PROFESSIONAL STANDARD
SPIRITUAL CAREGIVER 2015

Vereniging van Geestelijk VerZorgers

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<h1>Introduction

Spiritual care is in transition. Practiced for centuries, it adapts to ever-changing circumstances. In the Netherlands, we see the following major developments:

- The role of traditional churches in the Dutch religious/spiritual landscape has diminished, whereas the number and the diversity of religious/spiritual sources have increased.
- The healthcare system – a major field of operation for spiritual care – is increasingly characterized by market forces; brief hospitalization periods, with as much care as possible to be provided within the patient's home environment; improved medical technology, sparking old and new ethical questions; and an increased focus on compliance with standards and protocols.
- Spiritual caregivers have to re-define their role. Many are employees, but a significant number now operate as independent professionals. Many have an endorsement from an officially recognized religious or spiritual organization, but a significant number now have a mandate issued by the Raad voor Institutioneel Niet-Gezonden Geestelijk Verzorgers (Council of Institutionally Non-Commissioned Spiritual Caregivers).
- Spiritual caregivers increasingly provide care for fellow staff members and for their organization as a whole.
- The establishment of Stichting Kwaliteitsregister Geestelijk Verzorgers SKGV (Foundation Quality Register Spiritual Caregivers) reflects the increasing focus on professionalism in spiritual care.

The present *Professional Standard* seeks to do justice to these far-reaching developments. Instead of a reworking of the earlier *Standard* (2002, revised version 2010), this is a completely new text. It comprises the following elements:

I. Professional profile

As an outline of what a spiritual caregiver is, the professional profile is for use in positioning and profiling spiritual care. The intended readership includes interested parties who are not themselves active as spiritual caregivers, such as clients, managers, and fellow professionals in other disciplines.

II. Quality Standard

The Quality Standard includes, first, a definition of spiritual care, with specifications of its aim, domain, dimensions, activities, characteristics, and roles. Second, it specifies the various qualifications that a spiritual caregiver has to meet. Finally, it lists the several types of spiritual care. The intended audience of these detailed descriptions consists of the members of the profession themselves, the trainers, and the purchasers.

III. Professional Code

The Professional Code is comprised of the rules of conduct to which spiritual caregivers have to comply while exercising their profession. The Complaints Statute is part of the professional code. It specifies how complaints about spiritual caregivers acting against the Professional Code are handled.

Appendix I
A further explanation of the core definition and the competences of spiritual care.

Appendix II
An outline of the history of the profession of spiritual care in the Netherlands.

The Professional Standard indicates what can be expected of a spiritual caregiver. It is intended for both external and internal use. Externally, it will serve as a reference document in any situation where spiritual care is on the table, i.e. in consultations with employers, clients and clients' organizations, commissioning or mandating institutions, educational institutions, health insurance companies, and the government. Internally, it will serve as a basis for the continued development of the profession, in consultations on local, regional and national levels. Finally, the Professional Standard will be a source of information for those who are not themselves active as spiritual caregivers but to whom spiritual care is relevant in one way or another.

The Professional Standard pertains, first of all, to spiritual care in healthcare situations. Yet its wording seeks to be applicable to spiritual care in other settings (such as the military, the judiciary, and the police) as well. It is recommended that the Professional Standard be worked out so as to reflect the specifics of the various work settings, in health care and beyond, where spiritual care is provided.

Draft versions of the Professional Standard have been submitted to parties such as healthcare managers, educational institutions, religious/spiritual organizations, and (associations of) spiritual caregivers in various work settings. The commission responsible for the Professional Standard is grateful for their many valuable comments.

The Commission for the Review of the Professional Standard was established December 3, 2013, by the General Board of VGVZ. Its members were drs. Suzan Doodeman, drs. Christien den Draak, drs. Roel Hekking, drs. Vicky Hölsgens (minutes secretary), drs. Jan Hein Mooren, drs. Ralf Smeets, drs. Joost Verhoef (president), drs. Lydie Vermeulen, prof. dr. Martin Walton.

The Professional Standard was adopted by the VGVZ General Assembly on June 22, 2015.

<h1>I. Professional profile of the spiritual caregiver

This professional profile offers an outline for clients, managers, professionals in other disciplines, referrers, and other interested parties, of what the profession of spiritual caregiver entails.

<h2>What is spiritual care?

Spiritual care is professional support, guidance and consultancy regarding meaning and world views. Spiritual caregivers enter the scene at times when the routine of normal daily life is disrupted: in situations of life and death, parting and loss; when there is an intense sense of belonging, or abandonment; or when moral dilemmas present themselves. They are experts in dealing with existential questions, questions on the meaning of life, spirituality and ethical considerations.

<h2>What does a spiritual caregiver do?

Spiritual caregivers offer guidance to both individuals and groups, typically through conversation. They seek to uncover the client’s sources of strength and inspiration, in relation to the client’s own life narrative and religious/spiritual background. They can also provide support through rituals and sacraments.

Spiritual caregivers help safeguard the constitutional freedom of religion and belief for people living in a healthcare institution, for detainees, and for military personnel. This is referred to as the ‘sanctuary’ function, as it offers access to spiritual assistance to all citizens, without control or approval by any third party.

Spiritual caregivers may also be called on by other professionals and the management within their organization. They play an advisory role in matters concerning ethics and beliefs, they contribute to staff training, and they help shape the religious/spiritual outlook of the institution as a whole.

Spiritual caregivers engage in interdisciplinary cooperation, while observing their professional confidentiality.

Spiritual caregivers can be employees as well as independent professionals.

<h2>For whom?

Spiritual caregivers can be called on by anyone, irrespective of the caller’s religion or convictions. In principle, each spiritual caregiver is capable of providing spiritual care to each client. A client who specifically wishes to see a spiritual caregiver of the same background will be referred accordingly. Likewise, when spiritual caregivers meet the limitations of their own competence, they will refer the client to a colleague.

<h2>What is the spiritual caregiver’s background?

Spiritual caregivers have an academic or a professional master’s degree in Theology, Humanistic Studies or Religious Studies. They are either endorsed by an officially recognized religious or spiritual organization or mandated by the Raad voor Institutioneel Niet-Gezonden Geestelijk Verzorgers (Council of Institutionally Non-Commissioned Spiritual Caregivers). An endorsement issued by a religious or spiritual organization implies the authorization to act as a representative of that community.

<h2>What are a spiritual caregiver’s competences?

Each area of activity (care, judiciary, military) requires its own specific competences. However, all spiritual caregivers are capable of reflecting on religious, spiritual and ethical issues that present themselves in their personal lives as well as within organizations.

- Spiritual caregivers have a broad knowledge of meaning and world views, religion, spiritual resources, and ethics.
- Spiritual caregivers are capable of sharing their knowledge and reflections with others, and of bringing people together.
- Spiritual caregivers have their own authentic spirituality, which they actively maintain and which constitutes the foundation of their work.

Inclusion in the Stichting Kwaliteitsregister Geestelijk Verzorgers SKGV (Foundation Quality Register Spiritual Caregivers) ensures that spiritual caregivers maintain an adequate level of knowledge and skills through continuous further training.

<h2>Professional Code and Complaints Statute

As members of the Netherlands Association of Spiritual Caregivers (VGVZ), spiritual caregivers endorse the Professional Code. They are subject to disciplinary law. When applicable, clients or organizations may file complaints against spiritual caregivers in accordance with the provisions of the Complaints Statute.

<h1>II. Quality Standard

<h2>1. Definition

Spiritual care is professional support, guidance and consultancy regarding meaning and world views.[1]

There are four dimensions to the notions of ‘meaning and world views’.

a) The existential dimension, pertaining to a person’s existence as it is experienced in its everyday reality and with its (contingent) experiences of horror, and wonder, and all things in between.
b) The spiritual dimension, pertaining to transcendental meaning and experience.
c) The ethical dimension, pertaining to values, standards and responsible conduct.
d) The aesthetical dimension, pertaining to constitutive experiences of natural and cultural beauty.

<h3>1.1 Aim

Individually and together with others, people search for purpose and meaning in their lives. Exceptional or stressful situations – such as childbirth, death, illness, disability, confinement, foreign military operation, bonding, transition, loss, or trauma – move people to feel that their sense of purpose and meaning is at stake. They lack orientation, as connections are disrupted or subjected to change. Professionals and organizations can likewise be confronted with important questions of meaning, pertaining to motivation, inspiration, mission and ethics.

