands

Abstract
Health care chaplains participated in a multicenter trial to explore an implementation strategy for the Dutch multidisciplinary guideline for spiritual care. The intervention was a concise spiritual care training for hospital staff of departments where patients in curative and palliative trajectories are treated. Data were collected in semi-structured interviews with chaplains who acted as trainers, before and after the intervention. Results based on nine pre-intervention and eleven post-intervention interviews are presented. During pre-intervention interviews, chaplains describe the baseline situation of palliative care in Dutch hospitals, barriers and opportunities for improving spiritual care. In the post-intervention interviews, characteristics of the training, effects, and critical success factors were identified. Positive effects such as lowering barriers, increasing health care professionals’ competences, and increasing health care chaplains’
profile are possible. Chaplain-led, multidisciplinary spiritual care training is a feasible method to start implementation of spiritual care in hospitals, as described in the multidisciplinary guideline.

**Keywords**: chaplaincy, education, multidisciplinary team, spiritual care, palliative care.

**Introduction**

The World Health Organization’s definition of palliative care,(1) which involves formulating a bio-psycho-social-spiritual model of care, does not only challenge all health care professionals to provide spiritual care to patients in palliative trajectories. It is also likely to have opened a new door for chaplains to reformulate the specific characteristics of their profession. It offers opportunities to articulate the contributions that chaplaincy can make to the quality of patient care, to the multidisciplinary team, and to the culture and organization of the health care institutions where chaplains work. In the literature, the integration of spirituality and the development of a more person-centered, compassionate care within health care is considered by nature a multidisciplinary discourse, with contributions from areas such as nursing,(2) medicine,(3,4) social work,(5) and should not be limited to PC, as explicitly illustrated in title of the *Oxford textbook on spirituality in healthcare*.(6) Although patients value attention to spirituality on the part of doctors, nurses and other health care professionals (7,8), the provision of spiritual care (SC) is infrequent due to a perceived lack of SC training (9).

An important development in these discourses has been the publication of consensus documents on defining and integrating spirituality in modern palliative care (PC), such as the Consensus Report from the United States.(10) And, in the Netherlands, one year after the publication of the US Consensus Report, the publication of a consensus-based multidisciplinary guideline on spiritual care (hereafter: the SC guideline).(11) This SC guideline was published in the
national guidelines for the practice of multidisciplinary PC. (12) English, German and Spanish translations are available online. (13)

One of the essential characteristics of the Dutch PC program is that PC is part of the mainstream healthcare provided by general care providers. (14) Therefore, the SC guideline has been developed primarily for physicians and nurses who are not specialists in PC.

After its publication, this SC guideline was positively received in the field, but there was no strategy for its implementation. (15) Because the guideline acknowledges the position of healthcare chaplains as SC specialists who are available in most hospitals and nursing homes, (16) it created an opportunity for chaplains to explore what they could contribute to a national strategy for the implementation of this guideline. The guideline considers nurses, physicians and health care chaplains to be members of the multidisciplinary team with a common interest to improve the quality of spiritual care for patients, however with different roles and tasks. On a local level that the physicians and nurses will have to be aware of their tasks and be competent on a basic level of SC, and the health care chaplains should take responsibility for implementation of the SC guideline and training their medical colleagues in its recommended methods.

Many chaplains do not have much experience in training other healthcare professionals and the barriers and facilitators of the implementation of the SC guideline will differ both between and within organizations. So a multicenter trial using an action research approach - in which the chaplains acted as trainers and as coresearchers - seemed appropriate. Action research allows the chaplains to improve their practice in a process of change, and the participation in this process of change allows them to gain more insight into the organizational barriers and facilitators of the implementation of the SC guideline. In the multicenter trial it proved to be possible to train physicians and nurses effectively within reasonable time limits. The quantitative results of the pilot training on the quality of care in patient-reported outcomes and on barriers to SC and SC compe-
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tences for health care professionals have been published in medical journals.(17,18)

Aims

This paper reports on the qualitative results of a study that was part of a greater research project. The aim of this project was to start the implementation of the Dutch multidisciplinary guideline on SC. For this purpose a multicenter trial in ten hospitals was planned using a mixed-method action-research approach. The intervention in this exploratory practical trial was a SC pilot training for physicians and nurses that was planned in wards where patients are treated in curative and palliative trajectories.(18)

In this article, we focus on the barriers and critical success factors for implementation of the SC guideline, as reported by the participating health care chaplains as co-researchers, based on nine pre-intervention and eleven post-intervention interviews.

Methods

Participants

In August 2013, the chaplaincy teams of all 27 members of the Association of Tertiary Medical Teaching Hospitals (Stichting Topklinische Ziekenhuizen, STZ) were invited by email to participate in the study. These hospitals are not university clinics but larger general hospitals for standard and complex specialized care, and they play an important role in the teaching of medical and nursing disciplines and in research and innovation in Dutch health care. Interested chaplaincy teams were invited for an Expert Meeting in November 2013, together with 20 national and international experts on PC and SC. In this meeting, the requirements for the intervention, the pilot training ‘spiritual care for multidisciplinary teams’ (referred to hereafter as the training), and the action research approach were discussed and determined.
The mixed-method study of which the interviews were a part was designed and conducted in accordance with the WHO Good Clinical Practice (GCP) Guidelines. Ethical approval was granted by the medical ethical committee in Leeuwarden, Netherlands on July 4, 2013 (nWMO22). The study was registered at the Dutch Trial Register: NTR4559.
The hospital inclusion criteria were as follows: membership in the STZ, active involvement in developing PC, and implementation of a PC quality improvement program.

