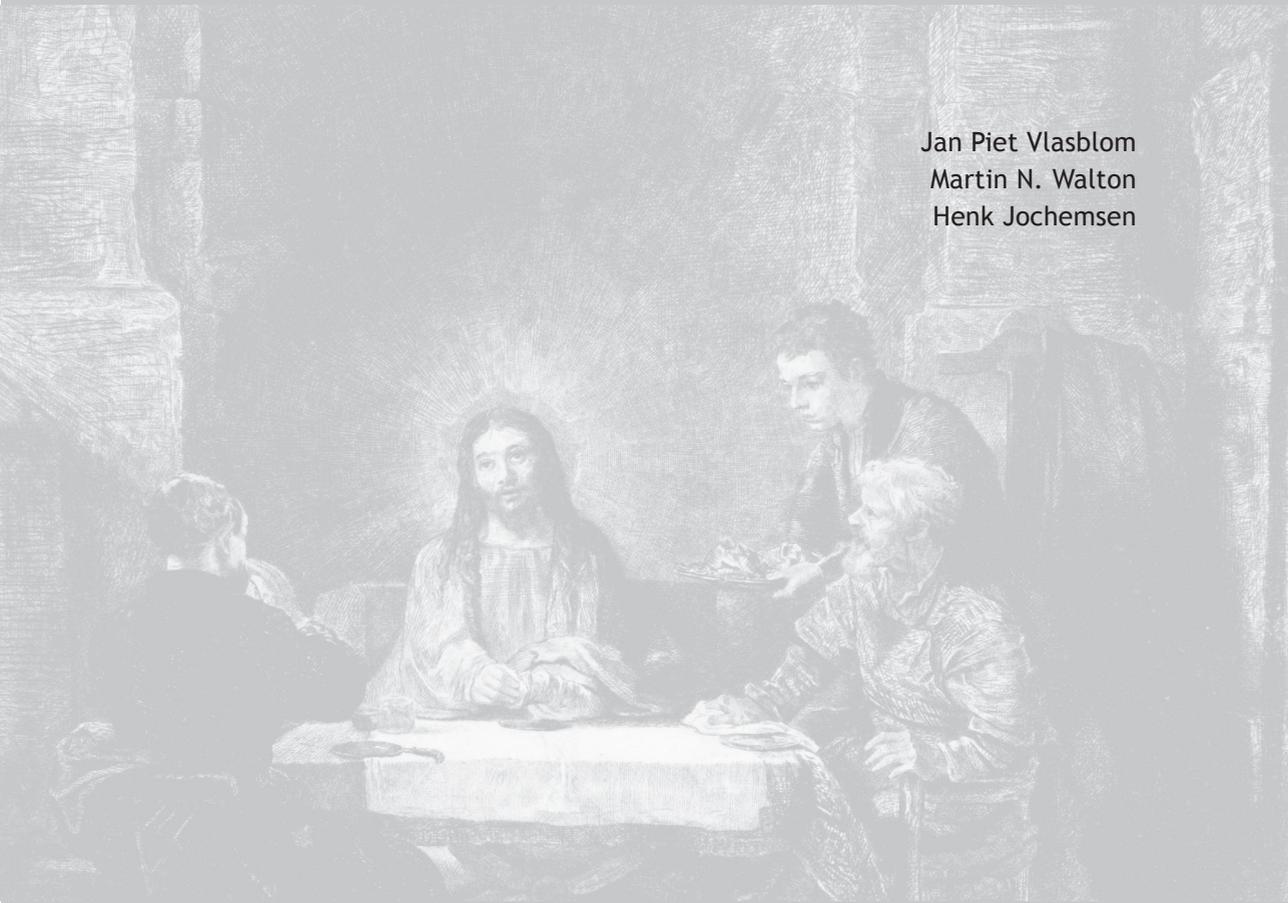


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Ministry in Spiritual Care

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Introduction

In the search for potential improvement of spiritual care, we cannot ignore the discussion in the Netherlands about the significance of endorsed ministry in spiritual care. Traditionally holding an office in a religious or worldview institution guaranteed quality, as one could only hold the office after successfully completing an education and training. Over the years doubts about the value of the office have increased within the profession. Central to this discussion was the question whether the office of the spiritual caregiver enhances the quality of spiritual care, whether it might even constitute a hindrance to the intended level of quality. In 2013 the questions raised led to the first major spiritual caregivers association in the Netherlands relinquishing the requirement of official (ministerial) endorsement by a religious or worldview organization for spiritual caregivers. Now that spiritual caregivers who do not possess official endorsement¹ are also admitted to the Association and to the professional register of spiritual caregivers, thus ending the internal polemic on the subject, reflection on the effects of that admission is appropriate.

Based on a review of the literature regarding (ministerial) theology we describe in this article the development of the vision on the office of ministry within the VGVZ. We then reflect on office and official endorsement of spiritual caregivers and their significance for the quality of spiritual care, especially with a view to accommodation of the patient population.

Setting

Until well into the 20th century the churches provided spiritual care, generally referred to as pastoral care, in hospitals. Protestant spiritual caregivers, who were employed as ministers by the local churches, visited members of their parish in the hospital. From the nineteen-sixties, ministers, who were initially employed by a local church, were allowed to fulfil their office in the hospitals.

In the Roman-Catholic hospitals the rector, who was paid by the church, was charged primarily with care for the nurses and daily mass, going around the hospital to enable patients to participate in the celebration of the Eucharist. Over the years it became more common for spiritual caregivers to be employed by the health care organizations, while they retained official affiliation with their religious community. This affiliation with an endorsing religious or humanist

¹ These spiritual caregivers who gave no official endorsement are also referred to as free, independent, or general spiritual caregivers. These terms will be used interchangeably, often depending on quotations presented.

