

Synopsis of 'Spiritual Care in a Hospital Setting. An Empirical-theological Exploration' by Wim Smeets.

8.1 Synopsis

In the introduction we outlined six research questions about institutional, worldview-related and professional factors pertaining to spiritual care and their effects on the goals of spiritual care (cf. scheme 8.1).

Scheme 8.1 Research questions

1. How do spiritual caregivers view quality assurance in health care?
2. How do spiritual caregivers view the function of worldviews in health care?
3. What are the personal worldviews of spiritual caregivers?
4. How do spiritual caregivers view the legitimacy and position of spiritual care as a professional discipline in health care?
5. How do spiritual caregivers see the goals and tasks of their profession?
6. What are the effects of health care, the spiritual caregivers' personal worldviews and the professional discipline of spiritual care on the goals of the profession, while controlling for relevant background variables?

Let us answer these questions, with reference to conceptual and empirical material from earlier chapters.

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How do spiritual caregivers view quality assurance in health care?

One of the principal developments in health care is quality of care. We confine ourselves to quality assurance at the meso level of care institutions and at the micro level of interaction with care consumers. In our scrutiny of quality care at meso level we focus on the phenomena of proceduralisation, protocolisation and registration. We define procedures as legitimised, routinely monitored standard events in an organisation, and protocols as comprehensive documents spelling out the goals, plan of approach and agreements on evaluation and management. In quality assurance there is a risk of excessive bureaucratisation, manifested in such things as goal modification and undermining solidarity with care consumers. Care procedures and protocols also have implications from a worldview and ethical perspective. Spiritual caregivers are critical of proceduralisation and protocolisation and are keenly aware of the danger of bureaucratisation. They consider reflection on worldviews and ethics important. By registration we mean creating and maintaining a register of professionals, who have to meet certain requirements in regard to training, refresher courses and professional practice to qualify for registration. This is a way of regulating, promoting and safeguarding the quality of their work. Spiritual caregivers are moderately positive about professional registration. As for quality care at the level of interaction with care consumers, there are three conditions such care should meet in recognition of the self-determination to which patients are entitled by virtue of their intrinsic human dignity. From the patients' point of view it is a matter of safeguarding their rights, inter alia by means of the right to self-determination. On the part of caregivers it involves two attitudes:

compassion in the sense of empathy with others because of the suffering they have to endure, and symmetry in the sense of equality and reciprocity in relations between caregiver and patient based on the fellowship of the weak. Their interaction entails demand-driven care at micro level, that is methodical action in which caregiver and patient jointly solve problems. Spiritual caregivers maintain that patients' self-determination is given only limited recognition. They attach particular value to the attitudes of compassion and symmetry as the way to patient-oriented care. They are ambivalent about a patient-oriented, demand-driven approach in their interaction with patients.

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Conclusion: spiritual caregivers favour quality assurance mainly at micro level, and to a much lesser extent at meso level. The motion of quality care centres chiefly on their own attitude of compassion and symmetry in their relations with patients and takes little account of organisational aspects and preconditions at the meso level of the institution.

How do spiritual caregivers view the function of worldviews in health care?

We break up the question about the function of worldviews in health care into two sub-questions: how does a worldview approach relate to the medical approach, and what functions do worldviews fulfil in health care?

In response to the first question we consider the medicalisation of health care. This is manifested partly in somatisation, which puts the accent mainly on the physical aspect of health, and partly in medical compliance in the sense of a strong orientation to the medical profession as the bringer of 'salvation and healing'. Spiritual caregivers are ambivalent about the idea that medicalisation imposes any restriction on the scope for worldviews. Worldviews have their own place in health care: the assimilation and endurance of illness, suffering and death in a perspective of contingency. The experience of the transience of life—in relation to mortality—is crucial to patients; this establishes a link with worldviews where that experience, and responses to it, are likewise focal. Spiritual caregivers are doubtful whether contingency (i.e. transience and mortality) are in fact so crucial; they clearly do not rate it very highly.