<table>
<thead>
<tr>
<th>Chaplain</th>
<th>Gender/Age</th>
<th>Work experience as (years)</th>
<th>Denomination</th>
<th>Pilot</th>
<th>Ward</th>
<th>Hospital / Beds (n)</th>
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<tr>
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<td>M &gt;50</td>
<td>&gt;10</td>
<td>Prot.</td>
<td>P. 1</td>
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<td>H. 1/643</td>
</tr>
<tr>
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<td>&gt;20</td>
<td>RC</td>
<td>P. 2</td>
<td>Lung</td>
<td>H. 2/883</td>
</tr>
<tr>
<td>(duo)</td>
<td></td>
<td></td>
<td>RC</td>
<td>P. 3</td>
<td>Lung</td>
<td>H. 3/623</td>
</tr>
<tr>
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<td>&gt;15</td>
<td>RC</td>
<td>P. 4</td>
<td>Lung</td>
<td>H. 4/600</td>
</tr>
<tr>
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<td>&gt;15</td>
<td>RC</td>
<td>P. 10</td>
<td>Oncology</td>
<td>H. 5/148 (848)</td>
</tr>
<tr>
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<td>M &gt;55</td>
<td>&gt;25</td>
<td>RC</td>
<td>P. 6</td>
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<td>Prot.</td>
<td>P. 7</td>
<td>Lung</td>
<td>H. 6/468</td>
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<td>Chpl. 6</td>
<td>F &gt;45</td>
<td>&gt;10</td>
<td>Prot.</td>
<td>P. 8</td>
<td>PC + Palliative Care + ambassadors</td>
<td>H. 8/850</td>
</tr>
<tr>
<td>Chpl. 7</td>
<td>F &gt;45</td>
<td>&gt;5</td>
<td>Prot.</td>
<td>P. 10</td>
<td>Lung</td>
<td>H. 3/623</td>
</tr>
<tr>
<td>Chpl. 8</td>
<td>M &gt;50</td>
<td>&gt;15</td>
<td>RC</td>
<td>P. 9</td>
<td>Renal</td>
<td>H. 8/850</td>
</tr>
</tbody>
</table>

Prot. = Protestant, RC = Roman Catholic;

Pilot not performed, chaplaincy and palliative care team became understaffed after the start of the project

The first training and postintervention interview were performed as a duo (Chpl.4.4); the second training and postintervention interview was performed by the male chaplain (Chpl.4.10);

Number of beds at a site which is part of one multi-site hospital organisation, total number of beds between parentheses;

PC + Palliative Care

| Table 1 Co-Researchers/Trainers, Pilots, Hospitals |

The chaplaincy team inclusion criteria were as follows: active involvement in the PC improvement program in the hospital, feeling responsible for the way in which SC is developed in that program, having at least one member of the team specialized in SC in PC (mandatory specialized training program) available as trainer, willing to train local departments according to study protocol.
Our target was to include ten hospitals. Eleven chaplaincy teams showed interest in participating in the trial, but two of these did not meet the inclusion criteria, and one withdrew because of methodological objections, however without specifying these objections upon inquiry. Ultimately, the chaplaincy teams from eight hospitals received approval from the medical-ethical or local research committees and hospital management to participate in the study (see Figure 1).

Procedure
Key concepts of action research are a better understanding, participation, improvement, reform, problem finding, problem solving, a step-by-step process, modification and theory building. (20) In such a step-by-step research process it is essential to collect the co-researchers’ reports of the new practical knowledge from time to time. We planned to interview the chaplains one month before the intervention, to collect practical knowledge about planning and organizing the research project and the intervention; and one month after the intervention, to collect the chaplains’ reports of new practical knowledge based on how the training was performed.

Action research is context bound, which means that variation in the intervention is expected, because local adjustments of the study protocol are accepted as a problem-solving strategy, which could generate new knowledge. Stimulating medical professionals to integrate SC with PC in their working process as a multidisciplinary team can only be successful if it builds on location-specific resources that are connected to the unique culture of each participating hospital or department. Therefore, adjusting the training to local circumstances is not considered a deviation from the study protocol and did not lead to hospitals being excluded from the study.

The participating chaplains were as co-researchers responsible for conducting the study according to the protocol: planning and carrying out the training in the intervention wards, including the participating health care professionals in the study of the effects on
barriers and competencies for SC, selecting control wards, and - in cooperation with the local PC consultation teams - organizing the process of selecting palliative patients for the study of the effects on the quality of care。(18)

The chaplains were familiar with the interviewer (first author, JvdG), a male senior healthcare chaplain, PhD candidate and accredited GCP researcher, as a trainer in and ambassador for multidisciplinary SC. The relation between the local chaplains and the investigator during the interviews in this action research approach is best described as a joint continuous learning process for both parties, sharing newly generated knowledge.