Spiritual care, by paying specific and methodic attention to questions of purpose, meaning, and belief, enhances people’s well-being. It improves the way they relate to themselves, to others and to their personal environment. It also helps professionals, networks and organizations to improve their functioning. Its aims are to foster spiritual growth, resilience, strength, and control, and to reduce vulnerability.

In their professional contacts, spiritual caregivers tune in on the client’s motivation, focusing on their sources, strengths, and perspectives, by means of conversation, ritual, presence and whatever may be expedient. Worship ceremonies, art projects, mediation, consultation and education also belong to their scope of activities.

Spiritual caregivers, in their various work settings, fulfill the ‘sanctuary’ function that derives from the constitutional freedom of religion and belief. The ‘sanctuary’ ensures access to spiritual guidance for all citizens, without indication, control or approval by any third party.

[1]See Appendix I for an account of the terminology used in this document.

<h3>1.2 Domain

The aspect of ‘spirit’ in spiritual care refers to the human desire to derive meaning from life and assign meaning to life, which expresses itself in an active appreciation of life and a quest for connection and orientation.

‘Meaning system’ and ‘world view’ are related concepts which cover various aspects of the quest for meaning, and religious practice: formal and informal, passive and active, communal and individual, related to both process and content. Thus defined, the domain of spiritual care is related to the disciplines of Theology, Humanistic Studies, and Religious Studies. Building, in addition, on insights and using skills from Social Sciences related to professional care and service settings, the spiritual caregiver is capable of reflecting on religious, spiritual and ethical issues that present themselves in society at large and in specific contexts. Spiritual caregivers are active as employees or as independent professionals. Spiritual caregivers have specialist knowledge of their specific work settings, and can employ methods appropriate to those settings. Spiritual caregivers have broad as well as in-depth knowledge of human quests for meaning.

<h3>1.3 Activities

Spiritual care involves support, guidance and consultancy, on three levels:

a) The micro-level concerns individuals with their personal quest for meaning, motivation, and inspiration; their personal struggle when faced with adversity and bereavement; their longing for a good life; and their aspiration to realize their own religious/spiritual potential.
b) The meso-level concerns professionals and volunteers in care and service institutions. The spiritual caregiver’s work includes moral deliberation and education programs.
c) The macro-level concerns organizations and networks. The spiritual caregiver’s work includes advising on policy fostering the organization’s sense of identity, participating in networks and discussions.

<h3>1.4 Characteristics

Spiritual care tunes in to the client’s life narrative and addresses their specific questions on life. Spiritual care does not confine itself to one aspect of human existence. It can be provided in various shapes and forms, always in function of the client’s background and needs.

<h3>1.5 Roles

a) The spiritual caregiver acts as a *counsellor* to people who are facing existential crises, and helps people develop their spirituality and art of living. Individually or in a group, through conversation or ritual, the spiritual caregiver offers help and support for every individual’s way of coping.

b) To many people, the spiritual caregiver acts as a *representative*, e.g. of some specific religious or spiritual tradition or, more generally, of the realm of meaning and world views as such. In this role, the spiritual caregiver fulfills a sanctuary function, which safeguards the client's constitutional freedom of religion and belief.
c) The spiritual caregiver acts as a *liturgical leader* in prayer services, meditational gatherings, and rituals.
d) The spiritual caregiver acts as an *educator*, offering training and instruction in religious/spiritual and ethical matters, to professionals, volunteers, and future spiritual caregivers.
e) The spiritual caregiver acts as a consultant to fellow-professionals in such projects or processes which involve religious/spiritual and ethical matters.
f) The spiritual caregiver acts as a *coordinator* of volunteers and professionals in projects or processes aimed at enhancing or maintaining the quality of care and service in a broad sense.

<h2>2. Qualification

<h3>2.1. Legitimacy

a) The spiritual caregiver's *expertise* is derived from an academic or a professional master's degree in Theology, Humanistic Studies or Religious Studies, from practical experience, specialization, and from permanent education.
b) In addition, the spiritual caregiver as conceived of in this Professional Standard must either have received an *endorsement* from an officially recognized religious or spiritual organization or be *mandated* by the Raad voor Institutioneel Niet-Gezonden Geestelijk Verzorgers (Council of Institutionally Non-Commissioned Spiritual Caregivers). One of the functions of this authorization is to safeguard the sanctuary function to which each client is constitutionally entitled.
c) Through *registration*, the spiritual caregiver demonstrates his or her initial education at an accredited institution, continued efforts to maintain a sufficient level of expertise through permanent education, and authorization by either endorsement or mandate.

<h3>2.2 Competences

In order to professionally fulfill the various roles defined above, the spiritual caregiver must possess certain competences that are acquired through education and training. Each role requires several competences, and each competence can be relevant to more than one role. Roles and competences thus are dynamically related to each other and to the contexts in which they are implemented.

<h4>A. Substantive competences

Substantive competences pertain to the spiritual caregiver’s work regarding meaning and world views.

Hermeneutic competence: the ability to clarify questions of meaning, to shed light on beliefs and customs relevant to the context or the situation, and to provide religious and worldview counseling. This competence includes the ability to detect, articulate and interpret meaning as it is contained in texts, images, practices, life narratives, traditions and new forms of spirituality – relating to existential and spiritual questions, sources of beliefs and ethics, modern society, religion and culture. The crucial ability is to detect and articulate emotions, unasked questions, and implicit assumptions.

Therapeutic competence: the ability to be mindfully present with others, to listen to them, to systematically clarify and analyze their life questions and crises, to offer them assistance in coping and in their quest for (life) orientation, and to help them realize their art of living. This competence uses knowledge of therapeutic processes, and distinguishes between sound and unsound forms of spirituality and religion.

Spiritual competence: the ability to help people discover and renew sources of spirituality and belief. This competence is based on a broad knowledge of such sources, and the ability to adapt and present them where necessary in rituals and symbolic ways of expression.

Ethical competence: the ability to facilitate reflection on ethical aspects of care and service, and to clarify ethical questions and moral dilemmas through moral counseling and moral deliberation.

<h4>B. Process-oriented competences

Process-oriented competences pertain to the organizational and social contexts within which the spiritual caregiver is active.

Agogic competence: the ability to assist individuals as well as groups in processes of change and growth, aiming at development, change, and growth in humanity and spirituality.

Mediating competence: the ability to act as an intermediary or an advocate in internal and external networks (including public and religious organizations), concerning guidance of people, ethical questions and the interaction between belief and the care and service industries. The crucial ability is to create openness while ensuring confidentiality.

Communicative competence: the ability to establish contacts and promote exchanges of information and ideas between people in various contexts, from various walks of life, aimed at the best possible support, cooperation, and information supply; and the ability to bring across what spiritual care has to offer, both generally and in specific situations.

Educational competence: the ability to educate, train, and advise individuals as well as groups concerning the spiritual aspects of care and service provision;

and the ability to enhance sensitivity to other people’s perspectives with professionals and volunteers.

Organizational competence: the ability to engage in interdisciplinary cooperation, to facilitate processes, to actively participate in teams and networks; being a loyal, critical and accountable colleague and employee in one’s organization or network, being aware of organizational and social contexts, and knowledgeable about relevant rules and regulations.

Methodic competence: the ability to file, register, document, analyze and evaluate one’s own professional activities, aimed at quality improvement; the ability to make use of the results of research, and to take part in research; the ability to articulate and clarify what one has to offer and how one can help realize goals; the ability on a structural level to make more people acquainted with spiritual care and promote its availability.

<h4>C. Personal competences

Personal competences pertain to integrity and self-reflection as requirements for practicing spiritual care, and as a basis for determining which roles and competences are required in any given situation.

Self-reflective competence includes autobiographical and religious/spiritual reflection, the ability to reflect on one’s own world view, so as to be able to reach out to others in a balanced, free and authentic way.

Dialogical competence: the ability, in interactions, peer exchange and supervision, to recognize one’s own assumptions and biases, and to respect other people’s identities and points of view.

Existential competence: the ability to take position in existential, spiritual and ethical questions, in order to authentically and responsibly reach out to others.

Integrative competence: the ability to integrate various competences, responsibilities and roles in one’s own thinking, sentiments, aspirations, and actions.

<h2>3. Differentiation of qualifications

Spiritual caregivers come from different backgrounds, have degrees issued by various educational institutions, are authorized by a wide range of bodies, and are deployed in various ways. Hence the qualifications of spiritual caregivers can be differentiated as follows.

