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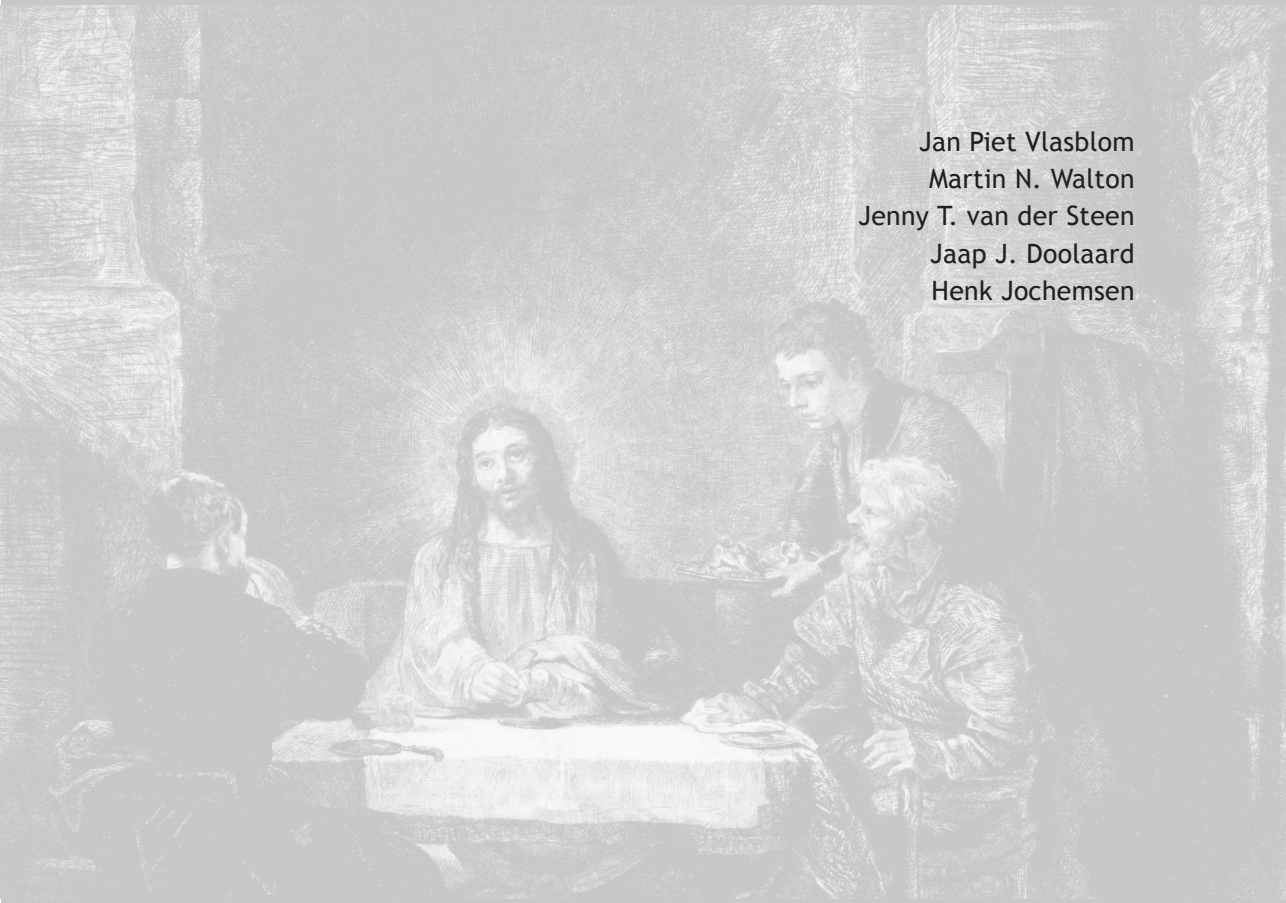
Developments in Healthcare Chaplaincy in the Netherlands and Scotland: A Content Analysis of Professional Journals



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Abstract

Chaplaincy care has undergone a significant evolution in recent decades, and the end is not yet in sight. It has not always been a simple task to retain the essence of the profession during these changes. In order to gain insight into the core identity of spiritual care in the healthcare sector, we have analysed the journals of two leading professional associations, focusing on key issues, in order to allow the past to help us gain insight into the future. Our analysis of the Dutch journal Tijdschrift Geestelijke Verzorging (Journal for Spiritual Care) and the Scottish Journal of Healthcare Chaplaincy has shown that, although both journals have converging views on several key issues, there are also significant differences. The observations have resulted in different recommendations for professionals of the two countries. To spiritual care professionals in Scotland recommendations are made to increase the focus on multicultural spiritual care, while the value of evidence-based practice, and working in accordance with best practice, is brought to the attention of their Dutch colleagues.

