Chapter 8. General discussion

This final chapter addresses our primary research question: ‘What training do primary health care professionals (physicians, nurses) need to use hermeneutical diagnostic tools for multidisciplinary spiritual care and to integrate these tools in their professional practice, with the expert support of health care chaplains?’

First, we summarize the findings based on our research questions. The final Conclusions for the primary research question will be followed by a Discussion and an overview of the Strengths and limitations of this study.

Because this practical research project began six years ago, in 2011, it is important to address Where we are now? prior to closing with the Implications of our conclusions for additional development in practice, spiritual care training, research, and policy making in this area.

Conclusions

Multidisciplinary spiritual care in palliative care in the Netherlands in 2012.

Chapter 2 described ‘the baseline for developing multidisciplinary spiritual care in the Netherlands in 2012’, which was the beginning of this research project. We concluded that there was a partially completed infrastructure for developing spiritual care in the Dutch health care system at the time. Groups of dedicated chaplains in the Netherlands who were motivated to engage in the local and national development of spiritual care had been trained in the ‘Masterclass on spirituality and health care chaplaincy in palliative care,’ beginning in 2007; other health care professionals also started to attend the masterclass, which developed into a programme for multidisciplinary groups and changed its name to the ‘Masterclass on spirituality in palliative care’ in 2012.
In 2012, the challenge was to propose a spiritual care project in palliative care as an example of good practice, which could then be used and implemented in the Improvement programme for palliative care from 2012-2016. At that time, there was no project that was ‘mature’ enough for inclusion.

**Hospitals in the Netherlands were pioneering and searching for structure and organization in hospital palliative care between 2012 and 2017.**

To answer our second research question ‘How have teaching hospitals in the Netherlands structured and organized inpatient palliative care, and the component of spiritual care?’ Based on the findings from 9 of the 28 teaching hospitals, we integrate our findings for this question in Chapter 7 with the results from a questionnaire that was designed by Galesloot et al., which allowed us to contribute questions about the delivery and organization of spiritual care, as well as a recent publication by Brinkman-Stoppelenburg et al., which provides a representative description.

At the beginning of our research project, 10 of the 28 teaching hospitals were interested in participating in this study and met the inclusion criterion as they had some type of palliative care improvement programme or a Palliative Consultation Team. The researchers in the participating hospitals reported a large variation in the staffing, setup, structure, and financial support for the palliative care (consultation) teams, and four of the eight were able to build a fruitful cooperation with these teams to conduct the study according to the protocol. They noticed a predominantly curative attitude among the health care professionals in their hospitals that was combined with a lack of knowledge about palliative care, which often resulted in failing to recognize when patients’ were at the beginning of the palliative or even dying phase. Those hospitals did not use diagnostic tools for spiritual care, and only three of the eight researchers reported the use of the distress thermometer for the
Because the 2013 publication by Galesloot et al. (2) is only available in Dutch, we summarize the findings for the items that we provided on the delivery and organization of spiritual care. The response rate for the questionnaire was 62% (57 of the 92 approached hospitals). In 51 hospitals, there was a health care chaplain for more complex spiritual needs. For the responsibility of the spiritual care policy, 44 facilities reported that the chaplain, 7 hospitals reported that the medical discipline, 10 reported that the nursing discipline, and 9 hospitals reported that a manager was responsible. Screening for spiritual needs was completed by nurses in 44 hospitals, physicians in 28 hospitals, and chaplains in 20 facilities; one organization reported that this duty was performed by a volunteer and another was performed by a case-manager. In approximately 50% of the hospitals, there was some spiritual care training as part of a broader training programme (16 hospitals) or as a distinct module. In 14% of the hospitals, the Guideline had been translated into a local protocol for spiritual care, and it was integrated into a policy document on spiritual and/or chaplaincy care in two hospitals.