<h3>3.1 According to education

The Quality Standard that has been worked out in the previous sections comprises a range of activities and roles of a spiritual caregiver, as well as the competences they require. To meet this standard, the spiritual caregiver needs

to have an appropriate level of education. European regulations define several levels of education, each with its own characteristics.[2] Each level has its own rankings for aspects such as autonomous functioning, complexity of tasks, responsibility, use of skills, (application) of knowledge and understanding, judgment, communication, and learning skills.

These rankings make it possible to find matches between specific education programs and specific professions, so as to answer the question, which education program at which level is required for any given profession?

The Quality Standard of the spiritual caregiver requires a certain level of functioning on the aspects just mentioned. Typical requirements are the ability to apply skills and knowledge in various and new situations; to conduct interdisciplinary discussions; to communicate with and to teach coworkers on all levels within the organization. In addition, the ability to autonomously shape one's own practice and to develop and assess one's own professional functioning. This level of functioning corresponds to the attainment levels of a master's degree.[3]

The required capability, the master's degree, is differentiated as follows:

a) Most spiritual caregivers have an **academic** (university) master's degree in Theology, Humanistic Studies or Religious Studies. This academic background enables them to contribute to the further development of their profession through active participation in research. In addition, they are used to integrating insights and results from neighbouring disciplines such as psychology, psychotherapy, social sciences and communication sciences. Complex interdisciplinary sharing of ideas, and therapeutic consultations likewise require an academic background. For admission to the profession of spiritual caregiver, this background needs to be supplemented by an internship.
b) The **professional** master Spiritual Care (from an institute of applied science) is a professional training with a strong practical component. This educational program highlights all aspects of practicing the trade in various types of organizations, as well as focusing on the skills of an independent professional. In all programs, internship is an important part of the curriculum.

<h3>3.2 According to authorization

The spiritual caregiver, as a professional with specific competences, is at the same time the guardian of the 'sanctuary' which safeguards the exercise of the client's right to freedom of religion and belief. This position derives from the role of the spiritual caregiver as a representative of a religious/spiritual tradition, or, more generally, from the role as a mediator of religious and worldview issues. Authorization for these roles cannot be arbitrarily owned by

[2]European Qualifications Framework (EQF), adopted by the European Parliament on April 23, 2008 as an implementation of the 1999 Bologna Declaration.
[3]EQF level 7.

just anyone, but can only be attributed upon due appraisal of the spiritual caregiver's qualities.

In addition, the spiritual caregiver's personal attitude is an important aspect of the realization of authorization. This attitude is arises from the use that is made of religious and worldview sources. The spiritual caregiver is able to use those sources in personal life as well as in professional practice, recognizing them and making them available in guidance of patients and clients. The personal attitude also requires appraisal.

There are two types of bodies that can confer authorization based on appraisal:

a) A religious/spiritual organization may confer an **endorsement**, testifying that the spiritual caregiver has been educated and trained within its religious/spiritual tradition. In function of this mission, the spiritual caregiver may act as (ordained) representative of the endorsing organization, and in some cases as a celebrant in leading ceremonies, performing particular rituals and rites.
b) The Raad voor Institutioneel Niet-Gezonden Geestelijk Verzorgers (Council of Institutionally Non-Commissioned Spiritual Caregivers) may confer a **mandate**, testifying that the spiritual caregiver has been educated and trained to work in the field of religion and world views, which he/she represents in professional practice. The authorization also makes the spiritual caregiver into a bearer and representative of one's own religious or worldview sources.

The types of qualifications just discussed can be summarized as follows:

- Academic master's degree, and endorsement
- Academic master's degree, and mandate
- Professional master's degree, and endorsement
- Professional master's degree, and mandate.

<h1>III. Professional Code for Spiritual Caregivers

<h2>1. Preamble

1. This Professional Code, in conjunction with the Quality Standard and the Quality Register, is an important safeguard for the quality of the spiritual caregiver. The Professional Code and the rules of conduct that derive from it can be considered to be a form of self-regulation. They function as standards of professional appraisal for spiritual caregivers who are members of the professional organization VGVZ. By joining the VGVZ, the spiritual caregiver agrees to adhere to the Professional Code.

2. Wherever applicable, any regulations issued by the spiritual caregiver's employer and/or their commissioning body apply alongside this Professional Code (cf. below, section 4.1, the Preliminaries of the Complaints Statute, article 53).

3. This Professional Code is to a certain extent a *target* code which articulates important ideals worth pursuing. It also contains concrete rules of conduct, enforceable by the professional group, that define a lower *limit* which members of the professional group shall not trespass.

a) To members of VGVZ, the relevance of the Professional Code lies in its formalizing the norms and values that spiritual caregivers are supposed to uphold.
b) To external parties, the Professional Code ensures that upholding these norms and values meets the government's and the general public's demands regarding provision of good care.
c) To the client,[4] the Professional Code offers a normative base for their trust relationship with the spiritual caregiver.

4. In the case of suspected non-compliance with the Professional Code, the client or any other interested party has the right to file a complaint with the Complaints Commission of VGVZ. (cf. the Complaints Statute, section 4 below).

5. The Professional Code as presently formalized is not static. It will have to be reviewed and adapted to new circumstances on a regular basis. In addition, case-law as it evolves will be one of the determinants of the spiritual caregiver's conduct.

6. As of its adoption by the VGVZ General Assembly, the present Professional Code (in its original Dutch version) substitutes all earlier versions of the professional code, which are now annulled.

<h2>2. Preliminaries

7. The spiritual caregiver respects each person's uniqueness and dignity. As a matter of principle, each person is entitled to receive spiritual care, irrespective

[4]The term, 'client', covers patients, residents, coworkers, volunteers, inmates, and military personnel.

of their ethnic background, nationality, age, sex, sexual orientation, political preferences, way of life, personal beliefs, or social status.

8. There is a distinctly personal component to the contact between the spiritual caregiver and their clients, clients' relatives, and co-workers. The spiritual caregiver, therefore, is accountable for who they are and what they stand for.

9. The spiritual caregiver is constantly aware of the asymmetrical relationship between themselves and their client. The spiritual caregiver does not exploit the authority deriving from their expertise and/or position.

10. The spiritual caregiver is personally accountable for their professional conduct. They therefore maintain an appropriate level of knowledge, attitude, skills and spirituality, through education, training, peer review, supervision and collegial assessment, following the criteria as detailed by the Quality Register.

11. The spiritual caregiver has their own well-considered and authentic world view, being at the same time open and respectful towards other beliefs.

12. The spiritual caregiver shall always act, both professionally and in their personal lives, so as not to harm the dignity of the profession and the reputation of spiritual care.

13. The spiritual caregiver is aware of the fact that their own conduct is often determined by a weighing of interests. They aim at providing transparency, and are ready to be held accountable for their actions.

<h2>3. Rules of Conduct

14. The spiritual caregiver's practice is characterized by respect, personal integrity, confidentiality, collegiality, and an interdisciplinary orientation. This leads to the following rules of conduct.

<h3>3.1 Respect

15. The spiritual caregiver's attitude towards the client is characterized by respect for the client as a person and an awareness of the client's own responsibility. The spiritual caregiver shall act in dialogue with the client (or, if necessary, with the client's legal representative) as much as possible.

16. The spiritual caregiver is responsible for any guidance, assistance and consultation provided to their clients.

17. As a matter of principle, spiritual care is available to anyone who might request it. In case of such a request, the spiritual caregiver will indicate within a reasonable period of time whether and in what way they are able to provide the care requested.

18. If the spiritual caregiver cannot, for whatever reason, meet the request for spiritual care, or if they wish to discontinue an existing care contact, they

present their considerations to the (prospective) client. Upon request, they advise the client on further steps and ensure proper referral.

19. The spiritual caregiver ensures that the care contact between themselves and the client can be entered into, continued, and discontinued freely. The client has the right to end the spiritual caregiving contact at any moment.

20. If the client is not capable of realistically assessing their own interests in a given situation, the rules of this code are applicable to the caregiving to a degree reasonable and possible in the given situation and in consultation with others working with the client. The client’s individuality and known preferences are respected as much as possible.

<h3>3.2 Personal integrity

21. The spiritual caregiver who is an employee, shall not, when entering into or maintaining contact with a client, be guided by considerations of self-interest or personal gain, other than the possible use of data for training or supervision purposes with prior consent of the client. By the use of data the anonymity of the client must be guaranteed.