Introduction

The spiritual care profession has an extensive history, rooted in the pastoral care provided by churches. The profession as we know it in the context of present day healthcare, however, is still relatively young (Kuttschrütter, 1991; Swift, 2009).
The Dutch Vereniging van Geestelijk Verzorgers in Ziekenhuizen (Association of Spiritual Caregivers in Healthcare Institutions) was founded in 1971 and incorporated separate departments for Roman Catholic priests and Protestant hospital pastors. The Association helped create and shape the profession of Spiritual Caregiver. The Historische Schets (Historical Review), published on the occasion of the Association's 20th anniversary, comments that, during the early years, the Association focused on "clarifying the following: What does spiritual care actually mean? What does it contribute to the healthcare process?" (Kuttschrütter, 1991, 53).
The first issue of the Scottish Journal of Healthcare Chaplaincy was published in 1998. It included a paper by Georgina Nelson, who, reflecting on an article by Coutts (Coutts, 1998), asked the following question on the nature of spiritual caregivers: "What do we do?" (Nelson, 1998). In 2005 Mowat and Swinton published a report entitled "What do chaplains do?" (Mowat & Swinton, 2005). It seems to be a question that characterizes the profession of chaplaincy, which is still evolving and has been trying to establish a distinct identity.
In the early years of spiritual care, enormous strides were made in the field of healthcare. The spiritual care profession, while still searching for an identity, evolved along with healthcare (Orton, 2008; Rebel, 2006). At a time in which changes in the comprehensive field of healthcare succeed each other rapidly, spiritual caregivers should pause to consider who they are and what drives them. "What is critical is that chaplains are aware of this dynamic, understand its impact and are confident to respond from a position of authenticity, theological rigour and spiritual depth" (Cobb, 2007). The identity issue, "Who am I?" is not always easy to resolve amidst all the changes and developments. Zock (2006) even speaks of an identity crisis in chaplaincy.
In order to gain insight into the core identity of the spiritual care profession as it evolved in recent years, we analysed the journals of two leading professional Associations in their respective countries, by asking how often certain topics are being discussed and in what type of publications. In other words, what have been the leading subjects and questions in these journals over the years? And what do they tell us about the identity of the spiritual care profession and, more importantly, about how the profession might evolve in the years to come?

Setting

For a long time the Association of Spiritual Caregivers in Healthcare Institutions (Dutch abbreviation: VGVZ) was the only professional association in the Netherlands. It was founded by merging the Roman Catholic and Protestant hospital chaplain associations. As such, the Association is open to spiritual caregivers of all kinds of hospitals, non-denominational as well as denominational. The Association gradually opened up to Humanist and Jewish caregivers and, in recent years, the Association has been joined by Islamic and Hindu caregivers (Healthcare Chaplaincy in the Netherlands nd). In 2013, the Association subsequently began to include spiritual caregivers not affiliated with any specific denomination. The situation in the United Kingdom is quite different from that of its neighbour across the Channel. The National Health Service (NHS) was created in 1948 and established one national institution for all healthcare provision in the UK. Although the NHS is one central healthcare organization, there are various professional associations for spiritual caregivers (chaplains), partly denominational, partly sector orientated, which makes collaboration a significant challenge (James, 2004, 6; Mitchell, 2006, 37). The differences between those various associations seem too large to overcome in order to establish a uniform identity. The publication of the Scottish Executive Health Department Letter 76 "Spiritual Care in NHS Scotland — HDL 76" (Scottish Executive HDL, 2002) signalled the beginning of a new direction for spiritual care in Scotland, and it quickly became a leader in the field of spiritual care both for the UK and abroad (English, 2005; Fraser, 2012). Given the role played by Scotland in the UK, our research focuses on the identity of chaplains in Scotland.

Spiritual Care in the Netherlands

We investigated the evolution of the spiritual care profession in the Netherlands by conducting an analysis of Issues 1 — 66 (1995-2012) of the journal published by the leading association of spiritual caregivers in the Netherlands since 1995. Issues 0 — 9 were published under the journal's initial name, Geestelijke Verzorging — Tijdschrift van de VGVZ, with issues thereafter being published as Tijdschrift Geestelijke Verzorging (TGV; 'Journal for Spiritual Care'). From its inception, the journal focused on how to shape and present the profession (Nieuwenhuis, 2011). Prior to the publication of its first journal in 1995, the Association published a circular ("Rondzendbrief") twice a year, initially in the form of stencilled leaflets and subsequently as a magazine. Unfortunately, few copies appear to have been retained. The copies of the circular that were recovered, all of which were from the final volumes, were used to gain insight into developments between 1991 and 1995.