Regarding the functions of worldviews, our answer is as follows.

Worldviews have two functions, one intrinsic, the other extrinsic.

These may be viewed from the perspectives of both spiritual caregiver and patient. The intrinsic function concerns the experience that a worldview is valuable in itself. The extrinsic function is the 'usefulness' of worldviews for patients' health, more particularly for the processes of healing and assimilation. Spiritual caregivers agree unanimously that communication about worldviews contributes to the spiritual aspect of health, hence they put the accent on the extrinsic function. They find the intrinsic function, which relates to questions about the meaning of life, less important.

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What are the personal worldviews of spiritual caregivers?

The question of how spiritual caregivers see themselves in terms of

their own worldviews is answered as follows. The spiritual caregiver's personal identity is seen as a narrative identity. By that we mean that the integrated nature of human life corresponds with that of a narrative, and that people's identity takes shape through the stories they tell about themselves or that others tell about them. Following Ricoeur, we differentiate between three aspects of identity: historicity, sociality and praxis. At a historical level the focus is the uniqueness of the human person, that is the way humans are constantly refashioning the relation between continuity and discontinuity. Under sociality the focus is attestation in the sense of a vulnerable commitment and a promise to the other. At the level of praxis we concentrate on its passive side, which in a health care context chiefly concerns suffering and the tragedy of life. Spiritual caregivers take a narrative view of their personal identity and emphasise both its uniqueness and its pathic nature. They attach less value to the attestatory aspect of personal identity.

As for spiritual caregivers' worldviews, we follow Geertz's distinction between three dimensions of worldviews: culture, meaning and ritualism. Culturally it is a matter of the worldview prevailing in the person's environment. The dimension of meaning concerns the way an individual's worldview symbolises the ultimate order of existence, suffering and death. The ritual dimension of worldviews lies in establishing a connection between the everyday world and a symbolic order. In the first—cultural—dimension of worldviews we distinguish between four terms: collective worldview, worldview associations, tradition and multiple worldviews. By collective worldview we mean that people assign meaning to the world in terms of supra-individual symbolic systems. As for worldview associations, their power is declining at present as they undergo a process of de-institutionalisation. Nonetheless worldview traditions continue to form a major cultural substratum. Finally, a multiple worldview refers to openness to dialogue with other worldview traditions. Spiritual caregivers are negatively ambivalent about the significance of a collective worldview, implying that they set greater store by individualised worldviews. They value their own worldview tradition positively and are open to dialogue with other worldview traditions, but are fairly negative about their own worldview institution or association. We conclude that in a sense

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spiritual caregivers accept the individualisation and de-institutionalisation of worldviews. The same cannot be said of tradition: they attach great importance to worldview traditions and are perfectly open to engaging other traditions in dialogue on worldviews.

In the second dimension of worldviews—that of ascribing meaning—we distinguish between three terms: ultimate reality, suffering and death. The first term is differentiated into religious and nonreligious meaning. Under religious meaning we distinguish between panentheistic and deistic interpretations. The former regards God as both transcendent and immanent, as a close presence, even closer to us than we are to ourselves (Augustine). The latter regards God as absolutely transcendent, neither close to people nor caring about them. Under nonreligious meanings we differentiate between immanentist

and atheistic interpretations. The former claims that the meaning of life must be sought exclusively in this world, the latter that there is no such thing as a religious, universal order of existence. Spiritual caregivers from religious traditions believe in the existence of a transcendent reality and reject the immanentist and atheistic views. Spiritual caregivers from the humanistic tradition reject belief in a transcendent reality. They agree with the immanentist view and are ambivalent about atheism.