22. The spiritual caregiver who is an employee, when offered gifts or legacies by clients or their relatives, shall act with extreme reluctance, in compliance with the regulations of their employer. There shall be no financial liabilities between the spiritual caregiver and their client.

23. The spiritual caregiver who is an independent professional shall practice transparency concerning their fees. When offered gifts or legacies by clients or their relatives, they shall act with extreme reluctance.

24. While working with a client, the spiritual caregiver shall not enter into a personal relationship that is incompatible with their role, nor shall they express the wish to do so. The client’s personal, physical and mental integrity is respected at all times. The spiritual caregiver shall not physically touch the client with sexual or erotic intentions, nor in a way that could be perceived as bearing sexual or erotic intentions. The spiritual caregiver shall not respond to sexual advances by the client.

25. The spiritual caregiver, upon detecting any circumstances that might be harmful to the client’s well-being, shall inform the staff and advise them on possible improvements. The spiritual caregiver shall, where possible, first inform the client, and shall make sure not to violate any confidentiality regulations (cf. below, section 3.3).

26. Should the spiritual caregiver feel unsure on how to act in a specific case, they shall consult with a colleague, a confidential adviser, an expert, or a superior, while respecting confidentiality regulations.

27. Where applicable, the spiritual caregiver maintains an attitude of respect and loyalty vis-à-vis their employer and their commissioning body with

recognition of each party’s responsibility. To both, they report on their functioning.

28. In case of a moral dilemma, or of conflict of loyalties vis-à-vis their employer or their commissioning body, the spiritual caregiver shall give precedence to the fundamental respect for the client’s beliefs and personal integrity – without neglecting their institutional reponsibilities. Should the spiritual caregiver be unable to reconcile the different interests with each other or with their own conscience, they should be allowed to refer the client to another spiritual caregiver.

<h3>3.3 Confidentiality

29. Unless the client decides otherwise, the spiritual caregiver is obliged to maintain confidentiality of everything that is shared with them in confidence while practicing their profession, as well as of everything they notice and of which they may reasonably be expected to appreciate the confidential nature.

30. The obligation of confidentiality remains valid after the discontinuation of the contact between spiritual caregiver and client, even after the client’s passing away.

31. Even if the client has granted permission to breach the confidentiality, it remains the spiritual caregiver’s own decision to disclose confidential information. They shall do so only if all of the following requirements are met.

a) It is (almost) certain that maintaining the confidentiality will seriously harm or endanger third parties or the client themselves.
b) It is (almost) certain that breaching the confidentiality will prevent or diminish harm or danger to third parties or to the client.
c) Danger can only be averted or harm can only be prevented by breaching the confidentiality.
d) Maintaining the confidentiality will cause a moral dilemma for the conscience of the spiritual caregiver.
e) Everything has been done to obtain the client’s consent.
f) The confidentiality shall be breached only to the extent necessary to avert danger and prevent harm to third parties or to the client.

32. In breaching the confidentiality, the spiritual caregiver shall do everything they can to account for their action, to inform the client, and to obtain their cooperation.

33. Strict application of the confidentiality obligation as stated below in article 34 is not obligatory when it comes to sharing information as part of the provision of care. The spiritual caregiver is allowed to share information with other care providers working with the client concerned, under the conditions that the client has given their consent, that the information is relevant to the provision of care, and that confidentiality is guaranteed by the other care providers concerned.

34. The spiritual caregiver is obliged to invoke their privilege in court[5] if testifying or answering specific questions would violate the confidentiality. Only if all conditions mentioned under 31.a-f are met, can the obligation to invoke the privilege be lifted.

35. If privilege is not granted in court, the spiritual caregiver shall only provide such information as is purely factual and precisely answers the questions being asked. They shall not express value judgments concerning the client. In answering the court's questions, confidentiality is respected as much as possible. If the spiritual caregiver decides not to answer any questions, they will be subject to sanctions by the court.

36. The rules stated in articles 29–33 also apply in full to the spiritual caregiver's activities in their own practice, for any customer, their institution, co-workers and volunteers of the institution, the training of co-workers and volunteers, and to whatever comes to their knowledge during worship services and meditational gatherings.

37. The spiritual caregiver is not relieved from their confidentiality if a complaint has been filed against them. If there is reason to breach the confidentiality, the spiritual caregiver needs to obtain permission from the client. This applies also if a complaint has been filed by a party other than the client. Even so, the spiritual caregiver shall exercise restraint and shall breach the confidentiality no further than is strictly required for their defense.

38. The spiritual caregiver shall gather no more data on the client's person and circumstances than are relevant to their care contacts. They shall share data with other persons or entities only to the extent that it is in the client's interest and only with the client's prior consent. The confidentiality must be guaranteed by such third parties. This also applies to client data recorded by the spiritual caregiver in an electronic medical record system. The client shall have access to any report on them by the spiritual caregiver, whether in digital form or on paper. The spiritual caregiver shall facilitate access. If the spiritual caregiver is personally responsible for the retention of data, the maximum retention period is 15 years, unless determined otherwise in legal provisions for their specific area of operation. Thereafter, the spiritual caregiver shall make sure the data is destroyed.

39. If in a particular case the spiritual caregiver is aware of assault, sexual abuse or domestic violence, or has strong suspicions thereof, they shall consult with the appropriate institutions, without revealing the client's personal data.

<h3>3.4 Collegiality

[5]Privilege in court is not reserved exclusively to spiritual caregivers who are endorsed or mandated by an officially recognized religious or spiritual organization. Cf. T. Meijers. 'De geestelijke'. In: F.A.W. Bannier (ed.), *Beroepsgeheim en verschoningsrecht. Handboek voor de advocaat, medisch hulpverlener, notaris en geestelijke*, 171-199 (187). Den Haag, Sdu, 2008.

40. In public comments on colleagues, the spiritual caregiver shall express themselves professionally and respectfully, also in the case of disagreements. They shall take note of the plurality of views and beliefs.

41. When confronted with criticisms concerning a colleague, the spiritual caregiver shall refer the critics to that colleague or to competent authorities, and shall adopt an attitude of restraint.

42. If a colleague’s functioning is seriously called into question, the spiritual caregiver shall address that colleague.

43. In case of serious suspicions of disciplinable behavior, the spiritual caregiver shall notify the competent authorities.

44. The spiritual caregiver is ultimately accountable for the compliance of assistants, volunteers, and apprentices with the Professional Code, who reside under leadership of the spiritual caregiver.

45. In acquisition of clients, the spiritual caregiver shall always be mindful of the interests of the professional group as a whole.

<h3>3.5 Interdisciplinarity

46. In the client’s interest, the spiritual caregiver shall be prepared to work together with professionals from other disciplines, being aware of the value of what they contribute, respectful of their responsibilities, and willing to share information with them, under observance of confidentiality as stated above, article 33.

47. The spiritual caregiver shall make sure that their expertise can be called upon by the co-workers in their institution.

48. The spiritual caregiver shall refrain from providing any type of guidance which is outside their own expertise. Whenever necessary and possible, they shall refer the client to other care providers.

49. Whenever a contact has to be handed over to another professional, the spiritual caregiver shall ensure a proper sharing of relevant information with the new care provider, in consultation with the client and under observance of confidentiality as stated above, article 33.

50. The spiritual caregiver shall refrain from publicly criticizing professionals from other disciplines, and shall seek to discuss any issues in interdisciplinary consultations.

<h2>4. Complaints Statute

<h3>4.1 Preliminaries

51. This Complaints Statute enables interested parties to file complaints against spiritual caregivers who are, or have been, or aspire to become members of the VGVZ. Interested parties may include clients, clients' relatives, and colleagues, other professionals, or volunteers working with the spiritual caregiver.

52. Any complaint shall address the spiritual caregiver's conduct which the complainant considers to contravene the VGVZ's Professional Code. As a typical first step, the matter is discussed with the spiritual caregiver themselves. If necessary, one of VGVZ's confidential advisers can facilitate such talks. VGVZ has assigned a number of confidential advisers, of both sexes.

53. Should a face-to-face discussion fail to resolve the issue, the following options are open, depending on the specifics of the situation.

a) A complaint can be filed with the spiritual caregiver's employer, in accordance with that employer's Complaints Statute.
b) A complaint can be filed with the spiritual caregiver's commissioning or authorizing body, if it concerns their ministerial functioning.
c) A complaint can be filed with the VGVZ, in accordance with the present Complaints Statute.