Our analysis of the journal was preceded by a study of the history of spiritual care up to 1995, using sources such as the Historische Schets (Kuttschrütter, 1991) and historical articles from the Nieuw Handboek *Geestelijke* Verzorging (New Handbook for Spiritual Care) (Doolaard, 2006).In our analysis of the journals, we followed the standard method of content analysis (Stemler, 2001; Vaismoradi, Turunen & Bondas, 2013). Content analysis provides an empirical basis for monitoring shifts in public opinion (Stemler, 2001). In a first analysis of TGV, all the articles were assigned a topic (label) as a designation of the main theme of that article. The derived themes were then clustered into main themes, in collaboration with a second researcher who had carried out the same analysis. The theme "relation with the church", for example, merged into the main theme "identity", just like "registration'' merged into "professionalization". The main themes thus originated from the analysis through a process of interpretation by two researchers, who at first worked independently and subsequently exchanged views and reached a consensus. In the last step, the other authors of this article were involved.
In a second, more detailed analysis, all the articles were labelled with one of the main themes identified in the first round of analysis. The second researcher followed the same procedure independently. The results of both analyses were then compared and discussed until a consensus was reached regarding the categorization of the articles.

Spiritual Care in the UK/Scotland

In order to construe the historic evolution of spiritual care in the UK, a variety of publications and internet sources were employed (Battle, n.d.; CHCC, n.d.; Cobb, 2005; SACH, n.d.; Swift, 2009). Our study of the evolution of spiritual care in Scotland entailed an analysis of all the Issues (1998-2013) of the Scottish Journal of Healthcare Chaplaincy. (NB: in 2013, the journal merged with The Journal of Health Care Chaplaincy and is now published as Health and Social Care Chaplaincy.) The analysis employed the same method as the TGV analyses. However, when sorting the Scottish journal articles into various key categories, a number of new categories needed to be added and certain topics were interpreted differently. In particular, the notions of development and evolution play different roles in the two journals. Our research then focused on the five main categories that were most frequently the subject of publication in the two journals.

Findings

Identity (110)

The most frequently occurring category is that of "identity" and within it we may differentiate between two subcategories: *the identity of the spiritual care profession* (81) and a more specific secondary issue, the relation between religious (or world view) *endorsement and professionalism* (29). (We speak of world view endorsement because endorsement is provided not only by the churches but also by the Humanist Society.)

The identity of the spiritual care profession

Following the establishment of a new profession of "spiritual caregiver", the profession's identity becomes the subject of a great deal of reflection. Within the category of the "identity of the spiritual care profession", we can differentiate between two directions (schools) of thought. Some articles take an inward direction, asking questions such as: Who am I? How am I grounded? Wherein am I rooted? Others have an outward focus: What do I do and how do I do it? Issue 1 (1996) contained a report on a humanist seminar about "the profile of spiritual caregivers" and a report from the Roman Catholic national conference, during which the subject of Roman Catholic identity was discussed on three occasions.
The articles written during the first few years focus, primarily, on the inwardly directed aspects of this issue.

Box 1 Five main categories in SJHC en TGV

Categories TGV	number of articles	Categories SJHC	number of articles
Identity	110	Developments	64
* Identity of the spiritual care profession	81	* Developments in the field of spiritual care	43
* Worldview endorsement — professionalism	29	* Professionalization	21
Developments	72	Spiritual care	46
* Developments in the field of spiritual care	22	Experiences and practices	35
* Transmuralisation	28	Identity	34
* Multicultural spiritual care	22	Research	23
Experiences and practices	62		
Professionalisation	46		
Methodology	14		

In the same period of time, a "professional profile" (VGVZ, 2002) was published. The question of "Who am I?" resurfaces regularly in reports of conferences and annual meetings. In later issues, the emphasis shifts to "the place of spiritual care within the healthcare sector/institution". Issue 18, for example, contained a report of the Protestant conference that discussed the subject of defining the spiritual care profession and increasing its visibility within the healthcare sector. Both directions of attention, inward and outward, continue, however, to resurface regularly.
In 2006, following a symposium at the general meeting of the Association dedicated to the matter, an entire edition was devoted to the question of identity. In an editorial, the editor-in-chief writes, "During the general meeting we found that the 'crisis of identity' of spiritual caregivers was not merely a theoretical issue" (Boer de, 2006). In subsequent numbers of TGV the twofold focus, inward and outward directions, remains. (Kemper, 2006). In 2002, the professional profile (VGVZ, 2002) was modified to include the phrase, "offering professional advice regarding ethical and/or world view aspects of healthcare provision and policy-making", which reflected actual practice.