In the case of suffering we focus on the theodicy problem: how does one reconcile the experience of suffering with belief in an all powerful, benevolent God? Van der Ven identifies seven theodicy models. Three of them are oriented to transcendence: the apathy model, based on the assumption that God keeps aloof from suffering; the retribution model, which assumes that suffering is divine retribution for human sinfulness; and the plan model, which posits that suffering has a place in God's hidden plan for human history. Three of these models are immanently oriented: the solidarity model, which assumes that God has compassion with suffering humans and comforts them with his closeness; the vicarious suffering model, which assumes that God has solidarity with suffering humans and presents self-sacrifice for the good of others as a way to salvation; and the mystical model, which maintains that suffering establishes an intimate relationship between God and human beings. Midway on the continuum between transcendence and immanence is the developmental model, according to which God sees suffering as a means of purification. Spiritual caregivers from religious traditions subscribe to only one theodicy model—that of solidarity. The others they either

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reject or view with negative ambivalence; the transcendently oriented models in particular are rejected. Spiritual caregivers with a humanistic worldview reject all the theodicy models. They are particularly negative about the retribution and plan models, and object least to the solidarity and apathy models.

As for views on death, we distinguish between belief in life after death, reincarnation, immanentism and agnosticism. In the first case the belief is that death does not put a brutal end to life, but that it continues in a transformed state. Reincarnation holds that after death life on earth continues in a different guise. Immanentism is confined to what people can know and experience of death here and now without breaking their heads about what happens afterwards. The agnostic view is that human beings do not know whether there is any continuation of life after death. Spiritual caregivers from religious traditions subscribe to the traditional Christian conception of life after death, more particularly to the immanentist view. They are ambivalent about the agnostic attitude to death and reject reincarnation outright. Spiritual caregivers from the humanistic tradition concur with the agnostic and—very strongly—with the immanentist conceptions of life after death. They reject reincarnation and the Christian approach to life after death.

The third dimension of worldviews is ritualism. According to Geertz the performance of rituals gives the ultimate, symbolised reality of

worldviews an aura of factuality. This means that rituals occupy a focal place in worldviews, and are in fact called 'religion's final answer' to the contingency of life. Rites of passage, which mark the transition to a new social role or phase of life, have a distinctive function in health care as well. Spiritual caregivers from a religious tradition more or less agree with the significance of the ritual dimension generally and are positively ambivalent about the specific meaning of rites of passage. Those from the humanistic tradition are ambivalent about the significance of the ritual dimension generally and negative about the specific meaning of rites of passage.

How do spiritual caregivers view the legitimacy and position of spiritual care as a professional discipline in health care?

We distinguish between two aspects of spiritual care as a professional discipline: its legitimacy and its position in health care. Legitimacy concerns the various justifications of its claims as a health care

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discipline. These justifications may be couched in terms of health care, in terms of worldview and in terms of its own domain. The legitimacy of spiritual care in terms of health care derives from statutes and policy. Its statutory legitimacy hinges on the enabling Quality Care Institutions Act of 1996. Its legitimacy in policy depends on the approach to care outlined in the institution's policy and on its legitimacy from the patients' point of view—the value patients attach to worldview-related experience as such and their perception of its usefulness in treating health problems. Legitimacy in terms of worldviews stems from worldviews' notions of care and the contribution of worldviews to patients' health. Finally spiritual caregivers can base their case for the legitimacy and necessity of spiritual care on themes specific to their profession, such as transience, mortality, suffering and death. Spiritual caregivers find all the forms of legitimacy that we investigated important. They put most emphasis on the existence of a need for spiritual care among patients. We explore two possible positions of spiritual care in health care: isolation and integration. The first position is when spiritual care sees itself as distinct from other disciplines and claims a separate position in the organisation of the institution. Integration is when it neither isolates itself from other disciplines, nor adapts to them completely. In the case of integration the focus is process integration, where spiritual care is closely linked with the care process. Process integration presupposes integration at both the organisational level and that of policy making. Spiritual caregivers are in favour of integration and reject an isolated position in care institutions. The legitimacy and position of spiritual care can also be approached in a worldview perspective, which is when an official ministry and a privileged position enter into it. Here we focus on arguments for and against such legitimacy at the micro level of relations with patients, the meso level of the care institution and the macro level of health care and society. At micro level the argument for spiritual care as an official ministry is that it facilitates dialogue with patients in that caregivers communicate better with patients from the same worldview tradition; the counter argument is that the significance of

spiritual care remains confined to its ritual task. At macro level the argument for this form of legitimacy is based on the importance of representing a worldview association, and the counter argument on the dwindling social significance of these associations as a result of de-institutionalisation and de-traditionalisation. Spiritual caregivers

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disagree with the idea of the limited significance of the official ministry—both in society and in their tasks in interaction with patients.