All respondents were experienced chaplains and educators. Most chaplains had experience with teaching nurses, and only two had experience with teaching physicians. None of the chaplains who were interviewed had any previous experience in research.

The participants received the questions before the semi-structured interviews were carried out on site in the hospitals. All participating chaplains were interviewed, and no non-participants were present. Twelve chaplains were interviewed, six of whom worked together as pairs in the training; these pairs participated in a paired interview. In the interviews with this latter category, no differences were observed in the reports of their joint performance and experiences, so they were treated as one respondent (see Table 1).

During the project, 20 interviews were conducted: nine interviews at eight sites before the training (at one site, two separate pilots were conducted with different chaplains as the trainers) between December 9, 2013, and September 25, 2014; one on-site interview between a first and second training; and ten interviews at eight sites (at two sites two pilots were carried out) after the training between September 29, 2014, and March 18, 2015 (duration 50-85”, average 55”).

All interviews were audio recorded, field notes were made during the interviews, and transcripts were checked and corrected
by the researcher if necessary. Transcripts were not returned to the participants for comment.

Analysis
In order to structure a problem-driven content analysis of the pre-intervention interviews, we developed an initial coding tree, based on the questions sent to the chaplains to prepare for the interview. Transcripts were coded in ATLAS.ti Version 7.1.4. The interviews were coded by two researchers (JvdG, Suzanne Lub (SL)), adding new codes and sub-codes to the tree. They discussed their codes until consensus was reached on coding policy and coding tree, and then they discussed the results with a senior researcher (HZ). One of the researchers (SL) performed the problem-driven content analysis.

For the post-intervention interviews, the initial coding tree was based on the final tree of the pre-intervention. Transcripts of the post-intervention interviews were coded in ATLAS.ti Version 7.5.10. Again, two researchers (AV, JvdG) coded the interviews, adding new codes and sub-codes to the tree. They discussed their codes until consensus was found on the codes and coding tree. A problem-driven content analysis was performed by JvdG. The results of this analysis were also discussed with the senior researcher. An example of a qualitative theme and supporting quotations is presented in Table 3 Coding Example Post-intervention Interviews.

After all participating chaplains were interviewed in two rounds using a semi-structured format that enabled the chaplains to answer the research questions, and new information was not found the authors considered data saturation to be reached within the context of this small study. The research team was confident that they had sufficient data and considered that the presented themes reflected the chaplains’ findings.
Pre-Intervention Interview Results

The topics of the semi-structured interviews included motivation for participation, PC in the hospital, chaplains’ participation in PC, experiences with teaching SC, characteristics of the participating wards, planning the training, use of diagnostic tools for SC, new experiences or knowledge based on participation in the study, and further plans for implementation of the SC guideline.

General findings are summarized below, and the three themes that are most relevant to the exploration of an implementation strategy for SC are addressed in more detail: (a) the context of PC in the hospitals, (b) chaplains’ views on developing SC, and (c) new knowledge based on participation in the study. As an impeding factor for the development of SC, the chaplains mentioned the combination of the obvious curative attitude among primary health care professionals throughout the hospital on the one hand and a lack of knowledge about PC on the other. This often impedes the recognition of the shift to the palliative phase in the treatment of patients or even the start of the dying phase. At the same time, the chaplains observed willingness to improve end-of-life-care and the recognition of healthcare professionals’ need for PC training, which they considered supporting factors for developing PC and SC. In general, the chaplains reported a positive attitude towards the project among the nurses. Creating physicians’ commitment to the project was described as more difficult, but when forced by the protocol to approach physicians in order to include them in the training, the chaplains usually encountered an appreciative attitude towards the development of SC; in only one case the chaplain in question was confronted with an indifferent or even degrading attitude.

a. Context of Palliative Care in Dutch Hospitals at the Time of the Study

For half of the hospital sites, the chaplains reported the cooperation with the PC teams to be stimulating. Although one of the inclusion
criteria for hospitals was the presence of a quality-improvement program for PC or a PC consultation team, a large variation in staffing, structure, and financial set-ups was observed. There was no standard for PC in hospitals at the time. At hospital 5 the PC team was disbanded after the start of the study and had not been reinstated at the end of the study.

In none of the hospitals or PC teams any diagnostic tool for spiritual screening was used. Three chaplains reported the use of the distress thermometer (21) by oncology nurses, a tool recommended in national guidelines for oncology care for the screening of somatic, psycho-social and spiritual distress. This tool, however, is not approved by the Dutch health care chaplains’ organization VGVZ (Vereniging van Geestelijk Verzorgers).

b. Chaplains’ Motivations and Perspectives Concerning the Development of Spiritual Care

All participating chaplains declared themselves to be strongly aware of the need to develop a more research-based chaplaincy. Their motivation for participating in the study was connected to a desire to improve the quality and profile of the chaplaincy and the opportunities that our study could provide for developing SC as a multidisciplinary dimension of care. Respondents mentioned a tension between their language as chaplains and the common medical language between primary health care professionals.