Worldview Endorsement and Professionalism (29)
The second highest number of articles within the "identity" category concern "worldview endorsement — professionalism" (29). Within those arti-cles we can identify the dichotomy of care by endorsed spiritual caregivers (formally affiliated with a religious or worldview organization) versus non-denominational or general spiritual care. The theme is closely linked to the definition of spiritual care formulated by the Spiritual Care Committee of the National Hospitals Council of the Netherlands, which refers to offering "professional and ministerial [i.e. endorsed] guidance and support to people, through and based on a religious belief system" (Dienst Geestelijke Verzorging in organisatie en beleid 1987). The addition of "and ministerial" to the definition was new. When the VGVZ was founded, such an official religious connection was self-evident and therefore not included in the definition. At the time, all spiritual caregivers were employed by their respective churches in an official (ordained) capacity, and answered to them. Even when the non-religious department (later called the humanist department) was founded, affiliation with the Humanist Association was still the norm. The double emphasis on "professional" and "official served to indicate that spiritual care is both professional in its accountability to the healthcare setting ánd endorsed work in its accountability to world view organizations. Spiritual caregivers must not only have relevant (academic) qualifications (a requirement in previous definitions), but must also be connected to a religious denomination in an official capacity (e.g. ordination).

Later years saw a growing number of spiritual caregivers reject official world view affiliation. There had also always been members who could not obtain vocational employment (primarily Catholic), due to their marital status or sex, and who were given a sui generis position. The question concerning the desirability of formal world view affiliation gave rise, in part as a result of the definition, to a supposed tension between official affiliation and professionalism. Over the years, that tension has been the subject of heated discussions. The VGVZ general meeting in 2006, saw emotions run high concerning the issue of whether vocational affiliation should be required in order to allow professional registration — so high, indeed, that the proposal was not put to a vote (Algemeen bestuur, 2006). The controversy led to articles being published emphasising either the value of official affiliation (Pieper & Verhoef, 2007; Wisse, 2006) or that of professionalism (Smeets, 2006, 2007). In addition, a number of articles attempted to resolve the resulting polarization situation (Walton, 2010). In 2010 the VGVZ published a brochure on the endorsement issue (VGVZ, 2010) which moved towards opening the door to non-affiliated spiritual caregivers.

Developments (72)
In response to the constant state of development in the healthcare sector, a great deal is published on changes in the field of spiritual care. This main category can be subdivided into three sub-categories: “developments in the field of spiritual care”, “transmuralization” and “multicultural spiritual care”.

The first category, “developments in the field of spiritual care” (22), is primarily concerned with the various developments in the field of healthcare and the role of spiritual care in specific contexts. As early as Issue 3 concerns are voiced by the chairman regarding the growing number of institutions reducing their budget for spiritual care (Van de Voorzitter 1996). The question of funding of spiritual care is also a recurring topic, with, in Issue 39, Financiering (2006) stating that, although the position of spiritual care is uncontentious, it is as yet unclear how it is to be funded.

“Transmuralization” (28) first appears in Issue 4, in a report on a seminar in the field of psychiatry. The term “transmuralization” originated in a mental healthcare context, as well as in care for the mentally disabled. In lieu of intramural care provision in large institutions, there is a growing trend towards extramural care in small residential units in residential areas. That development has had a significant impact on the spiritual care sector, with at least two special editions of the journal discussing the subject of transmuralization (Issues 12 and 20). In Issue 15 we

read that, "the Board has charged a Committee on Transmuralization [Commissie Transmuralisering] with the task of taking stock of all current activities in the field of transmural spiritual care". The committee comprised representatives of all the various fields. However, in part, due to the substantial differences between those fields, the committee was unable to carry out its task. The sources pertaining to the sub-category of transmuralization are primarily reports on seminars, and reports written by practitioners working in a transmural setting.