54. To handle complaints, the VGVZ has established a Complaints Commission, that acts in accordance with the present Complaints Statute. The Commission may advise the parties concerned to further discuss the matter with each other, if it believes the issue may still be resolved that way. If desired, one of the VGVZ's confidential advisers may assist the complainant in such talks.

<h3>4.2 General Provisions

55. The Complaints Commission and the Board of Appeal handle complaints concerning compliance with the VGVZ's Professional Code.

56. The Complaints Commission is the first to assess a complaint. It may impose disciplinary measures on the defendant who acts or has acted in breach of the VGVZ's Professional Code.

57. The Board of Appeal handles notices of appeal against rulings of the Complaints Commission.

58. The complaints procedure is not conducted publicly. The members of the Complaints Commission and the Board of Appeal are under the obligation of confidentiality.

59. The notice of complaint shall be filed not too long after the incident which it concerns has taken place.

60. The Complaints Commission will not consider anonymous complaints.

61. The Complaints Commission will not consider complaints on which it has already ruled.

62. The Complaints Commission will not consider complaints that regard issues outside the scope of the Professional Code.

63. If the defendant is involved in another procedure – be it a complaints procedure, a (civil) court procedure, or a procedure involving an arbitrator or a binding advisor – which regards the same complex of facts referred to in the complaint, the Complaints Commission may decide not to consider the complaint, or to suspend its consideration or its ruling.

64. If the Complaints Commission decides not to consider a complaint, or to suspend its consideration or its ruling, it will inform the complainant and the defendant of this decision and its motivation. The Board of the VGVZ will also be informed of the decision.

<h3>4.3 Composition of the Complaints Commission and of the Board of Appeal

65. The Complaints Commission consists of five members or members emeriti of the VGVZ.

66. From their midst, the members of the Complaints Commission appoint a chairman, a vice chairman, and a secretary.

67. Membership of the Complaints Commission is granted by the General Assembly of the VGVZ, in a four-year term. A member of the Commission may serve a consecutive second term. Only in exceptional circumstances may a member serve a third consecutive term.

68. The Complaints Commission retains its authority even in case of vacancies.

69. The Board of Appeal consists of two members or members emeriti of the VGVZ, one of whom acts as the Board’s secretary, and an independent legal expert, who acts as its chairman. Articles 67 and 68 equally apply to the Board of Appeal, but in view of the size of the Board, any vacancies must be (provisionally) filled as soon as possible if such is in the interest of the continuation of any procedure.

70. Members of the VGVZ serving on the Complaints Commission or the Board of Appeal are not granted remunerations for their work. They are, however, entitled to the reimbursement of any costs incurred while exercising their duties.

71. The independent legal experts receive a fee for their services, to be determined by the Board of the VGVZ.

72. Members of the Board of the VGVZ are excluded from serving on the Complaints Commission or the Board of Appeal.

73. Every year, before April 1st, the Complaints Commission and the Board of Appeal report to the Board of the VGVZ on their activities during the previous calendar year.

<h3>4.4 Filing a complaint

74. Complaints must be substantiated and are to be filed with the Complaints Commission in writing.

75. Complaints submitted over e-mail are considered to be in writing. The date of receipt is recorded on the document by the secretary.

76. The complaint bears the signature of the complainant. It shall at least include

a) name, address, and place of residence of the complainant
b) date
c) name of the defendant
d) (if applicable) name and address of the institution concerned
e) substance of the complaint.

77. If necessary, or upon request, the secretary of the Complaints Commission will provide a template, as an aide to (re)phrasing the complaint.

78. The secretary of the Complaints Commission will inform the complainant and the defendant of the possibility of consulting one of the VGVZ's confidential advisers.

79. The complainant and the defendant are free to engage legal advisers.

80. The secretary of the Complaints Commission will acknowledge receipt of the complaint to the complainant within three weeks, and preferably as soon as possible.

81. Upon the submission of a complaint, the Complaints Commission will appoint two of its members in a subcommittee. In addition, two legal experts will be engaged to join the subcommittee, as chairman and secretary. The subcommittee will exclusively handle the complaint.

82. The members of the subcommittee will consider whether the matter or any other aspect of the complaint are such that their impartiality could possibly be called into question. If such is the case, they will ask to be excused.

83. The secretary of the Complaints Commission will notify in writing the complainant and the defendant of the subcommittee's composition.

<h3>4.5 Handling of complaints

84. The secretary of the subcommittee will forward the notice of complaint to the defendant, allowing them to enter a statement of defense. The complainant will be notified thereof.

85. The statement of defense must be entered with the secretary of the subcommittee by the defendant within six weeks after receipt of the notice of complaint. The secretary will forward the statement of defense to the complainant.

86. Should the defendant fail to enter a statement of defense, the subcommittee will act as deemed appropriate.

87. Both the complainant and the defendant are allowed to call in witnesses and/or to submit evidence, within a reasonable period of time. If necessary, the subcommittee can suspend the handling of the complaint.

88. As soon as possible, and at the latest within six weeks after receiving the statement of defense, the subcommittee will decide on how to continue the procedure, and it will notify the two parties of its decision without delay.

<h3>4.6 Hearing

89. The subcommittee is free to organize a hearing. It must do so upon request by the complainant or the defendant. In case of a hearing, the secretary of the subcommittee will establish its date and location, taking into account the parties’ schedules as much as possible.

90. The parties shall be heard in each other’s presence, unless the facts and circumstances are such that one party cannot reasonably be required to tolerate being heard in the other party’s presence. In that case, the other party is authorized to be represented by a third party of their choice.

91. During the hearing, both the complainant and the defendant may be assisted or represented by a third party of their choice. Should the complainant or the defendant fail to attend in person, the subcommittee will act as deemed appropriate.

92. The hearing is aimed at establishing the truth of the matter. It may also serve to explore ways of achieving an amicable settlement. In all questions and answers it will be the chairman who speaks or is addressed. The last word is reserved for the defendant.

93. The secretary of the subcommittee will compile a report on the hearing.

<h3>4.7 Further handling of complaints

94. If there is no hearing, the defendant and the complainant are given the opportunity to submit their reply, and their subsequent rejoinder, respectively, each within a period of four weeks.

95. The subcommittee, whether on its own initiative or upon the complainant’s or the defendant’s request, may gather information from witnesses or experts. The parties are notified by the secretary of the subcommittee of its intention to

do so. They are also notified of the substance of the gathered information, and are allowed to respond to it.

96. After considering the case, the subcommittee will issue its ruling. It will do so within twelve weeks after its decision as mentioned above in article 88. Should votes tie within the subcommittee, the chairman's vote will count double.

97. In its motivated ruling, the subcommittee will declare the complaint to be justified, or partly justified, or unjustified.

98. Should the subcommittee declare the complaint to be (partly) justified, it will take one of the measures as specified below in article 101.

99. The secretary of the subcommittee will send a copy of the ruling to the complainant and the defendant, as well as to the Complaints Commission, by registered mail. The ruling bears the signatures of the chairman and the secretary of the subcommittee.

100. The secretary of the Complaints Commission will send a copy of the ruling to the Board of the VGVZ as soon as the ruling has become irreversible.

<h3>4.8 Sanctions

101. If the complaint is found to be (partly) justified, the subcommittee can impose sanctions on the defendant as follows.

a) No sanction.
b) Warning.
c) Reprimand.
d) Conditional expulsion from VGVZ membership, during a probationary period of one year.
e) Suspension of VGVZ membership for a period not exceeding one year.
f) Disqualification for future VGVZ membership for a period to be determined by the subcommittee.
g) Expulsion from VGVZ membership.

102. The subcommittee will motivate any ruling it issues.

103. If the spiritual caregiver is an employee, the subcommittee may decide to inform the spiritual caregiver's employer in writing of its ruling, as soon as the ruling has become irreversible.

104. As soon as the ruling has become irreversible, it will also be made known in writing to all members of the VGVZ, or published in an appropriate medium – in anonymized form if one of the sanctions as specified in article 101.a-f has been imposed, but with mention of the defendant's name in case of the sanction specified in article 101.g.

105. The subcommittee's ruling becomes irriversible as soon as the period for lodging an appeal has expired without an appeal against the ruling having been lodged with the Board of Appeal by one of the parties.