Chpl. 4.4: Will we really be able to express what we mean by spiritual care? I myself often have the feeling that I am too vague, but at the same time, people do sense what you mean. That’s what I find so difficult sometimes.

They formulated the need for a multidisciplinary common language that is complementary to the medical discourse and includes symbolic or metaphorical language.
Chpl. 5: … therefore, you develop a common language. Now, we have only a medical language that we can speak, but we lack a language for the symbolic reality. And I do hope that the intervention brings some awareness of that.

The chaplains were aware of the fact that developing this language is not possible as a one-way communication; it needs to be developed in dialogue.

Chpl. 4.4: In this kind of care, it is about a way of being, an attitude. You can only do something about that by talking about it together and, let’s say, exchanging views referring to that.

Chpl. 3: I think that the chaplain can also learn from the professionals what they mean by spiritual care. Maybe both parties will have to adjust the images they have of spiritual care.

All respondents shared the conviction that SC training is a challenge and an opportunity for the chaplaincy to be more integrated in the multidisciplinary team. Some chaplains pointed to the need to modernize chaplaincy, a process that they characterized as a shift from chaplaincy as a domain to chaplaincy as a specific expertise.

Chpl. 3: So it is not our domain, forbidden to others, but an expertise you want to communicate.

c. New Experiences or Knowledge Based on Participation in the Study

The procedure for obtaining permission for the research project within the hospital was new for all chaplains, but it was considered a fruitful learning process that also improved their profile:

Chpl. 6: You are taken more seriously when you are doing a research project.

It provided chaplains with both new knowledge about the organizational structures in their hospital and new experiences in con-
ducting a quality-improvement project in an action-research approach. It created new relations with physicians and managers.

Chpl. 7: I enjoyed it very much at my lung ward, how, step by step, I was able to get that manager to go along. And how fruitful now [before the training] it already is. He has asked me to initiate a discussion about ‘How do we handle troublesome patients?’ He would never have done that if we had not embarked upon this study. So now he already has a completely new perspective on me and my work.

Post-Intervention Interview Results

The topics for the semi-structured post-intervention interviews included preparation of the intervention and data collection, the baseline situation in intervention wards, characteristics of the training, critical success factors, health care professionals’ preferences for specific SC diagnostic screening tools or models, chaplains’ new knowledge and skills, and training effects. After providing the general findings from the post-intervention interviews, we present the most relevant themes for the implementation of SC as reported by the chaplains: (a) characteristics of the training as performed by the chaplains, (b) critical success factors, (c) chaplains’ new knowledge and skills, and (d) effects of the training.

The overall finding from the interviews is that the chaplains experienced the research project as a demanding, time-consuming, but fruitful and positive process. For all chaplains, the mandatory specialized training in SC was vital to their preparation for the training, and for most chaplains, the additional training on educating professionals (learning styles, teaching methods) and the exchange of experiences in three group meetings were also vital.

Three chaplains expressed frustration due to external factors: in hospital 1 no pilot was performed because of an understaffed PC team; in hospital 7 the pilot had not been developed fully according to protocol because of the integration of the pilot in a larger PC
training program; and one chaplain reported suboptimal performance during the pilot because of sickness during preparation.

The overall preparation was described as a process, and seven of the nine chaplains reported that, in their view, the objectives of making health care professionals aware of the spiritual dimension of their work and enhancing their competencies were achieved (in particular among nurses).

Nevertheless, chaplains who trained physicians (either mixed with nurses or in mono-disciplinary groups) expressed their doubts about whether their training had met the physicians' training need sufficiently, although they reported to have been able to build bridges between nurses and physicians, and by doing so created possibilities for the implementation of the SC guideline in the departments’ working processes.

Three chaplains said they planned to use one of the diagnostic SC tools on which they had trained as a format for reporting their visits in patients’ medical records. The other chaplains did not formulate any specific implementation strategy to structure a working process for SC.

Four of the chaplains were planning to offer future structural training on SC in cooperation with education departments, PC consultation teams, or third parties outside the hospitals.

a. Characteristics of the training as performed by the chaplains

The SC training intervention was performed nine times in seven hospitals, between February 2014 and February 2015. The wards that appeared to be most open to SC improvement were the lung and oncology wards. The characteristics of the training varied locally. For a table detailing all requirements of the training, we refer the readers to our study protocol (van de Geer et al., 2016a). The conclusion from the experiences and reports of this group of chaplains was that having only one training session was less effective. Two sessions, preferably of 90 minutes each, made it possible to start in the first lesson
with the basic theory illustrated by the case descriptions prepared earlier. The time between the sessions was used to stimulate participants to provide detailed personal case descriptions, applying the theory learned in the first session. With this setup, these case descriptions were available in the second session to illustrate and practice the trained models and diagnostic tools. These second sessions appeared to be more practical, resulting in enhanced commitment and better evaluation rates.