The third sub-category is "Multicultural spiritual care" (22). In 1993, the VGVZ appointed a Committee on Multicultural Spiritual Care [Commissie Multiculturele Geestelijke Verzorging] "and, for a number of years this was, in fact, the only activity carried out by the VGVZ. One might even say that the Association more or less left that committee to 'run' things" (Doolaard, 2011). Despite the fact that the Association's involvement with multicultural spiritual care was minimal, a total of 22 papers were published on the subject. Issue 18 (2001) refers to the establishment of an Islamic division, with two imams and one pandit as its members, who are provisionally exempt from meeting certain formal requirements (endorsement and academic qualification). Ari van Buuren, Head of the Spiritual Care Department at the Academic Hospital Utrecht (later the University Medical Centre Utrecht), in particular was highly committed to multicultural spiritual care. His efforts in part led to the initiation of a guidance and research project between the hospital and the Ministry of Health, Welfare and Sport, to further multicultural spiritual care in the healthcare sector (Van Buuren, Doolaard, Karagül & Ramdhani, 1999). Issue 37 subsequently informs us that the interfaith work done by the Life Orientation and Spiritual Care Department at the UMC was awarded the "INTRA Projektpreis für Komplementarität der Religionen". "The INTRA prize means recognition of Van Buuren's vision, namely, that spiritual care has a preventive function within the healthcare system" (Internationale prijs, 2005). Interestingly, the attention to multicultural aspects of spiritual care was often tied to attempts to secure endorsement by Islamic, Buddhist and Hindu "denominations". At the same time, attention was drawn to an increasing plurality in spiritual experience among the health care population beyond denominational limits.

Experiences and Practices (62)

Another issue was discussed in a broad range of articles, in which professional chaplains would report on a specific component of the profession, often dealing with initiatives taking place within one institution. Articles on "experiences and practices" are more frequent in later volumes of the journal than in earlier ones. Most of the articles on this topic appear in the "impressions" section. This section

is dedicated to colleagues relaying their impressions of [components of] their work. A number of reports on specific seminars also belong in this category, for example, the use of life stories in a psychiatric setting (Van der Wouw, 1998), on follow-up care for the parents and families of deceased children (Van der Wal, 2000), or on a weekend at a monastery for hospital employees (Jordens, 2006).

Professionalization (46)
The initial volumes of the journal contain an "information" section, the opening section of each issue, which contains the heading "leerroute" (educational track). In addition to taking part in the "introduction weeks", new members are also required to take a course in Clinical Pastoral Education. Particularly the low level of participation in the "intro weeks" is a frequently treated subject.
In addition to the "bestuurcommissie leerroute" (executive committee on educational track), a separate committee on professionalization (commissie professionalisering) was set up and assigned the task of studying the role of the spiritual caregiver within an institution (Issue 5, 1997). In 1999, the committee published a report in an Association brochure (VGVZ 1999). The brochure lists the main tasks of caregivers in healthcare institutions and ascertains to what extent the various educational tracks train caregivers to execute those duties. In 1999 (Issue 11), the committee recommended establishing a register for spiritual caregivers. The proposal was presented for debate at the general meeting in 2006. However, diverging views regarding endorsement (see heading) prevented a decision from being made (Algemeen bestuur, 2006). This fact gave rise to a series of publications. Finally, during the 2007 general meeting, the decision was taken to set up a register.

Methodology (14)
Methodology features as a key category. In the journal's fourth issue, Johan Bouwer reported on a fact-finding visit to the US, where he encountered pastoral diagnosis (Bouwer, 1997). Bouwer's case for pastoral diagnosis led to a long, occasionally heated, discussion in 14 articles. This resulted in the creation of two "camps", Bouwer representing pastoral diagnosis on the one hand and Andries Baart representing a theory of presence. Others attempted to bridge the differences between the two. A working group was set up to develop diagnostic models for various specific contexts. In 2003 the annual VGVZ symposium focused on methodology. The symposium addresses were consequently published in a special edition (Issue 28, 2003). The subject came up four more times. Issue 30 outlines the appointment of a new working group for life orientation diagnosis. Discussion of the subject is brought to an end following an appeal by Job Smit, in Issue 46, to fuse the pillars of diagnosis and presence theory (Smit 2008).

Five Key Categories in the Scottish Journal of Healthcare Chaplaincy

(see Box 1 above, p. 88)

Developments (64)

This category can be divided into two sub-categories, the first being "*developments in the field of spiritual care*" (43). At a time when society, healthcare and spiritual care are continually in a state of evolution (Cobb, 2007), it is not surprising that a substantial number of articles were published, in addition to numerous editorials, focusing on various developments both in healthcare in general and in the field of spiritual care in particular. Only in 2006 was it agreed that all the Scottish spiritual caregivers/chaplains would become employed by the NHS. This gave rise to numerous articles. Volume 8.1 contains a great number of papers on the subject.