The publication by Brinkman et al. (3) is based on responses to a questionnaire from 74 of the 92 hospitals in the Netherlands about the disciplines that are represented in the palliative care consultation teams, the procedures that teams follow, the number of consultations and team meetings as well as quality assurance procedures. Although Brinkman et al. observed an increase in the number of palliative consultation teams (39>77%) in 2015 and reported 65% of health care chaplains (spiritual caregivers) were part of those teams, there are still misconceptions in situations when palliative care consultation teams are contacted too late. Misconceptions include thinking that ‘palliative care is only appropriate for patients nearing death’ or that ‘involving palliative care professionals can be conceived by patients as a sign that there is no hope left’. The Dis-
tress Thermometer was the most commonly used instrument by both generalists and specialists in palliative care (4).

As such, our 2012 conclusion that there was a specific infrastructure for spiritual care in Dutch health care was premature. In the section ‘Where are we now?’, we reflect on the current situation (2017).

In Dutch hospitals, diagnostic tools for spiritual care were not structurally implemented in palliative care

We can conclude that diagnostic tools for spiritual care have not structurally been implemented in Dutch health care. Chapter 4 addressed the research question ‘What diagnostic tools for spiritual care theoretically correspond to the multidisciplinary guideline, the needs of patients and proxies, the needs of health care professionals and their professional tasks and standards, and, from the primary health care professionals’ perspective, are suitable for practical application?’. We found that although there were more tools available in the international research literature that theoretically corresponded to the Guideline, the experts in the invitational research conference limited the training models in the pilots to a.) symbolic listening according to Erhard Weiher, (5) b.) translating the three screening questions that were developed by the Mount Vernon Cancer Network (MVCN), (6) and c.) the Dutch spiritual care model, Ars Moriendi(7), because these were the three models that were included and translated in the Guideline.

Our findings for the effects of spiritual care training reported in Chapter 5, based on patient-reported outcomes, were combined with the reports of the co-researchers about the positive impressions of and improved referrals to chaplaincy in Chapter 7, and provided indirect evidence that suggests that the trained diagnostic tools correspond with the needs of patients and proxies. However, it is not possible to determine how they correspond with patients’ and proxies’ spiritual needs based on these findings.
For professionals’ needs and practical application of the diagnostic tools, the findings that were reported in Chapter 6 suggest that the training was more effective for nurses than physicians. However, based on the reports from the co-researchers in Chapter 7, it is not possible to conclude that these tools are less useful for physician’s practice. Although our findings provide indirect evidence that indicates that the advised tools correspond with the needs of nurses rather than the needs of physicians, this was not supported in the interviews that Van der Werf conducted with 10 physicians who had participated in 3 different pilots at three different sites. (8) According to her report, the training did not sufficiently correspond with physicians’ training needs.

Based on the reports from the co-researchers that were discussed in Chapter 7, our hypothesis is that the model that is the most suitable for practical application is a combination of MVCN and symbolic listening. Additional research is needed to understand why Ars Moriendi received less attention in the training that was conducted by the chaplains.

Using two sessions for spiritual care training and detailed participants’ case descriptions will allow chaplains to support primary caregivers in clinical practice.

Our fourth research question, ‘How do chaplains concretise spiritual care training for primary caregivers in clinical practice?’, is reported in Chapter 7.

We concluded that implementing spiritual care in hospitals can be successful if it is based on: two training sessions with 90 minutes each (group size 8-20), and includes participants’ detailed personal case descriptions in the second session to illustrate and practice the models and diagnostic tools in the training in multidisciplinary groups.

Monodisciplinary training may be more practical, or easier to organize, and adjustable to specific learning needs. However, for multidisciplinary training, the co-researchers reported that the quali-
ty of training was improved by the participation of physicians, as this eliminated mutual stereotypes, and provided opportunities for influencing work processes. In multidisciplinary staff training, it is possible to make collaborative choices about implementing specific models/diagnostic tools for referral and multidisciplinary communication in (electronic) patients’ reports.