The chaplains interviewed reported a preference for small groups. For implementation in larger wards, although a training session in larger groups (including interactive training methods in small groups) seemed to be equally effective.

Whenever, for practical reasons, the chaplains opted for mono-disciplinary training of physicians and nurses, they found this to be easier to organize, having the advantage that the training could be adjusted to the specific training needs and reflective competencies of each discipline.

In contrast, chaplains who trained multidisciplinary groups reported that in these groups participation of and contributions by physicians enhanced the quality of the training because this deepened the reflections on case descriptions, broke down mutual stereotypes between physicians and nurses, created a collective commitment to the development of integrated working processes for SC in the ward, and legitimized nurses to engage in SC.

Chpl.5: I was greatly helped here by an internist, who put this into words clearly... She said ‘This [How do you make sense of what is happening to you?] is a different question from 'How are you today?' Then, patients start telling you… about their temperature… Asking about meaning is a different question.' Shortly before that, some nurses had walked the rounds with the specialists for a day and had been very surprised to find that these aspects did come up. ...The idea that 'the doctors do not see these things' has been turned completely upside down. But it does not always register with the other party. Of course, it’s not the language they speak with each other
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Pilot N = 9 Ward/# scheduled participants Multidisciplinary/monodisciplinary training # Lessons/# Groups/total minutes Group size Themes\(^2\) Comp. Trained\(^b\) Models trained\(^d\) Use of Particip.'s CD / CJ\(^d\)

<table>
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<tr>
<th>Pilot</th>
<th>Ward/ # scheduled participants</th>
<th>Multidisciplinary/monodisciplinary training</th>
<th># Lessons / total minutes</th>
<th># Groups / Group size</th>
<th>Themes(^2)</th>
<th>Comp. Trained(^b)</th>
<th>Models trained(^d)</th>
<th>Use of Particip.'s CD / CJ(^d)</th>
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<tr>
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<td>1.2.3.4.</td>
<td>1.2.3.</td>
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<tr>
<td></td>
<td>Mono.: nurses</td>
<td></td>
<td>1/60’</td>
<td>4/10-12</td>
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<td>1.2.3.</td>
<td>2.</td>
<td>CD/-</td>
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<td></td>
<td>1.2.4.</td>
<td>-</td>
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<td>1.2.4.</td>
<td>1.2. CD/-</td>
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<td>2/180’</td>
<td>5/16-25</td>
<td>1.2.3.</td>
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<td>1.2.3.4.</td>
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<td>Mono.: nurses</td>
<td>2/120’</td>
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<td>P. 9</td>
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<td>Mono.: nurses</td>
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<td>2/10-13</td>
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<td>1/3-5</td>
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<td>1.2.3.4.</td>
<td>1.2. CD/-</td>
</tr>
</tbody>
</table>

* = training started as multidisciplinary during 60’, then continued as monodisciplinary for nurses; ** = 1 physician;
\(^a\) 1 = sensitizing, 2 = reflecting on participant’s own spirituality and confrontation with end-of-life care, 3 = integrating into professional practice;
\(^b\) Competencies trained: 1 = recognizing, 2 = tuning and referring, 3 = self-reflectiveness, 4 = open attitude towards patients’ spirituality;
\(^c\) 1 = MVCN assessment tool, 2 = symbolic listening Weiher, 3 = Ars Moriendi Leget;
\(^d\) Use of participant’s CD / CJ = Case Descriptions (CD) / Coaching on Job (CJ).

Table 2. Pilot Training Spiritual Care

Chpl.2: And nurses... they do have much more of an antenna for that sort of thing. But they also feel a bit uncertain about whether the doctors are OK with it. 'If I take the time to talk to a patient, sit down with them -- do they understand?'

At first glance, Table 2 seems to show that in most cases all three themes required by the protocol (sensitizing, reflection on one's own spirituality and confrontation with end-of-life care, and
integration in professional practice) were included and that in most cases, all four SC competencies (recognizing, attuning and referring, self-reflectiveness, open attitude towards patients’ spirituality) were trained. However, most chaplains explained that a lack of time forced them to merely mention the relevance of reflection on one’s own spirituality and experiences in confrontation with end-of-life care. The main and most successful topics in the training were sensitization to and recognition of the spiritual dimension by using a diagnostic tool and symbolic listening. As Chaplain 3 mentioned,

That was an eye-opener. If a patient says: ‘Well, then, I may as well get rid of my caravan’, you can interpret that as ‘I am at the end of my life, I have to let go of the nice things in my life, I will die very soon.’ But you can also hear ‘that caravan has been an important part of someone’s life; it has been a source of joy.’ And then you listen differently. … Like, ‘hey, if someone says something like that, what has been the function of that caravan…What do you hear then?’

When asked which model the physicians and nurses preferred, six out of nine chaplains identified the questions of the Mount Vernon Cancer Network(22) assessment tool as the most practical and compatible with the medical model (see Table 3.). The three questions in this tool are ‘how do you make sense of what is happening to you?’, ‘what sources of strength do you look to when life is difficult?’, and ‘would you find it helpful to talk to someone who could help you explore the issues of spirituality/faith?’. In most training sessions, this screening tool for spiritual needs is combined with symbolic listening.(23) The latter is a method for interpreting patients’ daily conversations or answers to the screening questions and for guiding health care professionals’ reactions. The third model available for the pilot training, Ars Moriendi,(24) was mentioned only occasionally and was used by only two chaplains.