<h3>4.9 Lodging an appeal

106. Within six weeks after the ruling by the subcommittee, the complainant as well as the defendant may appeal against the ruling with the Board of Appeal.

107. Appeal may also be lodged against decisions as specified above in articles 63 and 64. In this case, if the Board of Appeal considers the appeal justified, it may refer the handling of the complaint back to the Complaints Commission.

108. The notice of appeal is submitted in writing, per registered mail or per e-mail, with the secretary of the Board of Appeal. The notice of appeal shall comprise at the minimum:

a) name, address and place of residence of the party lodging the appeal
b) date
c) a copy of the subcommittee's ruling which the appeal concerns
d) a motivation of the appeal.

109. The secretary of the Board of Appeal will notify the secretary of the Complaints Commission of the appeal being lodged, and will ask that secretary to provide them with copies of all the relevant evidence.

110. The secretary of the Board of Appeal will notify the Board of the VGVZ of the appeal(s) being lodged.

111. The Board of Appeal will decide on the appeal, confirming, or partly confirming, or changing, or annulling the subcommittee's ruling.

112. The decision of the Board shall comprise the grounds on which it is based.

113. Articles 84 through 105 (sections 4.5 through 4.8) apply, inasmuch as they are consistent with the nature of the appeals procedure.

114. The secretary of the Board of Appeal will inform the defendant, the complainant, the Board of the VGVZ, and the Complaints Commission in writing, per registered mail, of the Board of Appeal's decision.

<h3>4.10 Exclusion and objection

115. Members of the subcommittee or the Board of Appeal may be objected to if there are facts or circumstances through which their impartiality could possibly be called into question.

116. The objection must be raised as soon as the composition of the subcommittee or the Board of Appeal has been made known to the party raising the objection, or as soon as new facts or circumstances have emerged in the course of the procedure which appear to justify an objection. The motivated objection must be raised in writing and must be submitted to the secretary of the subcommittee or the Board concerned. The objection may be raised orally if it is prompted during the hearing.

117. In case of an objection, the procedure is suspended until a decision has been taken.

118. The decision on the objection shall be taken as soon as possible by the other members of the subcommittee or the Board concerned, after hearing both the party raising the objection and the member being objected to.

119. If the member being objected to acquiesces, or if the objection is granted, the handling of the complaint or appeal is suspended until a substitute member has joined the subcommittee or the Board concerned.

120. The party concerned may lodge an appeal with the Board of Appeal against the subcommittee’s decision on the objection, within one week after the decision has been taken.

121. The Board of Appeal’s decision shall be made known as soon as possible to the complainant, the defendant and the subcommittee.

122. Should a member of the subcommittee or the Board of Appeal feel themselves that their impartiality could possibly be called into question, they shall resign. The handling of the complaint or appeal is suspended until a substitute member has joined the subcommittee or the Board concerned.

<h3>4.11 Final provisions

123. All terms and periods specified in the present Complaints Statute can be waived under compelling circumstances.

124. In all cases not provided for in the present Complaints Statute, the body handling the complaint decides.

125. The secretaries of the commissions shall maintain records of all complaints dealt with, in such a way as to ensure confidentiality. After closing the case, the records are kept for a period not exceeding two years, or as long as required for the implementation of the imposed sanctions or for starting or handling an appeal procedure.

126. In consequence of findings in a specific case, the Complaints Commission and the Board of Appeal are free to suggest to the Board of the VGVZ measures aimed at preventing similar complaints in the future.

<h1>Appendix I
Defining spiritual care and the competences it requires

As a result of developments within the profession of spiritual care generally, and within the Netherlands Association of Spiritual Caregivers VGVZ in particular, our present definition of spiritual care differs from the that was used in the 2002 Professional Standard. We will now briefly account for this new definition – *Spiritual care is professional support, guidance and consultancy regarding meaning and world views*, cf. above, II.1 (page 000) – as well as for the choices we made in describing the compentencies that spiritual caregiving requires.

<h2>1. Definition

The key term **spiritual** has a wide range of meanings. According to Bouwer,[6] the word 'spirit' (Dutch: *geest*) refers to the human being in their entirety and integrity. Likewise, Veltkamp[7] interprets the spiritual domain ('geestelijk domein') as 'a dimension of the human being as a whole'. Schilderman,[8] following Popper, distinguishes three aspects of 'geest', viz. vitality, functionality (perception, consciousness), and meaning. In Schilderman's view, the aspect of signification comprises the pursuit of happiness, purpose ('human flourishing') and a good life, as well as dealing with contingency and moral issues. Mooren and Walton,[9] rather than using the term spirit, prefer to speak of a 'spiritual perspective', that is realized in humans' quest for meaning, and worldview. To the committee working on this Professional Standard, the dimensions of meaning and worldview, as well as the awareness of the entirety and integrity of human existence, have been of key importance.

Just like it was in the 2002 Professional Standard, the concept of **meaning** is central to our definition of spiritual care. Meaning refers to the active, informal and individual aspects of the process in which humans relate to their own existence and attribute meaning to it. This process involves all dimensions and aspects mentioned in the Professional Standard, including the spiritual.[10]

The second defining concept, **world view** (Dutch: *levensbeschouwing*), refers to the reflective, formal and communal aspects of the same process, as realized, for instance, in religious and humanist traditions. The concept of world

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[6]Bouwer, J. (2003). *Van de kaart naar het gebied. Het domein van de geestelijke zorgverlening* (Kamper Oraties 24), Kampen: ThUK.
[7]Veltkamp, H. (2006). 'Domein, identiteit en passie van de geestelijke verzorging'. In: J. Doolaard (red.), *Nieuw handboek geestelijke verzorging*. [pp. 147-159]. Kampen: Kok.
[8]Schilderman, J. (2009). *Wat is er geestelijk aan geestelijke zorg?* Nijmegen: Radboud Universiteit.
[9]Mooren, J. & M. Walton (2013). 'Geestelijke Verzorging. Over de veelvormigheid en de fluïditeit van het geestelijke'. *Tijdschrift voor geestelijke verzorging*, 16, 70, 24-32.
[10]Cf. Hekking, R. (2014). 'Geïntegreerd werken en niet anders'. In: S. Körver, *In het oog in het hart. Geestelijke verzorging 2.1* [pp. 59-72]. Nijmegen: Valkhof Pers.

view has gained importance over the past decades, as evidenced in the proposal by the Committee on Ministerial Affiliation to assign world view-related competence a central role.[11]

Thus, world view and meaning are seen here as related concepts. Together they encompass several aspects of the process of the search for meaning and of religious practices: formal and informal; passive/reflective and active; communal and individual; process-oriented and content-related. These dynamics of world view and meaning, together with the four essential dimensions, and the characteristics of the spiritual caregiver's practice (cf. above, II.1.3, page 000) comprise the entire domain of spiritual care.

In English-language literature on spiritual care, the core notion appears to be 'spirituality', rather than '(search for) meaning (in life)'.[12] A 'consensus definition' of spirituality in palliative care, published recently in the US, reads as follows: 'Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.'[13] Similarly, the European Association of Palliative Care understands spirituality in experiential terms. The 'spiritual field is multidimensional' and pertains to the whole of human life, including existential challenges, values, relationships and religious foundations.[14] In a review of definitions of 'spirituality' in health care Walton has discerned five different levels at which the term spirituality functions. Spirituality is seen, first, as a type of human experience (inner growth, connectedness, authenticity); second, as an activity or a set of practices; third, as a dimension of human existence relating to meaning and purpose; fourth, as a reference to specific traditions and institutions; and fifth, as a reference to a transcendent dimension.[15] The definitions refer to a wide range of religious and other sources of inspiration.

Spirituality thus defined shows a considerable overlap with the broad concept of meaning. Its inclusion (alongside 'meaning') in a definition of spiritual care would therefore amount to a duplication. At first sight, the element of transcendence which the term spirituality evokes does not seem to be covered

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[11] Mooren, J. & W. Smeenk (2010). Commissie Ambtelijke Binding. In: *Ambtelijke Binding* (VGVZ-cahiers 4), 73-109.

[12] The term 'spiritual care' seems to be the best generic translation of the Dutch 'geestelijke verzorging'. But the Dutch 'geestelijke verzorging' refers to care in all four dimensions of meaning and world view and not just in matters of spirituality. The functional equivalent in Dutch of contemporary usage of 'spirituality' is 'zingeving', which is at the same time similar to the notion of meaning.