community is referred to as official worldview affiliation. Closely related is the religious (or worldview) endorsement that the bearer of an office receives from his community to work in a healthcare institution. Official affiliation and endorsement have become synonymous and are used interchangeably in this article. In other countries this development of institutions rather than churches employing the spiritual caregivers started much later, or the spiritual caregivers are still being employed by the churches.

The Dutch *Vereniging van Geestelijk Verzorgers in Ziekenhuizen* – VGVZ (Association of Spiritual Caregivers in Healthcare Institutions) was the result of a merger in 1971 of the Roman Catholic and Protestant hospital chaplain associations (Vlasblom, Walton, Steen van der, Doolaard, & Jochemsen, 2014). At that time it was self-evident that all members conducted their work in the different healthcare institutions with an endorsement from their church. Most started out as local parish practitioners before entering the field of health care. A few years after the foundation of the Association, membership was also opened up to humanist and Jewish chaplains. Although the ministerial structure is alien to the humanists, they adjusted to the existing structure and they received their endorsement from the Dutch Humanist Association [*Humanistisch Verbond*]. Many years later the Muslims and Buddhists would join in the same manner.

Historical Developments

We find the first definition of spiritual care in the 1976 report ‘Identity and necessity of spiritual care [*Identiteit en noodzaak geestelijke verzorging*] by the Spiritual Care Committee of the National Hospitals Council of the Netherlands [Nederlandse Ziekenhuis Raad] [NZR]. This definition was: “Professional support and guidance of people in fundamental questions regarding life, illness, and death, offered through and based on a religious or worldview belief system” (Snelder, 1996).

This report was adapted in 1978 by the NZR board and forwarded to the hospitals. The qualification “professional” was added to the definition at the request of the directors of healthcare institutions, who were somewhat doubtful about the professional accountability of spiritual caregivers. The distinction between ministerial and professional quality was made with a view to hiring policies and the evaluation of the professional performance of the spiritual caregivers. The different positions and responsibilities of the health care institutions and the religious communities were acknowledged. The spiritual caregiver was accountable to the endorsing organization (referred to as ministerial) and to the employer (referred to as professional). The condition of professionalism, therefore, has a background pertaining to labour law (Mooren & Smeenk, 2010, p. 106). In the view of the Spiritual Care

Committee of the NZR both aspects, the ministerial and the professional, should always be closely linked (Mooren & Smeenk, 2010, p. 107). The definition reflects that it was still considered self-evident that spiritual care be provided by religious or worldview communities.