Three chaplains mentioned unexpected chances to secure the results of the training in occasional or structural team meetings and in moral deliberations. Coaching on the job appeared to be the most
effective - however demanding - means to secure the results of a training in SC. Only one chaplain was able to adopt it as a method whenever she was referred to patients in the 'training' ward. She said,

Chpl.7: I do that with all referrals I now get for that ward, I always ... make a point of saying 'look, this is what we talked about [in the training]. ... look what I have reported, there you can read what I do and what I recommend'. I now consciously use words from the training, so that they see 'this is what you already did and this is what I'm doing now' and 'this is the way you can take this up'. ... And then they want to hear back from you after you've been there. So, I do that much more often now. I do not always manage in person, but then I tell them where to find my report. ... So, this is all coaching on the job.

b. Critical Success Factors
For seven chaplains, a project-based implementation of the SC guidelines would not have been a matter of course without the study protocol or a clear mandate. As Chaplain 5 stated,

... before, I never felt obliged to implement the guideline. Odd, really ... I did not know where to start. I use the guideline occasionally in a lesson, if I'm allowed to give one. But in a hospital... where everything is in constant flux ... I would not have introduced a guideline of my own accord. I would have left it. Just because I would have no idea how and where to introduce it in this organization.

Other reported critical success factors with regard to the chaplains' attitude were authenticity, visibility, and personal commitment to the team members on the ward. The research project and the training offered opportunities to break down the traditional stereotypes of chaplaincy among nurses and physicians.
Learning spiritual care in Dutch hospitals

Chaplains’ Perspective on Health Care Professionals’ Preferences for Spiritual Care Diagnostic Tools

<table>
<thead>
<tr>
<th>Family Code: 03 Actual Characteristics of Intervention/Training</th>
<th>Code 3.7: Spiritual Care Tools Actually Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>03.1 Multidisciplinary vs. Monodisciplinary</td>
<td>Chpl.2: And while we practised listening in layers, in the second half, the question ‘how is it for you yourself’ also became very prominent.</td>
</tr>
<tr>
<td>03.2 Spiritual Care Competences Actually Trained</td>
<td>Chpl.3: Yes, I raised those three Mount Vernon-screening questions, and gave examples. Those are clear questions. I found that I could explain each example using Weiher; I know that would not have been as easy with Carlo’s model. Something I also stressed is focusing on sources of strength rather than problems.</td>
</tr>
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<td>03.3 [Participants’] Preparation via Project Website</td>
<td>Chpl.4: I kept things very basic for the nurses and limited myself to those three questions: what are you worried about, who would you like to have with you, from what did you derive strength before?</td>
</tr>
<tr>
<td>03.3.a [Participants’] Preparation via Answering Baseline Questionnaire about their Spirituality</td>
<td>Chpl.4.10: Certainly, I did discuss the three questions, but we also always referred to the four layers in the training.</td>
</tr>
<tr>
<td>03.4 Numbers of Sessions, Total Numbers of Minutes (per Participant)</td>
<td>Chpl.5: Mount Vernon, listening in layers, but Carlo Leget as well. But only in the second lesson.</td>
</tr>
<tr>
<td>03.5 Group Size, Total Numbers of Sessions and Participants</td>
<td>Chpl.6: The first lesson we practised layers, and wrote various questions that could be asked on the blackboard. That went quite well, so that in the second lesson we could refer back to that topic, like, last time we talked about listening in layers, this time we will do a bit of Ars Moriendi.</td>
</tr>
<tr>
<td>03.6 Structure and Composition of Lessons</td>
<td>Chpl.7: I just trained the three questions and the four layers. Chpl.8: It became clear that in any case we had to end on the three Mount Vernon questions. So I sort of wrote the training in that direction. In this way that was part of the preparation: this is it, folks. The session was supposed to take an hour and a half according to the study protocol, but this could be done in 45 minutes. We ended with what we then thought was the most practical tool: the three Mount Vernon questions. Chpl.9: For instance, I worked, but in a very limited way, with Carlo Leget’s model, the diamond; I also used Erhard Weiher’s three-part model, I especially focused on that.</td>
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<td>03.7 Spiritual Care Tools Actually Trained</td>
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</tr>
<tr>
<td>03.8 Practical Assignment, Case Description</td>
<td>Chpl.11: Effective teaching methods for the Expansion Phase</td>
</tr>
<tr>
<td>03.9 Chaplain’s Personal Freedom</td>
<td>Chpl.12: Effective teaching methods for the Rounding-Off Phase</td>
</tr>
<tr>
<td>03.10 Effective Teaching Methods for the Introduction Phase</td>
<td>Chpl.5: Mount Vernon, listening in layers, but Carlo Leget as well. But only in the second lesson.</td>
</tr>
<tr>
<td>03.11 Effective Teaching Methods for the Expansion Phase</td>
<td>Chpl.6: The first lesson we practised layers, and wrote various questions that could be asked on the blackboard. That went quite well, so that in the second lesson we could refer back to that topic, like, last time we talked about listening in layers, this time we will do a bit of Ars Moriendi.</td>
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<td>03.12 Effective teaching methods for the Rounding-Off Phase</td>
<td>Chpl.7: I just trained the three questions and the four layers. Chpl.8: It became clear that in any case we had to end on the three Mount Vernon questions. So I sort of wrote the training in that direction. In this way that was part of the preparation: this is it, folks. The session was supposed to take an hour and a half according to the study protocol, but this could be done in 45 minutes. We ended with what we then thought was the most practical tool: the three Mount Vernon questions. Chpl.9: For instance, I worked, but in a very limited way, with Carlo Leget’s model, the diamond; I also used Erhard Weiher’s three-part model, I especially focused on that.</td>
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Table 3. Coding Example Post-intervention Interviews