Our findings indicate that physicians’ training needs warrant more attention; thus, health care chaplains should familiarize themselves with physicians’ daily practices. Further, reflection on one’s own spirituality or confrontation with end-of-life-care is not possible in the limited time that is in general available for training professionals in hospitals.

**Spiritual care training improves the quality of care that is perceived by patients, and influences health care professionals’ attitudes and competencies.**

For our final research question on ‘the effects of spiritual care training’, our quantitative studies that were reported in Chapters 5 and 6 suggest that within the limited time that is available in hospitals for training health care professionals, it is possible to decrease 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 using the Spiritual Care Competence Scale (SCCS)(9) was successful because it allowed us to measure differences in time and between groups. No participants criticized the questionnaire as less applicable to physicians; thus, we conclude that this tool, which was originally developed to evaluate nursing education in spiritual care, may also be suitable for evaluating medical education in spiritual care.(10) A formal validation study is in preparation.

We believe that the decreased impact of the training on physicians is because the health care chaplains as trainers/co-researchers are more familiar with nursing practices than with physicians’ daily
practices, and, therefore, could not adjust their training methods to physicians’ training needs.

Based on the qualitative study, there were four primary effects on the chaplains: a.) new knowledge about and experience with research using an action-research approach, b) an 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.

**Spiritual care training as part of a quality improvement project can have sustainable effects**

In Chapter 3, ‘Effects of spiritual care training on patients and health care professionals: a systematic review’, we report the results from a systematic review that was performed in 2016-2017 that focused on effective training methods for spiritual care. We found diverse outcome measures, with a tendency towards competence-based measures.

Based on the qualitative synthesis, we concluded that improving spiritual care, or implementing a spiritual care standard, is optimal when it is designed as a quality improvement project. This type of project can follow a plan-do-check-act cycle that begins with (1) an initial audit to identify the barriers in the health care setting where this improvement is targeted; (2) formulating a spiritual care policy that is based on available national standards (plan); (3) providing training to decrease the identified barriers and provide the spiritual care as formulated in the policy (do); (4) evaluating the effects of the training as well as the policy (check); and (5) adjusting the training and/or policy based on the recommendations (act).

For this systematic review, we used methods that were commonly used in the medical field. Although the Cochrane paradigm is dominant in medical research and is suitable for reviewing the literature on standardized medical/therapeutic interventions, it may not be the most appropriate method for reviewing the research literature on spirituality and/or spiritual care. Improving or implementing
spiritual care is a complex social intervention; therefore, we recommend the Campbell method for future systematic reviews. This method is designed to ‘to inform policymakers, practitioners, researchers, and other interested parties about the extent, quality, and findings of the available research evidence on the effectiveness of social programmes, policies, or practices. Thus, suitable topics include the synthesis of research that investigates the effects of deliberate, organized social interventions intended to bring about change on some set of targeted outcomes that represents improvement in the conditions the intervention is designed to address for a population experiencing those conditions’.(11) Campbell reviews summarize both the best evidence available about the effects of the focal intervention(s), and the evidence that provides credible estimates of those effects, which may provide a better synthesis in the multidisciplinary field of spiritual care, where there is an intersection for the paradigms of science and humanities.

Concise training programmes for spiritual care in palliative care are effective in improving the quality of care in hospitals, decreasing spiritual care barriers, having positive effects on spiritual care competencies, improving multidisciplinary work, and enhancing the profile of chaplains.

As the final conclusion to our primary research question, ‘What training do primary health care professionals (physicians, nurses) need to use hermeneutical diagnostic tools for multidisciplinary spiritual care and to integrate these tools in their professional practice, with the expert support of health care chaplains?’, we believe the following critical factors for success are essential for the successful implementation of the spiritual care guideline:

1. At the local level, it is essential to have at least one (preferably two, depending on the chaplaincy team staffing) dedicated chaplain(s) who has additional training in spiritual care, and a clear mandate from the supervising physician, nursing director, and management related to responsibility for the spiritual care policy of the organization;
2. At the national level, it is important to provide an e-learning module or interactive learning environment for the theory of spiritual care based on the Guideline;

3. Space in hospitals’ education plans for wards in which patients are treated in curative as well as palliative trajectories. Our findings suggest that two sessions of 90 minutes each (or three of 60 minutes) result in a significant improvement in the quality of care. Because our findings suggest that chaplains’ knowledge of physicians’ practices is too limited to detect an effect on physicians, we suggest that these trainings should be conducted in pairs: a chaplain with a dedicated physician or nurse.