In 1987 the Committee on Spiritual Care in Hospitals of the NZR published the report *Spiritual Care Service in organization and policy [Dienst Geestelijke Verzorging in organisatie en beleid]*, which contains a modified definition of spiritual care. Spiritual care is defined here as: “The professional and ministerial [i.e. endorsed] guidance and support of people from and on the basis of a religious or worldview belief system” (Snelder, 1996, p. 71).

Compared to the 1976 definition we see the addition of ‘ministerial’. Whereas in 1976 it was self-evident that all spiritual caregivers performed their duties based on their affiliation to religious or world view communities, it was much less so in 1987, and it was considered advisable to include this in the definition. A similar development can be observed a few years later regarding the funding of spiritual care.

In 1986 the Dutch government set up the Advisory committee for the provision of support for religious and other worldview societies [*Commissie van advies inzake de criteria voor steunverlening aan kerkgenootschappen en andere genootschappen op geestelijke grondslag*], also known as the Hirsch Ballin Committee. In 1988 the Committee presented its 258 page-long report. In addition to recommendations regarding the maintenance of (monumental) church buildings, the report focuses on the funding of spiritual care. Although the Committee held the basic principle that the government plays no role in the financial support of churches and religious or worldview organizations, it makes an exception for spiritual care within the armed forces, the healthcare sector and penitentiary institutions. This is based on article 6 of the Constitution of the Netherlands. According to this article: “Everyone shall have the right to profess freely his religion or belief, either individually or in community with others, without prejudice to his responsibility under the law” (“The Constitution of the Kingdom of the Netherlands,” 2008) it is the government’s responsibility to ensure that persons in public institutions such as the armed forces, penitentiary institutions and hospitals have the opportunity to exercise this right of freedom of religion.

The government adopted the report of the Committee in 1988, with a few small amendments. It is important to note that this report is within the bounds of the Committee’s assignment: “provision of support to churches and other communities based on religious principles”.

The report clearly influenced the 1992 legislative proposal for the Care Institutions Quality Act. The explanatory memorandum to the proposal states that institutions

in cooperation with the endorsing institutions must guarantee spiritual care as part of the quality of care.

A fundamental shift appears to have taken place in the four years between the report of the Hirsch Ballin Committee and the legislative proposal. In 1988 the key issue was the support of religious or spiritual communities, in 1992 the focus is on quality of care. Although this seems to be no more than a difference in nuance in 1992, it will prove to be of fundamental significance in the development of the view on spiritual care.

In 1994 the Dutch Upper Chamber rejects the legislative proposal Spiritual Care in Healthcare Institutions and Penal Institutions for financial reasons.

On the 1st of April 1996, the Dutch Care Institutions Quality Act entered into force. In Article 3 we read: Regarding the care provided for the stay of the patient or client in the institution during a period of at least 24 hours, the care provider also ensures the availability in the institution of spiritual care corresponding as much as possible with the religious or worldview tradition of the patients or clients.

This implies another step in the development that began earlier. The government created the framework for spiritual care that from then on is one of the preconditions for good quality care, also in a legal sense. The healthcare institution is responsible for facilitating spiritual care. The worldview organizations provide the spiritual caregivers and organize their education.

In October 1984 eight members of the VGVZ requested the establishment of a sector for spiritual caregivers who are active without the endorsement of a (religious) community. In its response the board denied the request. It stated that spiritual caregivers do not function on their own behalf, but on behalf of a broader community. Furthermore, the board asked, if spiritual care is not certified by a (church) community, then what is it based upon? And how does it distinguish itself from other disciplines? (VGVZ, 2010, p. 6). In the years that followed the successive boards maintained the requirement of official endorsement.