They endorse the notion of representing a worldview association via the ministry, but doubt whether adherence to the same worldview tradition as the patient facilitates dialogue. Finally, when it comes to spiritual caregivers' rating of the ministry in terms of their personal worldview, we find that they assign it positive value. In the case of the privileged position of spiritual care we turn to the meso level: exemption from accountability to other disciplines (argument for) versus the risk of marginalisation in the institution (counter argument). Spiritual caregivers concur with the value of a privileged position in the sense of freeing them from accountability; they disagree with the notion that such a position results in a marginal position in the institution.

Spiritual caregivers handle the plurality of worldviews in various ways. It affects both their relations with other spiritual caregivers and their relations with patients. An option for counselling patients belonging to the same worldview association means that spiritual care will be denominational or categorical: counselees are selected on a denominational basis. Non-denominational or territorial spiritual care operates departmentally. Spiritual caregivers prefer a territorial mode of operation. By multiple worldview patient counselling we mean that no distinction is made between patients with different worldviews. Spiritual caregivers are positive about this kind of counselling. Multiple worldview cooperation means openness to, and cooperation with, caregivers who hold other worldviews. Spiritual caregivers are solidly in favour of such cooperation in spiritual care.

How do spiritual caregivers see the goals and tasks of their profession?

The professional activities of spiritual care relate to two aspects: goals and tasks. The goals of spiritual care are the results that spiritual caregivers hope to achieve with their activities and that may be regarded as generally feasible. Here we make a distinction between immediate goals and the ultimate goal at micro level, and the goal at meso level. The immediate goal of spiritual care at micro level is to promote communication on worldviews in interaction with patients. This communication has four aspects. First, it is experiential and affective: spiritual care focuses on worldview-related experience, questions and existential feelings. The second aspect is cognitive,

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in that spiritual care is aimed at exchanging worldview-related beliefs. The third aspect is social and moral, in that spiritual care concerns the moral aspect of social relations. Fourthly, there is a ritual aspect: spiritual care promotes patients' ritual expression of their worldview. The ultimate goal of spiritual care at micro level is to contribute to

the spiritual aspect of mental health: assigning life ultimate meaning as a contribution to health. At meso level the goal, which creates the conditions for goal achievement at micro level, is that spiritual caregivers, in interaction with other caregivers and institutional policy, should focus on the worldview dimension of care. Spiritual caregivers endorse all these goals. They attach most importance to the experiential-affective goal and the ultimate goal of promoting the spiritual aspect of mental health. The cognitive goal is rated least important.

Three broad orientations to the goals of spiritual care are examined. Spiritual care may concentrate primarily on patients' experience by assisting their self-discovery and offering comfort and encouragement. The second approach is challenge-oriented: patients are helped to evaluate their experience and are challenged to observe it detachedly with a view to future change. Finally spiritual care may be aimed at its own mission or message, with the accent either on the subjective inspiration of the spiritual caregiver (testimony) or the objective substance of the message (creed). Spiritual caregivers attach great importance to an experiential orientation; they consider the challenge orientation important but are negatively ambivalent about a mission orientation.

The tasks of spiritual care are the activities undertaken in pursuit of its goals. We explore various activities: aspects of counselling conversations, rituals, and supra-disciplinary interaction with fellow caregivers and policy makers. We investigated the following aspects of counselling conversations: their human fellowship character, in the sense that patient and spiritual caregiver engage in the relationship as fellow human beings; a demand/supply structure, in which the spiritual care supplied corresponds with patients' demands and needs; and initiation of communication by spiritual caregivers. Spiritual caregivers are in favour of a demand/supply structure and taking the initiative in establishing relations with patients; they reject a purely human fellowship approach.