The second sub-category is "*professionalization*" (21). Whereas, in the Netherlands, professionalization is a recurring subject from the beginning (even being given an independent committee), in Scotland it is viewed within the framework of new developments. Within the period of time that spiritual care seeks to become an integrated discipline within health care, the profession must professionalize (Editorial, SJHC, 2002). Evidence-based practice is a key aspect of that process. "The terms 'evidence' and 'evidence-based practice' are now commonplace in health care literature. Government reports make increasing use of these terms and seek to encourage all health professionals to base their practice on sound evidence" (Hundley, 1999). Although the actual understanding of the term "evidence-based" is not frequently discussed, evidence-based practice features prominently as a "research" category. The last issue of SJHC (Volume 16, January 2013) focuses on evidence-based practice.

Particularly after the publication of the 2002 Health Department Letter 76 (Scottish Executive, 2002), articles are published on professionalizing spiritual caregivers, referring to guidelines (Young, 2004) and a professional register for caregivers (Birrell, 2005). A number of articles also address the issue of Clinical Pastoral Education (CPE) as a training programme for spiritual caregivers.

Spiritual Care (46)

In November 2001, the conference "Spirituality in Health and Community Care" took place in Stirling. In response to that conference, seven articles were published on the subject of spiritual care in Volume 5.1. After the establishment of Spiritual Care in NHS Scotland (Scottish Executive, 2002), as a fruit of the conference, 11 articles regarding spiritual care were published in Volume 6.1. The conference, and subsequent report, strongly influenced not only spiritual care, but also the

overall care within NHS Scotland. Chaplaincy is "no longer the realm of the gifted amateur working at the margins of the institution, catering to the needs of a few, but a service provided by trained and accountable professionals, fully integrated and part of the health care team, who offer spiritual care to all; in one sense the chaplain will be the expert, and yet at the same time the one who affirms the shared nature of the task of spiritual care" (Editorial, SJHC, 2002). Spiritual care is no longer considered just the responsibility of chaplains, but rather a shared task for all who work in healthcare. Eventually, in 2009, "Spiritual Care Matters" (NHS Education for Scotland 2009) is published, which includes, as the subtitle suggests, "An Introductory Resource for all NHS Scotland Staff". In the various reports it is clearly stated that spiritual care is not only care for persons with specific religious beliefs. "Spiritual care is usually given in a one-to- one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation" (Scottish Executive 2002: 1). People are spiritual beings, and therefore spiritual care is an essential part of health care (NHS Education for Scotland, 2009: 6–8). The pastoral, or chaplaincy care, provided by specialists, is part of the far wider spiritual care which ought to be provided by everyone (NHS Education for Scotland 2009: 24). Mitchell (2006) believes that the fact that spiritual care went from the sidelines to a central component of health care in just a short period of time, is attributable to the limited proportions of spiritual care in Scotland, in combination with the influence from palliative care. Even though a great deal has been achieved, it will always be a challenge to implement the vision presented in the various reports. "A central challenge is to find the language to integrate spirituality with core NHS policies such as person-centred care, equality and diversity, and user involvement" (Stirling, 2012).

Experiences and Practices (35)

As in the Dutch journal, this category comprises papers which report on a specific component of the profession, frequently initiatives within one institution. The specific nature of these articles makes them hard to place in other categories. Examples of articles include, "Dementia Care: Supporting a Plea for Personhood" (Stoddart, 1998) and "Bereavement Assessment in Palliative Care — Identifying Those 'At Risk'" (Carmichael, 2005). Volumes one to seven contain more articles related to "experiences and practices" (22) than volumes eight to 15 (13).

Identity (34)

Healthcare chaplains have a rich history in the United Kingdom, where hospitals were traditionally built near a chapel. Traditionally, healthcare chaplains were clerics who had been assigned to a healthcare institution by the bishop, who were

accountable to the bishop and who were not integrated within the care institution (Swift, 2009). However, in a rapidly changing industry, chaplains must understand what their present position is (Banks, 2000). The matter becomes even more vital following the publication of the report "Spiritual Care in NHS Scotland" (Scottish Executive, 2002). That crucial report placed spiritual care, and as such healthcare chaplaincy, at the heart of health care. This requires chaplaincy to reconsider its position and identity (Swinton, 2003). Many healthcare chaplains started out as local parish clergy before entering health care chaplaincy, even, at times, continuing their parish work along-side their healthcare position. At the hospital they work in multi-disciplinary teams, where they are faced with the question of what, in fact, defines the work of a chaplain in comparison with that of other psycho-social workers (Avgoustidis, 2008; Williams, 2008). In the past, many healthcare chaplains remained employees of the church, which received compensation from the NHS for labour costs. However, in 2006, all spiritual caregivers became NHS employees. In addition to questions regarding pay and duties, that shift also raised questions concerning the identity of healthcare chaplains. Is it time for clerical priests to become general spiritual caregivers? (Duggan, 2004).