In later years increasing numbers of spiritual caregivers rejected official affiliation. These were not the VGVZ members, usually Roman Catholics, who due to their marital status or orientation did not qualify for official endorsement from their church. A special arrangement was created for the latter, who were denied the desired endorsement by their institution, by means of a hardship clause.

In 1984 the board stated: Whether the required affiliation should always be formalized by means of an official endorsement from a denominational body is, in our opinion, a different matter. This is not always possible. As an organization we offer no opinion on the matter. However, affiliation with, standing in the tradition of a worldview movement, is part of the identity of the spiritual caregiver (VGVZ, 2010).

Various developments resulted in a louder call to allow independent spiritual caregivers to join the VGVZ. Over against those who advocated (the possibility of) unaffiliated spiritual care, were others who wanted to maintain official endorsement. The debate on official affiliation resulted in polarization within the VGVZ on the subject of endorsement and professionalism, in which the two qualities named together in the 1987 definition increasingly are regarded as separate qualifications. Over the years that duality caused much and sometimes heated debate (Vlasblom et al., 2014). It became one of the main themes in *Tijdschrift Geestelijke Verzorging* (Vlasblom et al., 2014).

In 2006, after many years of preparation a quality register of spiritual caregiving was presented to the general assembly for approval. Emotions regarding the question whether official affiliation should be a condition for professional registration ran so high that the proposal was not put to a vote (Algemeen bestuur, 2006), delaying the start of the register.

A year later, in 2007, the decision was taken to instigate the professional register, initially only for VGVZ members, but with the explicit intention of opening it up at a later stage for colleagues from other associations and other contexts: armed forces, penitentiary institutions, police and youth care organizations (SKGV, n.d.). Membership of the VGVZ was required for admission to the register (VGVZ, 2010) and official affiliation was required to qualify for membership of the VGVZ. During the general meeting of June 2007 the board proposed a further investigation of the problem of official affiliation, both internally and externally. The members agreed to that proposal. In 2010 the results of those investigations were published in the fourth study report [*Cahier*] of the VGVZ (2010). In June 2013 it was finally decided to open up the register and the association to independent spiritual caregivers not formally affiliated with a religious or worldview institution. In February of 2015, a year after the formation of a sector for institutionally non-endorsed spiritual caregivers (Sector Institutioneel Niet Gezondenen (SING)), a reviewing board for the non-endorsed (Raad voor institutioneel-niet-gezonden Geestelijk Verzoekers (RING-GV) was constituted. Its task is to review the worldview competence of spiritual caregivers who have no endorsement from a religious or worldview organization. It thus fulfills the function of an endorsing organization. That meant that the requirement of endorsement by a religious or worldview organization was no longer requisite, but that a form of assessment of the “worldview competency” of new spiritual caregivers remained in force. By relinquishing the requirement of endorsement, the VGVZ Association made it possible for the Albert Camus Association for Spiritual Counsellors, who did not have the requirement of official endorsement, to integrate into the VGVZ.

