Implementing spiritual care at the end of life: the Netherlands

The development and implementation of spiritual care in palliative care is developing rapidly in many countries. In this occasional series, members of the European Association for Palliative Care Taskforce spiritual care report on national developments across in order to share ideas and stimulate the implementation of spiritual care. Here, **Carlo Leget** discusses the recent progress in the Netherlands

Traditionally a country where the Roman Catholic tradition was widespread in the southern and eastern parts, and Protestantism in the northern and western regions, after World War II Dutch society has changed into a culturally diverse and strongly secularised landscape where Roman Catholic (27%), Protestant (16.6%), Muslim (5.7%), Hindu (1.3%), Buddhist (1%) and people with no faith system (48.4%, of whom humanist organisations claim to represent 9.4%) live together.[1]

Since 1996, spiritual care in healthcare institutions has been provided by chaplains, who are organised in a professional body that comprises all religious and non-religious denominations.[2] These chaplains (some sent by a church) work as spiritual caregivers who can work with patients whatever their religious (or non-religious) background.

Patients who are cared for at home are the most problematic group from the viewpoint of spiritual care. Most of them are no longer connected to local churches and are not being cared for by the chaplains working in institutions. In the last decade, developments have taken place that contribute to the implementation of spiritual care in both institutional and home-care settings.

Recent developments

First, a process of developing a national consensus-based guideline on spiritual care for physicians and nurses has contributed to finding a common language and point of reference for people coming from various traditions. The result of a long process in which professionals from various disciplines were invited to comment and contribute, the guideline has provided those who were motivated to implement spiritual care with an authoritative text that helped them to address their managers, directors and boards.[3]

Second, focusing more closely on content, the guideline has helped to orient and promote the education of healthcare professionals and volunteers. In the past five years, more attention has been paid to spiritual care in the advanced palliative care education of physicians and nurses. In some regions, the same development has been seen in the primary education of nurses.

Third, from 2007 onwards, chaplains working in palliative care have been trained in small groups (master classes) to understand

Key points

- The Netherlands is a majority secular country; the largest faith communities are Catholics and Protestants.
- Since 1996, spiritual care at the end of life has been provided by chaplains, who can be of any religion.
- Providing spiritual care for those being cared for at home is more problematic than for those in an institutional setting.
- Launched in 2010, a national spiritual care guideline has provided education and direction for healthcare professionals. It gives guidance on raising the issue of spiritual care with health boards, and has led to greater attention being paid to spiritual care provision in the training of healthcare professionals.

the chances and possibilities of their position in stimulating the implementation of spiritual care. Often, chaplains were not aware of how palliative care in the Netherlands is organised (66 regional networks in which healthcare organisations work together). Becoming aware of their key position, they were stimulated to reach out to other disciplines and settings. From 2012, chaplains' training is being developed in a multidisciplinary fashion, in which professionals of different disciplines become aware of their specific opportunities in this area. The co-ordinators of the regional palliative care networks have constantly been informed about the development of the spiritual care guideline in national conferences. Multidisciplinary groups on spiritual care were founded; these organised education of professionals and volunteers, training of consultation teams, and better structures for spiritual care at home. Recently, a promising new initiative was developed: a healthcare insurance company was prepared to pay over a period of three years for spiritual care at home provided by chaplains from healthcare institutions organised in a pool of professional volunteers.[4]

Conclusion

The implementation of spiritual care is a process intrinsically linked with, and based on, ongoing research and education. In a rapidly changing and multicultural society, such as that of the Netherlands, the process of working from a common point of reference, the national guideline, has proved to be successful. From the perspective of implementation, however, this is only a first step. Only when attention to spiritual care is a normal part of the primary education of healthcare professionals, and all patients are reached, can one really conclude that the process of implementation is accomplished.

Declaration of interest
The author declares that there is no conflict of interest.

References
1. Bernts T, de Jong G, Yar H. Een religieuze atlas van Nederland. In: van den Donk WBHJ, Jonkers AP, Kronjee GJ, Plum RJJM. *Geloven in het publieke domein. Verkenningen van een dubbele transformatie WRR*. Amsterdam: Amsterdam University Press, 2006.
2. *Kwaliteitswet zorginstellingen* [Care Institutions Quality Act] 1996.
3. Leget C *et al*. Richtlijn Spirituele zorg. In: de Graeff A, van Bommel JMP, van Deijck RHPD *et al* (eds). *Palliatieve zorg: richtlijnen voor de praktijk*. Utrecht: VIKC, 2010.
4. Morel B, Brüll M. Geestelijke begeleiding voor pallitieve patiënten thuis. Agora Working Conference Spiritual Care. Houten, the Netherlands, 2012.

Carlo Leget, Associate Professor, Ethics of Care, Tilburg University, the Netherlands

In the next issue …

- **Nadia Khan** and **Dan Munday** provide an overview of the palliative care implications of using non-invasive ventilation for end-stage COPD.
- **Jenny Baulkwill, Andrea Dechamps, Julia Manning, Ninon van der Kroft** and **Malcom Payne** report on an evaluation of support groups for young people who are providing palliative care in the home.
- **Piotr Krakowiak, Agnieszka Paczkowska** and **Robert Witkowski** provide details of an innovative Polish project using prisoners to volunteer in palliative care services.
- Making decisions about artificial nutrition in end-of-life care is complicated. **Nicholas Herodotou** presents a decision-making pathway to help.
- As part of the ongoing 'A day in the life' series, **David Glenister** provides insight into his work as a visual artist and pastoral care practitioner in Australia.
- The occasional series of articles on spirituality in the European palliative care setting continues with **Laura Campanello, Cinzia Martin** and **Filippo Laurenti** discussing Italy, and **Bella Vivat** covering the UK.
- **Giampiero Porzio, Federica Aielli, Marco Valenti, Lucilla Verna, Enrico Ricevuto, Katia Cannita, Paolo Aloisi** and **Corrado Ficorella** look at the prevalence of symptoms in end-stage cancer.
- **Usama Hasan** discusses the understanding of life, death and illness in Islam.

All future copy may alter at the publisher's discretion.