General discussion

In this study, we wanted the participating chaplains to train health care professionals to use the diagnostic tools for spiritual care in such a way that patients’ expressions of spiritual needs and resources could be interpreted and addressed based on the patients’ verbal and non-verbal communication, with the health care professionals attempting to understand the meaning of the patient’s experiences. This type of interpretive use of diagnostic tools is typical of chaplaincy and is called ‘hermeneutical’ use of diagnostic tools. Using diagnostic tools for spiritual care in the medical process of diagnosing, i.e., as a process of determining the disease or condition that explains a person’s symptoms and signs, may reduce patients’ complex, nuanced, existential experiences to merely a series of ticks in a box.(12)

Although the chaplains who were interviewed reported inter- and intra-group differences in physicians' and nurses' reflective skills, they did not report a trend to reduce spiritual care to a tick-box mentality. It is possible that the past resistance that chaplains expressed related to diagnostic tools for chaplaincy care led to a fear that training physicians and nurses to use spiritual care diagnostic tools would medicalize spirituality. Based on our findings, this is a serious bias in chaplains, which could be overcome with intense
communication and cooperation between physicians and chaplains in patient care. Gijsberts’ noted, in the General Discussion of her thesis, that in the nursing home she visited for her ethnographic study, ‘and probably in many other Dutch nursing homes’, there was a spiritual counsellor who did not collaborate with the multidisciplinary team for residents’ spiritual issues at the end of life’, (13) and illustrates the need to intensify multidisciplinary and interdisciplinary forms of cooperation between chaplains, nurses, and physicians to develop spiritual care that adheres to the standards that are formulated in the guideline.

Another aspect of the ‘hermeneutical’ use of diagnostic tools in spiritual care could be the lack of a common language between the medical, psychosocial, and spiritual disciplines in Dutch health care, which still needs to be developed. (14) Spiritual needs are often expressed in metaphorical language, and more research is needed to determine whether the ‘hermeneutical reporting’ of spiritual needs is viable or if it demands a systematic taxonomy.

Spiritual care is a multidisciplinary activity, and our study design sought to explore and bridge the gap between different practices, research perspectives, and methodologies from medical (including nursing) science and the humanities (including theology). We believe that the strength of this study lies not only in the attempt to connect both research traditions but also in connecting clinicians (nurses, physicians, chaplains, and managers) to develop a multidisciplinary practice of spiritual care with a combination of implementation, education, and research that seeks to improve the quality of care.

The combination of international input (15), a multicentre design instead of the one-site study by Vlasblom et al., (16) patient-reported outcomes, and a team approach to improvements in the quality of care (17) is unique in chaplaincy studies in the Netherlands. This study allowed chaplains who were not able to conduct their own local research projects to participate in a pre-designed research pro-
ject and to collaborate to contribute to improving quality of care and developing a more research-based chaplaincy.

As we concluded in Chapter 3, the most effective spiritual care training studies were performed in specialized palliative care settings, as a component of a quality improvement programme. Our study indicates that it is possible to generate comparable effects in hospitals. However, we believe that our study would have been more effective had we specifically included the implementation of a spiritual care policy in our aims and methods.

Another strength of our study design was to examine ‘attention to life issues, existential and spiritual distress,’ as a patient-reported primary outcome, because it is the basic attitude that the Guideline promotes to patients and proxies who are in distress, and to every patient and proxy who is confronted with a life-limiting condition.

For implementing spiritual care in hospitals, our sample size, with 8 of the 27 teaching hospitals, provided a substantial impulse at the national level.