Research (23)

This category consists of articles that describe studies that have been carried out, or deal with, the research process itself. A research report (Hay, 2002) is among the first published in the SJHC following the November 2001 conference organized and funded by the Scottish Executive Health Department on the theme "Spirituality in Health and Community Care". Given the increased profile of spiritual care since 2002, it is not surprising that a substantial number of articles were published on research topics relating to spiritual care. Once spiritual care had become an integrated part of the healthcare system, chaplains were accountable to both their church and to the NHS. As is the case for all disciplines, chaplains must now employ evidence-based practices (Mowat, 2010). This requires research, and research can entail obstacles caregivers are not used to (Stirling, 2010), specifically regarding the ethical committees in charge of authorizing research. Chaplains must learn to appreciate the necessity of such committees (Atherton, 2010). In addition to several appeals for research, we encountered a number of reports on a broad variety of studies, such as "From 'Pastoral Contacts' to 'Pastoral Interventions'" (Carey, Cobb, & Equeall, 2005) and "The Spiritual Care of Staff in an ITU" (Brown, 2010).

Overview

The publication of the report "Spiritual Care in NHS Scotland" in 2002 signalled the dawn of a dynamic period for spiritual care in Scotland. Quickly spiritual care

moved from the periphery to become an integrated part of NHS care. All NHS employees share responsibility in the provision of spiritual care, in which chaplains function as specialists. That development requires chaplains, and other caregivers, to reflect on what spiritual care means in present settings and how it relates to the traditional situation. This also gives rise to the question of how to define this [new-found] identity of chaplains within the NHS. Further studies are required to ascertain the effects of those developments.

Discussion

In order to get an insight into the developments that chaplaincy in health care institutions has gone through, we analysed the major journals in this field in the Netherlands and in Scotland. Both are the journal of a professional association of chaplains. Both make regular calls on their members to report insights and [new] processes. The editors of both journals had the policy to pay attention to new developments. Thus, the method of content analysis, in which we have counted themes in both journals, appears to provide a reliable insight into the development of the professional field in both countries. Possible strategic considerations of editors to emphasize certain topics at the costs of others were not taken into consideration; our data referred to the actual content of the publications. Our presumption that these journals would reflect changes in position and self-understanding of the profession of chaplains in health care turned out to be correct, even though the developments in the two countries were different. Our analysis of the journals yielded both similarities and many differences between the two countries. Those differences precluded applying identical categories for both journals. Three categories appeared in both journals: “Identity”, “Developments” and “Experiences and Practices”. Within these categories we again found similarities and differences.

Identity

In both countries the spiritual care profession had its origin in the duties performed by the local clergy. Within a short period of time a new profession was born. A new profession in a new setting automatically engenders a new identity. In the Netherlands, the VGVZ has been an independent body since its foundation in 1971. Since the founding of the Association, the term “spiritual care” has been employed to indicate the profession, instead of the more clerical term “chaplaincy”. An underlying thought was that this expression would benefit integration within care as a whole. In 1976, a sector for Humanist counsellors was introduced into the Association, in addition to the Roman Catholic and Protestant sectors. Although

formal world view endorsement came under increasing pressure, until 2013 the Association's members were required to possess endorsement. At the June 2013 general meeting, the decision was reached that the register should be opened to independent spiritual caregivers, for whom a Council for Independent Spirituality (working title) is to be created, to warrant the world view competency of non-affiliated spiritual care professionals. In Scotland, chaplains have only been part of the NHS since 2006. Because in Schotland the majority of hospital chaplains remain members of the clergy, the sense of religious affiliation is far more dominant than in the Netherlands. This fits the ecclesiastical term "chaplain". Nevertheless, both journals contain articles on searching for a new identity, befitting the new profession. The (Dutch) sub-category "world view endorsement — professionalism" is closely linked to that search.

Developments

Our analysis yielded the "Developments" category in both journals, with both journals publishing articles on developments in health care and their implications for spiritual caregivers. Within this context, papers in the SJHC focused on "evidence-based practices" and "spiritual care", whereas in the Netherlands papers focused on "multicultural spiritual care" and "transmuralization". It seems likely that the differences in focus reflect the challenge of the NHS in Scotland and discussions on multicultural society in the Netherlands respectively. In both cases, however, the focus is relevant to developments in the broader European context, of transitions in health care and a shift in the place of spirituality and religion in society.