A reported critical success factor regarding the participating wards was their ownership of the project: active commitment on the
part of management and physicians and the sense of bottom-up commitment on the part of nurses.

According to Chaplain 7, it is important to stress that SC is not an additional task but inherent in health care professionals’ practice and deeply connected to their original, deeper motivation for choosing this profession.

Chpl.7: ... I think everyone has in fact been doing this for a long time, and I should not be selling this training as something entirely new, but rather as I'm offering you tools and empowerment to make you more aware of what you are doing and get more out of it. Also, I thought it was a real finding to be able to link it to, what I think was their original motivation for choosing health care as a profession, ... this would help to rediscover the human being behind the diagnosis and the patient. I found this a great help to win people over, eyes started to shine.

c. Health Care Chaplains’ New Knowledge and Skills
Action research proved to be an effective method to gather practical knowledge for developing and performing quality improvement or research projects. In our project, knowledge about learning styles and educational theory for training professionals was gathered or renewed, and chaplains’ training skills were enhanced. In particular, they discovered the value of learning by doing and the fact that chaplains are more theory-minded than other healthcare professionals.

The chaplains reported an improved understanding of the differences in professional practice between physicians and nurses and of the barriers to SC within both disciplines. They also discovered that the varying levels of reflective competencies within teams were independent of working experience.

Chpl.5: What also struck me is that a physician sometimes has more time for a palliative patient in a short meeting in his office than a nurse rushing from one patient to the next one.
The majority of the chaplains stated that the process reaffirmed their self-consciousness as professionals with a valuable contribution to health care:

Chpl.4.10: *True, I found that we do have a good story and that patients are actually waiting for it. More than one doctor confirmed this to me.*

### d. Effects of the Training

Although most chaplains are positive about the improvement in trainees' competencies, it is difficult for them to measure the effect on the quality of care as perceived by patients. Three chaplains thought that they had improved the quality of their profile and visibility on their wards, and they were able to indirectly deduce improved patient care based on the quality of the referrals.

For three other chaplains, the effect on patient care was outside their field of vision. The remaining three chaplains were skeptical or negative about the effect on patient care.

Six chaplains reported improved and intensified relations with physicians:

Chpl.2: *Less than a week after the training, two doctors came to me, one in the bike shed and one in the corridor, and said 'that was an excellent training, it really affected me, it did something'. Mind you, these were specialists, not just junior doctors. You can't tell by looking at them, but something has changed, something is happening. I now report more in the doctors' notes than I used to, I used to do that mainly in the nursing file... I now find it easier to drop in at a specialist's office and say 'Patient such and such has this or that problem.' So, for me, the barrier to contact a specialist has again become a bit lower.*

A summary of the findings and practical knowledge for the implementation of the SC guideline based on chaplains' reports is presented in Box 1.
7. Improving spiritual care - health care chaplains’ reports

### Findings based on pre-intervention reports

**Context op PC in Dutch hospitals**
- Large variation in staffing, structure and financing PC teams.
- No standard for PC in hospitals (during study).
- No SC diagnostic tools.
- Stimulating cooperation with PC teams.

**Physicians and nurses**
- Combination of curative attitude and lack of knowledge of PC.
- Willingness to improve End of Life care.
- Need for training PC (not only SC).
- Positive attitude towards improvement SC.

**Chaplains’ motivations and perspectives**
- Improve quality and profile chaplaincy.
- Developing a more research-based chaplaincy.
- Protocol provides opportunity to develop multidisciplinary SC.
- Tension between chaplaincy language and common medical language.
- Need for multidisciplinary (including metaphorical) language.
- Expertise based integration of chaplaincy in multidisciplinary team.

### Findings, practical knowledge for implementation SC based on post-intervention reports

**Action research project**
- Demanding, time-consuming, but fruitful process for clinicians.
- Training (study protocol, intervention) and interaction with co-researchers is vital for preparation.
- Raised awareness of spiritual dimension of health care professionals’ work.
- Multidisciplinary training creates more chances for implementation SC than mono-disciplinary training.
- Training SC diagnostic tools influences chaplains’ reports of patient contact.
- Action research is effective for identifying lack of knowledge, gathering practical knowledge, improvement quality of care.