[13] Puchalski, C. et al. (2009). 'Improving the quality of spiritual care as a dimension of palliative care: The report of the Consensus Conference.' *Palliative Medicine*. 12, 10, 885-904.

[14] https://www.eapcnet.eu/eapc-groups/reference/spiritual-care/. Consulted 2023-01-25.

[15] Walton, M. (2012). 'Assessing the construction of spirituality: Conceptualizing spirituality in health care settings'. *The Journal of Pastoral Care and Counseling*, 66, 3, 7: 1-16.

by the notion of meaning.[16] In our approach, however, the notion of meaning includes the existential, the spiritual, and the religious, which makes it an apt term to describe the entire domain of spiritual care. Spirituality, in our model, is one of the four essential dimensions of 'meaning and world views', together with the existential, ethical and aesthetical dimensions.[17]

Among the four essential dimensions just mentioned, the **aesthetical** may catch the eye. Previous definitions of spiritual and chaplaincy care do not feature it. Its present inclusion issues from the value attached by many people to natural and cultural beauty when it comes to experiencing meaning and well-being, particularly in situations where rationality fails to provide adequate answers. Art, poetry, and music are important tools in spiritual care.

<h2>2. Competences

The competences as outlined above (II.2.2, page 000) come in a triad of categories: substantive, process-oriented, and personal. This categorization is based on efforts by Hanrath to bridge the gap between ministry and professionalism in spiritual care.[18] The distinction between the two stems from the fact that spiritual caregivers are answerable, on the one hand, to their endorsing religious and other world view organizations (of which they may be ministers), and on the other hand to the healthcare institutions of which they are professional employees. Historically, this distinction has come to obscure the fact that world view organizations use the ministry as a means of safeguarding the professionalism of their staff. Ministry and professionalism, therefore, are now typically understood as two distinct aspects of spiritual care. Hanrath has tried to remedy this situation by positioning the professional identity of the spiritual caregiver in a triangular relation between the world view tradition, the healthcare system, and the spiritual caregiver's personal biography – i.e. between ministry, function, and person. Crucially, in the committee's view, Hanrath holds that the three aspects *together* constitute the spiritual caregiver's professionalism. The Committee on Ministerial Endorsement, in its 2009 report, holds that the essence of spiritual care as a profession is to focus on faith and life convictions in the support of people: 'spiritual care distinguishes itself from social work, psychotherapy and other types of counseling through its worldview-related competence.'[19] Worldview-related competence is described by the Committee as 'the ability to grasp the religious or worldview-related implications of the client's narrative, and to connect them in an authentic manner to the client's own life orientation.' Thus defined, worldview-related competence shows considerable overlap with what has elsewhere been called 'hermeneutic competence'.

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[16]VGVZ (2010). 'inner transformation, inspiration, transcendence, connectedness, and inner growth'. Resolution on the recommendations by the Commission on Spirituality and the Professional Standard, adopted by the VGVZ General assembly, June 7th, 2010.
[17]Mooren & Walton. (Ibid).
[18]Hanrath, T. (2000). 'Geestelijke verzorging in het hart van de zorg. De professionele identiteit van de geestelijk verzorger in een veranderende context'. *Praktische Theologie* 2000/4, 444–454.
[19]Mooren & Smeenk. (Ibid).

Hanrath's triad has been used by a work group of the professional association VGVZ's Protestant sector as the starting point for the development of a 'star model', presented at a conference in 2011. In line with other healthcare professional standards, this model comprises *roles* as well as *competences*. The competences, again, come in three categories: worldview-related, organizational, and personal.[20] Note that the model defines not just one worldview-related competences, but a cluster of world view competences (plural!), of which hermeneutic competence is one. In this model, the personal competences are the link between the other competences and the roles played by the spiritual caregiver.

A separate issue is the position of competences that are borrowed from social sciences. Mooren[21] distinguishes between primary and secondary frames of reference, with competences derived from social sciences, particularly from psychology, being among the secondary ones.The distinction has been challenged by Hijweege[22] and Zock,[23] in view of the changing role of meaning in modern society. These authors hold that the so-called 'secondary' competences are indispensable in good care. Without going into this discussion, we observe that a distinction between primary and secondary distinction is open to evaluative misinterpretation.

Based on these considerations, the Commission has opted for the functional categorization of a) substantive competences (first of which comes the hermeneutic or worldview-related competence), b) process-oriented, and c) personal competences. There is admittedly some overlap between the categories. The distinctions are not intended to be watertight.

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[20]Walton, M. e.a. (2011). Rollen en competenties van een geestelijk verzorger als expert levensbeschouwelijke zorgverlening. Stermodel. Protestantse sector VGVZ 2011/2013. [research document] https://www.pthu.nl/Over_PThU/Organisatie/Medewerkers/m.walton/downloads/spelt-walton-wiegers-stermodel-rollen-competenties-gv.pdf

[21]Mooren, J. (2008). *Geestelijke verzorging en psychotherapie*. 3e druk. Utrecht: de Graaff.

[22]Hijweege, N. (2010). '"Wat betekent dat" en "Waar staat dat voor"? Over de samenwerking tussen geestelijk verzorger en psycholoog'. *Psyche & Geloof*. 21/3, 196-212.

[23]Zock, H. (2007). *Niet van deze wereld? Geestelijke verzorging en zingeving vanuit godsdienstpsychologisch perspectief*. Tilburg: KSGV.

<h1>Appendix II
The history of spiritual care as a profession

We now present an outline of the development of spiritual care as a profession in the Netherlands. For the sake of brevity, we limit ourselves to spiritual care in the healthcare system, noting that there are many parallels with spiritual care in the military and the judiciary.

In the past, care for the sick and the needy was typically provided by religious orders. The physical and the spiritual would go hand in hand, which is only logical, given the central role of religion in people's personal lives as well as in society at large. For centuries, sickness and health, war and peace, good and evil, personal relations and sexuality, sowing and harvesting – all of these and similar phenomena have been experienced as a matter of course within a 'context of ultimate meanings and concerns'.

The self-evidence of this has gone, as a result of the 'demystification of the world', a process in which magical thinking and religious signification have made way for rationality and science. Medicine and psychology in particular have known such a boom as to marginalize the role of world view and religious significance in health and social care systems.

Spiritual caregivers have responded to this development by setting up their own professionalization project, which we will presently outline using five typical features of any profession: domain, trade organization, expertise, advocacy, and social recognition.

<h2>1. Domain

Spiritual care is provided in such various work fields as hospitals, nursing and care homes for patients with physical and/or mental disabilities, rehabilitation centers, psychiatry, child protection, and primary care. Within all of these settings, spiritual care is provided from a wide range of persuasions, represented i.a. by the various religious or spiritual institutions. Common to all spiritual caregivers are a number of competences, among which the 'worldview-related or hermeneutic competence' is of prime importance. This competence has been defined as 'the ability to grasp the religious or worldview-related implications of the client's narrative, and to connect them in an authentic manner to the client's own life orientation.' This competence is what distinguishes spiritual care from other professions. Whether implicitly or explicitly, spiritual care is always dealing in one way or another with the 'context of ultimate meanings and concerns', which is not the case with other types of care.

The special thing about the domain of spiritual care is that it is not new; it has not been recently discovered or developed. On the contrary, the 'context of ultimate meanings and concerns' has been around for a long time and is now facing marginalization and abandonment, as a result of the secularization of Western society. Modern spiritual caregivers have taken it upon themselves to keep this dimension in focus. However, they do so not only based on calling and religious convictions, but also with an eye on the client's health and well-

being. This is a new, secular, professional perspective, which has come to join the traditional ministerial orientation. Professionalism has gained importance after the Second World War, and the link between the ‘ultimate concerns’ on the one hand, and health and well-being on the other has come to play a major part in arguing for the legitimacy of spiritual care as a healthcare profession. The relations between the ministerial and professional aspects of spiritual care may have been strained at times, but we now know that there is no real opposition between the two (cf. above, Appendix I).

<h2>2. Trade organization

Since the second half of the twentieth century, spiritual care in healthcare in the Netherlands has developed into a trade of its own, with a professional organization of its own: the Vereniging van Geestelijk Verzorgers in Zorginstellingen VGVZ (Association of Spiritual Caregivers in Healthcare Institutions). The association advocates the provision of sufficient and adequate spiritual care to clients, patients and residents of care institutions, while safeguarding the professional quality of its members, and constituting a national knowledge center on spiritual care.