We believe that the small patient sample is a limitation that could be expected in an explorative study. Because this study explored and tested training methods for spiritual care and did not evaluate a spiritual intervention among patients who were in spiritual distress, we did not assess the content of patients’ spiritual needs.

From an action-research perspective, an important limitation (and a missed opportunity) is that the study design only included physicians and nurses as participants in the training, as they were not included as participants and co-researchers in the collaborative action-research process.

**Where are we now?**

We completed our summary of the baseline in 2012 with the observation that there was no project that was ‘mature’ enough to be included in the national improvement programme at that time.
However, we note that the new programme for developing palliative care in the Netherlands, Palliantie (18), is now partially complete (2015-2020) and includes a small but growing number of projects that are specifically aimed at developing spiritual care.

To increase alignment with evidence-based practice, the Spiritual Care Guideline from 2010 is now being revised under the authority of the Dutch Comprehensive Cancer Centre (Integraal Kankercentrum Nederland, IKNL) by a taskforce of multidisciplinary representatives from several medical professional organizations, including nursing, psychology, chaplaincy and patient organizations, all of whom will be asked to authorize the final concept.

The quality framework for palliative care (19) is being developed by a broader group of representatives from professional organizations under the authority of the Comprehensive Cancer Centre and the multidisciplinary professional organization for professionals in palliative care, Palliactief. This framework acknowledges that the provision of spiritual care as an essential dimension of palliative care from the patient’s perspectives.

Currently, the two projects that explicitly address the spiritual dimension in the national programme, Palliantie, are: testing a new four-dimensional version of the Utrecht Symptom Diary that integrates the Ars Moriendi model, and a training and implementation project that includes an electronic training and implementation toolkit that is based on the revised Guideline for spiritual care.

The first account of a systematic implementation of a spiritual care diagnostic tool sought to continue spiritual care in the chain of care in the Netherlands and was published this year by van Meurs et al. (20) This is an example of a quality improvement programme that is based on pre-formulated goals for providing multidisciplinary spiritual care, including e training and support for health care professionals from the expert health care chaplain or spiritual care provider, and assessing the policy’s results.

Internationally, there are validated tools for spiritual care and research in this field that are available in multiple languages. Health
Care professionals and researchers are connected with the World Health Organization through global networks, such as the Global Network for Spirituality & Health (GNSAH). Finally, the EAPC Taskforce on spiritual care has been invited by the EAPC Board to become a more structural component of the EAPC as a permanent Reference Group with long-term aims and goals.

At the time that this thesis was completed, in 2017, we conclude that health care chaplaincy is developing into a more evidence-based profession, and at a national level, there is more awareness of the importance of spiritual care in palliative care in the Netherlands. We believe that the combination of these developments creates new opportunities in hospitals and other health care organizations for integrating health care chaplains’ expertise in multidisciplinary teams.

Implications for medical practice

a. patients/general public:
We recommend additional implementation of the revised spiritual care guideline based on the outcomes that were described in Chapter 5, where we discuss the importance of health care professionals’ attention to life issues, existential and spiritual distress (on a 0-10 scale: 8.5 (1.6) 7.2 (2.9), and the effects of spiritual care training on the quality of care as reported by palliative patients.

b. physicians and nurses:
Based on the outcomes that were described in Chapter 6, which discusses the effects of training on barriers to providing spiritual care and the spiritual care competencies of physicians and nurses, we recommend additional implementation of diagnostic tools in hospitals consistent with the Guideline to improve the reporting and planning of spiritual care.

c. health care chaplains:
Based on interviews with the chaplains who participated in our study
(discussed in Chapter 7), in which chaplains stated that the specialized training was essential for preparing for this quality improvement project on spiritual care and that implementing the guideline had not been a priority, we recommend that spiritual care training be included as a component in a quality improvement project. Second, the qualitative synthesis in Chapter 3 concludes that the effects of spiritual care training were the best when this training was a component of an audited quality improvement project. Thus, we agree with Vissers, Van der Zande and Van Meurs (25, 26), and recommend a subspecialty within chaplaincy: a spiritual consultant for palliative care who has the explicit task of developing a spiritual care policy. For an organization in the Dutch health care system, a spiritual care policy should be created from the patient’s perspective and safeguard a continuum of care between hospitals, other health care institutions, and home care.