**Training SC**
- Two sessions are more effective and better evaluated than one session, but still too short to reflect on one’s own spirituality and experiences in EoL care.
- Small or larger groups are equally effective, mono-disciplinary training are easier to organize, better adjustable to specific training needs and reflective competencies.
- Multidisciplinary training deepens reflection, reduces mutual stereotypes, creates collective commitment.
- Chaplains assume symbolic listening and 3 screening questions to be more practical for physicians and nurses than Ars Moriendi.

A concise program of two sessions (90’ each) can include basic theory and training in 2 out of 3 models/diagnostic tools for SC, developing competencies SC aimed at sensitizing, integration of SC in professional practice.
- First session: basic theory (models, diagnostic tools SC), illustrated by prepared case descriptions. Between sessions: participants write detailed personal case descriptions SC applying theory.
- Second session: practical training SC models or diagnostic tools using participants’ case descriptions.
- Coaching on the job is a demanding, but effective method to secure results.

**Critical success factors**
- A clear mandate and/or study protocol for project based implementation of a SC guideline by chaplains.
- Chaplains’ attitude requires authenticity, visibility, personal commitment to the team.
- Ownership of the quality improvement project, bottom-up commitment.
- Presenting SC as connected to health care professionals’ motivation, not as an additional task.

**Effects of training**
- Reports about improvement of trainees’ (especially nurses’) competencies and patient care,
- Improved visibility and profile of chaplaincy,
- Research based quality improvement projects reaffirm chaplains’ self-consciousness.

### Box 1. Summary of findings based on chaplains’ reports
Discussion

Our main research question was: what are barriers and possibilities or critical success factors for implementation of the SC guideline as reported by chaplains?

As barriers the chaplains report that health care professionals in Dutch hospitals display a combination of a dominant curative attitude with a lack of PC knowledge, being unfamiliar with SC diagnostic tools. In addition chaplains realized that the tension between their own language and the common medical language forms a barrier for the development of SC. Since almost all participating chaplains gained knew knowledge about health care research procedures and organizational aspects of quality improvement, this could indicate that a lack of knowledge on these subjects could be characteristic for the profession.

The stimulating cooperation with the hospital based PC teams, the willingness to improve end-of-life care, the need for training, the positive attitude of physicians and nurses towards improvement of SC create possibilities for implementation of the SC guideline, as well as possibilities for chaplaincy to develop a more research-based integration of chaplaincy in the multidisciplinary team.

For project-based improvement of SC in hospitals using implementation of a guideline, a clear mandate and ownership, departments’ bottom-up commitment, chaplains’ attitudes of authenticity, visibility, and personal commitment to the team are critical success factors. Presenting SC as connected to health care professionals’ motivation, not as an additional task was a critical success factor in the training. And, last but not least: time is a critical success factor. The chaplains reported their own training and preparation to be essential for this demanding, time consuming quality improvement project.

According to the chaplains, training health care professionals in SC as an implementation strategy for the SC guideline was a fruitful endeavor. Although implementation of guidelines is a well-tested
method for improving patient care,(25) until now it was not an obvious activity for chaplains in the Netherlands. Working as a group in a multicenter trial - including 8 of the 27 non-university training hospitals in the Netherlands - these chaplains actually started an implementation process, collected essential new practical knowledge for a strategy to improve SC within the national PC program, and enhanced the profile of chaplaincy as a specialized, research-based health care profession.(26) The project created national visibility and was awarded twice.

By exploring training methods in an action-research design, the chaplains developed a more systematic approach, and they contributed to research-based answers to the needs of their colleagues in the multidisciplinary team. Thus, this study meets many of the needs of health care professionals, identified in in a worldwide survey by Selman and colleagues: understanding of SC (who/what/where), staff education, understanding of spiritual needs and distress, SC for nonreligious people and people of different faiths, and conceptualizations and definitions of spirituality/the spiritual dimension.(27)

The study shows reports of empowered health care professionals, improved understanding among chaplains, nurses, and physicians, enhanced participation in performing multidisciplinary SC, and indications of improved patient care.

Although the study protocol was limited to PC in hospitals, the chaplains’ group agreed that this training needs to be developed further, and it is transferable to nursing homes, hospice, and home care, as well as to forms of acute and chronic care.

Because of the explorative character of this study our results are indicative, and generate rather than confirm hypotheses. Finally, the sample of chaplains is subject to selection bias. The inclusion procedure selected those chaplaincy teams that were willing to work on the implementation of the SC guideline, expecting it to create opportunities to improve patient care and chaplains’ professional profiles. Therefore, this group of chaplains probably represents a group of pioneers.
The conclusion of this study is that from a chaplaincy perspective, chaplain-led, multidisciplinary spiritual care training is a feasible method to start implementation of SC methods in hospitals, as described in the multidisciplinary guideline. Positive effects such as lowering barriers to spiritual care, increasing health care professionals’ competences, and increasing health care chaplains’ profile are possible.
References


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