VGVZ was founded in 1971. Before that date, even with the so-called ‘pillarization’ of Dutch society already being in its twilight years, spiritual care was considered to be a responsibility of the churches. Strikingly, however, it was mostly faith-based institutions that started to take on spiritual caregivers (ministers and rectors) as employees of their own, rather than having them sent in by churches. The foundation in 1969 of the Nationale Ziekenhuisraad (National Council of Hospitals), marking the end of pillarization in the hospital sector, was an important trigger for working towards one single association for all spiritual caregivers in hospitals. Initially, VGVZ was comprised of three denominational ‘sectors’, Catholic, Protestant, and Jewish. In the mid-1970s it opened itself up to humanist colleagues by creating a ‘Non-ecclesiastical’ sector. Since then, Muslim and Hindu sectors have been added. Thus, spiritual caregivers from all those denominations are united in a single professional organization, working together on professionalization without giving up their denominational identities.

Still, the sectoral structure of VGVZ – complemented by a structuring according to ‘work fields’ such as hospital care, mental health care, youth care – can be seen as a trace of pillarization, just like the initial requirement that its members be ministerially bound to one of the officially recognized religious or spiritual organizations. From the 1980s onward, however, the Netherlands saw a growing number of well-trained spiritual caregivers who were barred from the ministry (for various reasons, such as level of education, marital status, gender), and therefore from VGVZ membership as well. Others began to consider the VGVZ outdated. This led to the founding of ‘Albert Camus’, a professional organization for non-ministerially-affiliated spiritual caregivers.

The issue of religious or worldview-related legitimization of spiritual care *through ministerial affiliation* has been handled since 2008 by two successive committees, the Committee on Ministerial Affiliation, and the Steering Committee (Regiegroep) on Ministerial Affiliation. VGVZ dropped ministry as a

membership requirement, so that ‘non-commissioned’ spiritual caregivers could join the association. Subsequently, Albert Camus was incorporated into the VGVZ, as the sector of ‘Institutionally Non-Commissioned’ spiritual caregivers (SING).

Lately, VGVZ has started working together with professional associations of spiritual caregivers in the military and the judiciary, in order to jointly promote the common interests of spiritual care. In 20?? it changed its name (dropping the focus on healthcare while retaining the acronym) into Vereniging van Geestelijk VerZorgers, Association of Spiritual CareGivers.

<h2>3. Expertise

Like any profession with specific competences, spiritual care requires a specific body of knowledge, which the aspiring spiritual caregiver acquires in dedicated training trajectories. There are several parts to this body of knowledge. Traditionally, spiritual care draws on theological and humanistic reflection on the major questions of life, as preserved in rituals, sacred texts, and a plethora of cultural customs and practices. In addition, insights from social sciences on the support of individuals and the structure of meaning making processes have gained importance since the postwar period.

Since its foundation, VGVZ has promoted professionalism in spiritual care, through conferences, study groups, and publications. The year 1995 saw the creation of the quarterly *Tijdschrift Geestelijke Verzorging* (Journal of Spiritual Care). In 1996, the *Handboek Geestelijke Verzorging* was published, with a second, revised edition in 2006.[24] The first version of the Professional Standard came out in 2002.

Traditionally, an academic degree in Theology or Humanistic Studies was a requirement for taking up the profession of spiritual caregiver. The courses involved were closely linked to the existing world view organizations, to the extent that they could also be characterized as denominational or ‘ministerial’ training trajectories, allowing their graduates to act as representatives of their tradition. In the early 1990s, the Hogeschool Diemen was the first institute of applied sciences to introduce a degree in spiritual care which was both non-academic and non-denominational. Since then, non-denominational training trajectories, both academic and non-academic, have been developed by several universities and institutes of applied sciences in the Netherlands.

The independent Stichting Kwaliteitsregister Geestelijk Verzorgers SKGV (Foundation Quality Register Spiritual Caregivers) has been established to manage a professional register of both individual spiritual caregivers and training trajectories. Its aim is to safeguard an adequate level of professionalism in spiritual care, and to promote public recognition of this profession. Inclusion in the register has to be applied for regularly, so as to make sure that spiritual caregivers keep their knowledge and skills up to date, by taking accredited courses and training activities.

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[24]Doolaard, J. (ed.) (2006). *Nieuw handboek geestelijke verzorging*. Kampen: Kok.

<h2>4. Advocacy

The aim of VGVZ has not only been to professionalize and organize spiritual caregivers internally, but also to represent their interests in their working environments and in society at large, in what could be seen as a process of external professionalization. The representation of interests has a history of its own.

Just after World War II, with Dutch society still being marked by ‘pillarization’, spiritual care in (health) care facilities was considered to be a responsibility of the Churches (and, later on, of the Humanistisch Verbond – Humanistic Association Netherlands). But the Nationale Ziekenhuis Raad (National Council of Hospitals, NZR), founded, as mentioned, in 1969, felt that special measures were needed to keep the ‘context of ultimate meanings and concerns’ in focus in an age of ‘de-pillarization’. It established a permanent committee to develop policies on spiritual care in hospitals. Remarkably, the representation of interests was not initiated by the professional organization (which by then was in its earliest stage), but by the NZR, based on the consideration that the ‘context of ultimate meanings and concerns’ is essential to any dealing with sickness, impairment, and death. The NZR’s Commissie Geestelijke Verzorging (Committee on Spiritual Care) was comprised of hospital board members and representatives of the various denominations. In a well-documented process, it reached the conclusion that spiritual care is an integral part of health care and should be treated as such. Thus, it distanced itself from the traditional view in which spiritual care is to be provided by the vicar or priest in whose parish the hospital happens to be located. Spiritual care had become a profession.

This view was confirmed by a committee named after its chairman, Professor Hirsch Ballin, that in its 1988 report *Overheid, godsdienst en levensovertuiging* (Government, religion and world view) stated that spiritual care is to be covered by basic health insurance. Under the 1996 Kwaliteitswet zorginstellingen (Quality of Healthcare Facilities Act), the provision of spiritual care has become obligatory.

VGVZ has made representation of interests one of its core tasks. Throughout its history, it has lobbied for spiritual care with stakeholders such as the government, insurance companies, educational institutions, and organizations of employers, patients and consumers. Stakeholders’ representatives are regularly invited to address VGVZ conferences or to join internal committees. The first Professional Standard of 2002 was presented to the then State Secretary of Public Health, Ms Clémence Ross-van Dorp.

Through effective lobbying, the VGVZ has managed to ensure that spiritual care has become permanently embedded in ever-changing legislation. In the Wet kwaliteit klachten en geschillen zorg, a new law on quality, complaints and dispute procedures in healthcare, the passage on spiritual care from the Healthcare Facilities Quality Act was retained. The Wet langdurige zorg, a long-term care act (in force as of January 1, 2015) states that the long-term care consumer remains in control of their own life, specifically including its aspects related to ‘religion or worldview’ (article 8.1.1.2.f). The Dutch government, in

its public communications on care, continues to mention the entitlement to spiritual care.

<h2>5. Social recognition

In spite of the legal and political embedding of spiritual care described in the previous section – which would seem to mark its final establishment as a fully-fledged profession – its position on the ground, i.e. in the healthcare facilities where it is to be implemented, turns out to be far less secure. Work needs to be done, and is being done, to remedy this situation.

Initially, the marginalization of the ‘context of ultimate meanings and concerns’ mentioned earlier (Section II.1, Domain, p. 000), made other professionals, such as social workers, lose sight of the specifics of spiritual care – ‘meaning’ as such being a rather broad concept, not to be claimed by one particular discipline. Over the years, however, spiritual caregivers have managed to demonstrate the specifics as well as the particular benefits of their work.

In another relevant development, healthcare is being provided increasingly within the patient’s home environment, not just by traditional healthcare institutions but by other providers as well. Adapting to this trend, a growing number of spiritual caregivers has established themselves as independent professionals. The VGVZ, for its part, has created ‘primary care’ as a new work field within its own constitution. It is consulting with all the relevant parties as to the funding of these new forms of spiritual care.

Even if the added value of spiritual care has gained sufficient recognition by now, sustained efforts are needed to keep the profession up to date. With the conflict on ministerial affiliation finally resolved, and with provisions for institutionally non-commissioned spiritual caregivers in place, the VGVZ is ready to continue working both on the professionalization of spiritual care and on securing its position in the ever-changing healthcare market.