<table>
<thead>
<tr>
<th>Patients/general public</th>
<th>Attend to the spiritual dimension and communicate this dimension using patient information tools.</th>
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<tbody>
<tr>
<td>Physicians and nurses</td>
<td>Implement the guideline on spiritual care and use diagnostic tools in primary care and hospitals based on the Guideline to improve reporting and planning of spiritual care.</td>
</tr>
</tbody>
</table>
| Health care chaplains  | - Introduce spiritual care training as a component of a quality improvement project.  
                          - Develop a sub-specialism within chaplaincy: a spiritual consultant (for PC) with the explicit task of developing a spiritual care policy. |

Table 1. Summary of recommendations for medical practice

Implications for training in spiritual care

a. patients:
Based on reports by Ford et al. (27) and Tait & Hodges (28), which were mentioned in Chapter 3, we recommend exploring the possibility of patients’ participating in training modules for spiritual care.

b. physicians and nurses:
  i. additional operationalization of training methods for professionals using *Ars Moriendi*
Based on the chaplains' reports that were described in Chapter 7, the *Ars Moriendi* model was used the least in the pilot training; thus, we conclude that chaplains need practical training methods to instruct physicians and nurses operationalizing the model in daily practice. Therefore, we recommend additional operationalization of training methods that are suitable for specialists who instruct other healthcare professionals.

ii. additional exploration of physician’s training needs, and the strengths and limitations of mono-disciplinary / multidisciplinary spiritual care training

Chapter 7 suggests that the decreased impact on the training of physicians occurred because the healthcare chaplains (as trainers/co-researchers) were more familiar with nursing than physicians’ daily practices and could not adjust their training methods to physicians’ specific training needs. We recommend exploring physicians’ spiritual care training needs and testing the effectiveness of specific training methods in both mono-disciplinary and multidisciplinary courses.

iii. develop special retreats for reflecting on one’s own spirituality and confrontation with EoL care

In Chapter 7, we report that chaplains explained that a lack of time forced them to only mention the relevance of reflecting on one's own spirituality and experiences in confronting end-of-life care. In Chapter 3, we describe examples of a spiritual care policy that includes stimulating self-care and reflection.

c. healthcare chaplains:

Because the findings that were reported in Chapter 7 suggest that chaplains’ knowledge of physicians’ daily practice is too limited to result in a significant effect, we suggest training multidisciplinary teams in pairs: a chaplain with a dedicated physician or nurse. We also recommend exploring additional training methods for improving spiritual care and methods that secure training results as a component of a more extended spiritual care policy.
Patients/general public

- Explore possibilities for patients’ participation in spiritual care training modules.

Physicians and nurses

- Further operationalize the training methods that are suitable for specialists who instruct other health care professionals.
- Explore physicians’ spiritual care training needs and test the effectiveness of specific training methods in both mono-disciplinary and multidisciplinary courses.
- Develop special retreats for reflecting on one’s own spirituality and confrontation with EoL care.

Health care chaplains

- Train multidisciplinary teams in pairs: a chaplain with a dedicated physician or nurse.
- Further explore training methods for improving spiritual care.
- Explore methods to secure training results as a component of a more extended spiritual care policy.