Considerations in the Discussion

Which major underlying developments have contributed to the rise of independent spiritual caregivers? Secularization is mentioned as the most important development regarding the emergence of independent spiritual care (VGVZ, 2010, pp. 20, 60, 86, 88). Secularization has considerably loosened the relation of the population to religious institutions. The publication *Faith in the Public Domain. Investigation of a Double Transformation [Geloven in het publieke domein. Verkenningen van een dubbele transformatie]* by the Dutch Scientific Council for Government Policy [WRR] (van de Donk, Jonkers, Kronjee, & Plum, 2006) describes how the presence of new forms of spirituality has increased in recent decades, but also how those new forms are a far cry from older forms of spirituality. Kronjee (2006) speaks in this context of religious transformation. In the new forms of spirituality self-fulfilment seems to be the key, without any significant input from religious institutions (van de Donk et al., 2006, p. 14). Secularization should therefore be interpreted primarily as deinstitutionalization (van de Donk & Plum, 2006, p. 33). No longer being affiliated with a religious or worldview institution, does not mean that people are less religious, but rather differently religious. Religiousness is less clearly defined and more fluid (Kennedy & Valenta, 2006). For this reason many patients in healthcare institutions no longer feel a connection with the religious or worldview institutions that the spiritual caregivers are affiliated with. The question is raised whether, in a secularized society in which the religious or worldview institutions have become much less important, it is realistic to demand of spiritual caregivers affiliation with those institutions. Even more so since spiritual caregivers indicate that their religious or worldview affiliation is less important to them. “Apparently they do not see how the endorsing organization can contribute to the foundation of their work” (Smeets, 2007). This is partly due to the fact that the organizations do not take “their” spiritual caregivers very seriously (Gärtner, de Groot, & Körver, 2012; Smeets, 2007). Research by Pieper and Verhoef (2005, 2007) demonstrates that the Roman Catholic spiritual caregivers do value their connection with the church, but that it is not what they had hoped for. In an open letter on offices of ministry written by the secretary of the general synod of the Protestant Church of the Netherlands, Arjan Plaisier, in 2014, there is reference to but no specific mention of the spiritual caregivers who are also ministers in the church. This is symptomatic of the (lack of) attention paid by the churches to their spiritual caregivers.

Nor have either the Roman Catholic or the Protestant churches devoted serious attention to the position of the spiritual caregiver in the church. The National Platform Church & Care [*Landelijk Platform Kerk & Zorg*], founded in 2003 to facilitate

a closer relationship between the churches and spiritual care, has been unable to alter that situation. A process of reflection on the office could, therefore, provide an ideal opportunity to also look at how spiritual care fits in to the church.

Secularization has not left spiritual caregivers unaffected. They, too, have become more independent of their institution as the endorsing organization (Vandenhoeck, 2007, p. 162; VGVZ, 2010, p. 87). Especially in the hospital setting, where religious or worldview plurality is experienced even more acutely than outside the hospital (Vanderhaegen, 2003), stressing professionalism has proven more appealing to many than emphasizing official endorsement.

Another related and frequently mentioned development is the process of depillarization of Dutch society (Schouten, 2002; VGVZ, 2010). Schouten (2002), for example, asks whether official endorsement is not a remnant of the past era of pillarization. However, whether depillarization and the questions it raised actually had an effect on official affiliation is questionable. The issue of official endorsement is not a typically Dutch phenomenon. In a report of a fact-finding mission to the United States, Zock states “Perhaps too much attention and energy have gone into discussions about the office and the role of religious and worldview institutions in the profession in the Netherlands in recent years” (Zock, 2008).

Spiritual caregivers in the field of healthcare, unlike their colleagues who work in penitentiary institutions and the armed forces, are appointed by the independent (healthcare) organization. These institutions are free to appoint unaffiliated individuals² as spiritual caregivers³. In the context of penitentiary institutions and armed forces only spiritual caregivers are appointed who have been nominated by their endorsing organization (Flierman, 2012, p. 135)⁴. In matters concerning worldview the government maintains relations only with (endorsing) institutions, not with individuals. Partly due to secularization and deinstitutionalization, policymakers in healthcare institutions increasingly opt for “general” spiritual care on the apparent assumption that endorsement or religious affiliation is a limitation. Despite the realization that non-affiliated spiritual caregivers likewise

² This freedom regarding admission policy is not only relevant for worldview endorsement, but also for the other admission criteria of the VGVZ, of which an academic degree is the most important.

³ Because the title of spiritual caregiver is not legally protected, all institutions are free to appoint whomever they want.