Experiences and Practices

In 2007, on the occasion of the tenth anniversary of SJHC, W. Noel Brown categorized the issues of the journal in order to answer the question: Is the journal best serving the chaplains of Scotland, or should the ingredients be changed? (Brown, 2007). In this analysis of SJHC, Brown formulated the category "Descriptive" for papers that "have their origin in rapidly-developing situations, where a pastoral response had to be created on the fly". In addition he introduced the category of "Professional practice of chaplaincy — clinical": "The papers within this group are descriptive and include new acts of ministry engaged in by chaplains". Our category, "Experiences and practices", includes those two categories, resulting in a broad category in which professionals report on aspects of their job, e.g. a paper on dementia care (de Haan, 1998; Stoddart, 1998) or a contribution focusing on the attack on the Twin Towers (Ulanov, 2007) or following the fireworks disaster in the city of Enschede (Strasser, 2001).

Differences Between the Journals

The 2001 Scottish conference on "Spirituality in Health and Community Care" was instrumental in shifting the position of 'spiritual care' to that of a central theme for all of NHS Scotland, not just for the field of chaplaincy. Shortly after, spiritual care and chaplaincy moved from the realm of well-meaning amateurs to that of key health care policy, becoming the responsibility of all NHS professionals. Spiritual care has also raised its profile in the Netherlands, particularly as a result of influence from the palliative health care sector (Holloway, Adamson, McSherry, & Swinton, 2011). Spiritual care seems to attract the most attention in the fields of medical, healthcare and nursing sciences (Leget, 2013). As in Scotland, chaplaincy could take on the co-ordination and organization of spiritual care.

The second major category, far less treated in TGV than in SJHC, is that of "research". The requirement of evidence-based practices within the NHS requires research to be carried out, despite the relative novelty of that scenario for most chaplains. In his analysis, Brown states that, "it was not always easy to decide whether an article was truly a research article or not. Or was it even intended to be?" (Brown, 2007, 13). Papers that describe research projects could sometimes have been put in a different category. However, due to the expressed interest in research, we have classified those papers as research. A research study on spiritual care, for example, similar to the Brown article previously mentioned (2010), was classified as "research" and not "spiritual care".

In addition, it is worth dwelling on the Scottish method of conducting research and the evidence-based practices related thereto. A number of articles mention the importance of evidence-based working. However, the term does not seem to be clearly defined. Of the issues we examined, only the last issue of the Scottish Journal of Healthcare Chaplaincy (Volume 16, 2013) focuses on this subject in depth. "Chaplains now developed an evidence based tool that can be used to measure the impact of spiritual care interventions on patients within the UK context" (p. 52), looking primarily at Patient Reported Outcome Measures (PROM). This entails patients filling out a questionnaire to give feedback on their experiences with their chaplain. However significant, this is a research method different from that generally used in the medical world, where the effects of interventions are measured and compared to control groups. Nevertheless, spiritual care research within Scottish chaplaincy is growing and is hardly imaginable without the central role played by the NHS.

In the Netherlands, where healthcare institutions are relatively independent and the position of chaplaincy and spiritual care depends on the management of the institution and how caregivers perform, the profession tends to remain focused on itself. Discussions regarding identity, affiliation and professionalism and diagnosis, though (perhaps) of interest within the profession, may not, from the outside, seem relevant or necessary within a larger healthcare context.

Conclusion

Recommendations for the Spiritual Care Sector in the Netherlands

We have seen that, in part, due to the central role played by the NHS, spiritual care has become a key issue in healthcare in Scotland. Although the role of the NHS cannot be emulated in the Netherlands, spiritual care can learn from the changes made in Scotland. A first step would be to turn the profession's inward gaze outward, suspending its reflection on its own "raison d'être" for the time being and focusing on outwardly raising its profile. A crucial step in that process is the implementation of research, in order to establish research-based best practices, as is the case in Scotland. We recommend a more critical or nuanced approach to research than is evidenced in the SJHC. Studies will have to be conducted to ascertain what best practices are in a Dutch context. Research of that kind will enable the profession to acquire validation and secure a more central position within the healthcare sector. Forty years on, it is now time for spiritual care to assume its place as a credible, professional discipline within the healthcare system.

Recommendations for the Spiritual Care Sector in Scotland

One of the Dutch issues that could be of value to spiritual care in Scotland is that of multicultural spiritual care. We recommend that multicultural spiritual care be considered further, both in respect of healthcare providers and care recipients. Part of the fruits of attention to multicultural spiritual care is not only the respect of cultures, but an increased understanding of the plurality of religious and world views, resulting in a variety of spiritual experiences.

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