Table 2. Summary of recommendations for spiritual care training

Implications for research on spiritual care

a. patients:
In this study, we report quantitative results on patients’ spiritual attitudes, interests, and needs. Chapter 7 highlights two independent patient-reported outcome measures that should be improved: health care professionals’ attention to patients’ spiritual and existential needs, and a significant improvement in patients’ sleeping patterns. Additional research is needed to analyse the relationship between health care professionals improved attention to patients’ spiritual needs and a decrease in sleeping problems. However, to better understand the content of spiritual needs, we need more research strategies that are implemented ‘with’ patients instead of ‘for’ or ‘on’ patients; therefore, it is important to use rigorous action-research methodologies and qualitative methods. We also recommend additional research on the effects of specific spiritual interventions on spiritual distress.

b. medical practice:
In our study, the chaplains participated as co-researchers. However, because spiritual care is a multidisciplinary activity, future studies that use action-research methods should include physicians, nurses,
nursing directors, health care management, health care chaplains, and patients as co-researchers.

c. **use Campbell systematic review methods:**
For systematic reviews on training and developing spiritual care policy, we recommend the Campbell review guidelines because they are more appropriate for social interventions that are intended to influence methods for education and improving policies and practices.

d. **health care chaplains:**
Our study was the first explorative study in this area in the Netherlands; thus, it is not possible to develop quality indicators for spiritual care training. Therefore, we recommend further research on effective methods for spiritual care training for nurses and/or physicians that is administered by chaplains. Based on our results, we conclude that the action-research method is effective for pre-formulated outcome measures as well as for the profile of chaplaincy as a more research-based profession. However, a more fundamental, theoretical analysis should determine whether critical action-research methods correspond with chaplaincy.

| Patients/general public | - Analyse the relationship between improved health care, professionals’ attention to patients’ spiritual needs and decreases in sleeping problems.  
|                         | - Develop mixed-methods action-research methodologies in collaboration with patients.  
|                         | - Test the effects of specific spiritual interventions on spiritual distress. |
| Medical practice        | - Include physicians, nurses, nursing directors, health care management, health care chaplains, and patients as co-researchers in action-research methodologies. |
| Systematic reviews      | Use Campbell systematic review methods. |
| Health care chaplains   | - Develop quality indicators for spiritual care training that are based on research on effective training methods for spiritual care with nurses and/or physicians.  
|                         | - Theoretically analyse critical action-research methods for chaplaincy. |

**Table 3. Summary of recommendations for spiritual care research**
Implications for policy

a. patients/general public:
Based on the positive effects on the quality of care, which was described in Chapter 5, we recommend additional implementation of the revised multidisciplinary Guideline for spiritual care.

b. physicians and nurses/health care management:
To disseminate the knowledge that is concentrated in the revised Guideline on spiritual care in the Dutch health care system, we recommend adding spiritual consultants to IKNL Palliative care Consultation Teams (PCTs) and to the hospital PCTs that have recently been developed based on oncology standards (SONCOS). We recommend developing a local spiritual care policy that is based on the implementation plan that will be included in the revised Guideline for spiritual care.

c. health care chaplains/VGVZ:
Based on the findings that were reported in Chapter 5, 6 and 7, we support recent developments towards a more evidence-based chaplaincy.

d. EAPC Spiritual Care Taskforce/Reference Group:
We recommend using the Dutch Palliantie matrix for the future EU project, Improvement of multidisciplinary SC in PC by training primary caregivers (action research, education, implementation).

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<thead>
<tr>
<th>Patients/general public</th>
<th>Further implementation of the revised multidisciplinary Guideline for spiritual care.</th>
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<tbody>
<tr>
<td>Physicians and nurses/health care management</td>
<td>Add spiritual consultants to IKNL Palliative Care Consultation Teams (PCTs) and the hospital PCTs. Develop a local spiritual care policy.</td>
</tr>
<tr>
<td>Health care chaplains/VGVZ</td>
<td>Continue developing a more evidence-based chaplaincy.</td>
</tr>
<tr>
<td>EAPC Spiritual Care Taskforce/Reference Group</td>
<td>Consider using the Dutch Palliantie matrix for the future EU project, Improvements of multidisciplinary SC in PC by training primary caregivers.</td>
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Table 4. Summary of Recommendations for policy making
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Learning spiritual care in Dutch hospitals