⁴ The fact that justice and the armed forces hold on to official endorsement has played a part in the discussions. It is hoped that a register can be realized in the future for all spiritual caregivers, which is why efforts were made to include justice and the armed forces in the decision making. The Commissie Ambtelijke Binding (Committee on Official Endorsement), one of the advisory bodies set up by the Board of the VGVZ in 2007, failed in this respect. One of the members could not agree to all of the Committee’s viewpoints and eventually presented a minority opinion.

have a particular world view (and that there is no such thing as a neutral spiritual caregiver), the assumption seems to be that non-endorsed are more generally employable in a secularized setting (Vreeman, Smeets, & Quartier, 2009). As a result of the preference of some healthcare organizations for generic, unaffiliated (and, in many cases, non-academically educated) spiritual caregivers, a growing number of educational institutions offers (academic or non-academic) programmes for “independent/general” spiritual caregivers. The worldview communities do not recognize those new programmes as official ministerial education. Therefore, the graduates from those institutions are unable to obtain official endorsement, should they desire it. As a result “the market” contributes to the emergence of a group of independent, unaffiliated spiritual caregivers.

In part due to their integration in the care institutions, spiritual caregivers who support only those patients who share their own religious or worldview beliefs (as was the practice when the VGVZ was founded) are a thing of the past. Presently most spiritual care is organized on a territorial basis. One exception in many institutions is the spiritual care to migrant populations, which is generally provided on a denominational basis. Official affiliation appears to be less relevant in a situation of territorial organization. Few people ask for a spiritual caregiver of their own denomination and patients utilize the services of the spiritual caregiver, regardless of his religious or worldview background.

Considerations that have been put forward in favour of maintaining the official religious or worldview affiliation

Religious or worldview office represents a tradition and a community related to a more than everyday (transcendent) dimension of existence. Without that connection with the transcendent, spiritual care loses its identity and hence its relevance (Nieuwenhuis, 2004). Contemporary, non-institutional forms of spirituality also entail references to sources of meaning and sometimes the transcendent but without initiation into a tradition and endorsement by a community the representation of such sources and of the transcendent dimension becomes diffuse.

Affiliation with a worldview organization provides an additional warrant of quality. Along with the quality requirements of the professional organization and the register, the endorsed spiritual caregiver demonstrates accountability to a religious or worldview tradition and community. The decision as to what comprises personal worldview competence, beyond matters of religious and worldview literacy, is itself a religious or worldview matter.

The sanctuary function of the spiritual caregiver (the right of all patients to speak with the spiritual caregiver in confidence), is connected to official affiliation,

which ensures non-interference from the management of health care or government organizations.

The sociological developments of individualization, detraditionalization and deinstitutionalization do not automatically result in a demand for general spiritual care. Secular individuals can also consider themselves to be spiritual (Berghuijs, Pieper, & Bakker, 2013). For these individuals denomination (whatever its significance for them) can provide access to the denomination-transcending, 'archetypal' ministerial nature of spiritual care (Hanrath, 2000).

It is generally recognized that there is no such thing as neutral spiritual care. Even when the patient has a different faith or is non-religious, it is important that the spiritual caregiver maintain his own, unambiguous worldview identity. One is only able to relate adequately to other positions from a position that can be personally articulated and reflected upon. Whereas the present master programs for non-affiliated spiritual care adhere to the position in the professional standard that spiritual care is never 'neutral' (VGVZ, 2010, p. 90,99, 122; Morice-Calkhoven, Smeets, Lammers, 2013), non-affiliation has at the same time been advocated as being a preferable and more accessible form of spiritual care in a secularized (and religiously de-institutionalized) setting (Vreeman, Smeets & Quartier, 2009). The argument is made despite the general practice, in compliance with the professional standard, that (official) spiritual care is accessible to all patients regardless of religious or other convictions or affiliations. (VGVZ, 2002 p. 2). There is no evidence that non-affiliation provides a better basis for spiritual care to patients not affiliated with a religious or worldview organization (Walton, 2010). The advocacy of unaffiliated spiritual care for the unaffiliated also disregards the fact that the worldview of the non-endorsed spiritual caregiver is no less particular than that of the endorsed spiritual caregiver. The proximity to the worldview of the patient is in both cases an open issue.

In any case, only the officially affiliated spiritual caregiver is authorized to perform the rituals and/or sacraments of his religious community.

Now that the heat of the debate has subsided and decisions have been reached, the opportunity arises to sift through some key aspects of the discussions. It seems wise to reflect on the consequences of relinquishing the requirement of official endorsement.