Rituals have an individual and a collective dimension. The individual dimension has an experiential-expressive and a cognitive aspect,

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while the collective dimension has a moral and a social aspect. The experiential-expressive aspect pertains to the way participants experience a ritual and to symbolic expression as the key component of rituals. The cognitive aspect concerns the worldview-related beliefs that the ritual conveys. The moral aspect refers to the link the ritual establishes with the norms and values embedded in the worldview, and the social aspect to the bond between the individuals enacting the ritual. Spiritual caregivers attach most value to the experiential-expressive and social aspects of rituals; they consider the cognitive aspect less important. They are negatively ambivalent about the moral aspect of rituals.

Supra-disciplinary consultation has a communicative and a managerial dimension. The communicative dimension is characterised by competition, division and image problems. Competition occurs when spiritual care and other disciplines regard each other as rivals; division

refers to the disparity between spiritual care and other disciplines as regards goals, concepts and methods; image problems arise to the extent that other disciplines may have a narrow or negative image of spiritual care. The managerial dimension refers to support for spiritual care, or the lack of it, on the part of institutional management. Spiritual caregivers deny that there is any competition with other disciplines, are ambivalent about image problems and division, and claim to receive sufficient managerial support.

What are the effects of health care, the spiritual caregivers' personal worldviews and the professional discipline of spiritual care on the goals of the profession, while controlling for relevant background variables?

The last research question concerns the determinants of the goal orientation of spiritual care. To investigate the goal orientation we focus on the goals, both immediate and ultimate, of interaction with patients. The immediate goal, we have said, is to promote communication on worldviews, which we differentiate into four aspects: experiential-affective, cognitive, social-moral and ritual. The ultimate goal is to promote the spiritual aspect of health. Our aim is to find out how these goals are affected by three sets of variables: health care, personal worldview and the professional discipline. In the process we control for a number of background characteristics: gender, training and membership of a professional association; two worldview-related

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characteristics (denomination and ministerial approval); and the spiritual caregiver's workplace, classified into institutions where patients are admitted for a short period only and institutions where admission is long-term.

Health care, personal worldview and professional discipline have the greatest predictive power in regard to three of the worldview-related goals: the experiential-affective, cognitive and ritual goals. It has least impact on the social-moral goal, and its impact on the ultimate goal, the spiritual aspect of health, is also limited.

To some extent the predictive power of health care applies to the social-moral and ritual goals, and to a lesser extent to the ultimate goal (spiritual aspect of health). Personal worldview has most predictive value for the experiential-affective, cognitive and ritual goals, but the spiritual caregiver's personal worldview plays hardly any predictive role in regard to the spiritual aspect of health. Professional discipline has most predictive power for interaction goals, more particularly the experiential-affective, cognitive and ritual goals and the spiritual aspect of health. When it comes to the effects of professionalism, personal worldview and health care as an institution on the goals of spiritual care, professionalism has most impact, personal worldview comes second and health care as an institution has least. An overview of the findings highlights three potential dangers for spiritual care. The first is that worldviews may be functionalised in the sense of being reduced to their extrinsic function. The second is that the legitimacy of spiritual care may become overly individualised. Spiritual caregivers tend to locate the legitimacy of their profession from the perspective of its goals mainly at the individual level of patients' demands and needs and themes pertaining to spiritual

caregivers' own domain. They attach little or no importance to statutory and managerial legitimacy or to legitimisation by their worldview association. The third danger is that of 'de-legalising' spiritual care in the sense that it is losing its significance as an official ministry. At the level of interaction with patients there are signs of a negative association between ministry and professionalism. These three trends give spiritual care a pronounced dyadic character: its legitimacy and goals depend largely on the interaction between spiritual caregiver and patient and their input into that interaction; spiritual caregivers do not perceive much support for their work from outside agencies.

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