The Office of Ministry

The discussion on endorsement focused mainly on aspects of office that could be relevant to (the quality of) spiritual care. In other words, it took a highly func-

tional approach. However, more can be said about the significance of office than its present-day functionality. In 1987 the qualification ‘ministerial’ (‘official’) was added to the definition of spiritual care, and the humanist sector was established that same year. However, the term ‘ministerial’ is derived from the office of the spiritual caregiver in an endorsing church. It is therefore important to investigate the content of the concept of office in general and the ministry of the spiritual caregiver in particular, as it is taught and experienced on the basis of a theological perspective in the endorsing churches where the profession of spiritual caregiver originated. Although it is impossible to describe a complete theology within the framework of this article, we do need, when reflecting on the office of ministry, to sketch a theological outline. And that proves to be complex.

In the Letters of Paul, as in the rest of the New Testament, we do not find an elaborated teaching on the offices of ministry (Berkhof, 1985, p. 374; Gosker, 2000, p. 54; Ridderbos, 1978, p. 531). The BEM report of the World Council of Churches (1982) also acknowledges that the New Testament does not provide a blueprint for a doctrine on the offices of ministry, because the NT does not describe one exclusive pattern of ministry (Gosker, 2000, p. 101). Although the Bible does not allow for unequivocal conclusions regarding a view on offices, we can infer several learning pathways regarding the concept of ministry (van Ruler, 1952, p. 33). These learning pathways can have very different outcomes, as the fundamental difference in the views on the ministry between Roman Catholic and the protestant ministerial theology demonstrate.

The central concept in the traditional Roman Catholic vision is the apostolic succession. In an unbroken chain of laying on of hands, the ministry of the twelve apostles chosen by Christ himself has been passed on, up to the current bishops. The church is a sign of God’s grace that loses its power without the activity of the ministries (Beker & Hasselaar, 1990, p. 76). One of the characteristics of the true church is that apostolic succession of ministry. In the activities of the clergy the body of Christ will continue. The faith of the members of the congregation coincides with obedience to the ministries (Beker & Hasselaar, 1990, p. 76).

This Roman Catholic ministerial theology appears to be less fruitful for a reflection on the ministries of spiritual care. Within the Roman Catholic sector most caregivers do not hold an office in the sense of Canon Law (Huysmans, 2006). In addition to a small minority of officially ordained priests in this sector, there are pastoral workers with an ecclesiastical endorsement, and a growing group – partly as a result of the policy of the bishops – of spiritual caregivers without ecclesiastical endorsement. A ‘hardship clause’ enabled the latter to join the catholic sector of the VGVZ without ecclesiastical endorsement. In terms of content, the value of the teaching of the apostolic succession appears to be limited to the bearers of an

office who hold to ecclesiastical endorsement and spiritual care of an explicitly Roman Catholic nature.

The Protestant path, on the other hand, provides a surprising perspective on the ministerial discussion within the VGVZ. In the Protestant theological understanding of Paul the institution of office in the New Testament church revolves around two words. One is “gifts” [*charismata*], referring to that which Christ through his Spirit, in diversity and freedom, gives to the congregation, and the other is “services” [*diakonia*] as the “characterization of the way in which these gifts function in the congregation” (Ridderbos, 1978, pp. 492-499). Although there is a wide variety of gifts, there is no hierarchy in which some are less “spectacular” or “pneumatic”. Caring for the poor is no less charismatic than glossolalia (speaking in tongues). To fully understand the significance of the term service it is important to realize that “every activity that is important for the edification in the church is to be viewed as *diakonia*”. “The charisma functions as a service in the church” (Ridderbos, 1978, p. 495). This illustrates the congregational nature of the gifts; they are present for the good of Christ’s body. Ridderbos (1978) emphasizes that there is no distinction between the charismata as the operative gift from Christ on the one hand and the institutional, organized services or ministries on the other. “We believe that the contrast between the charismatic and the institutional is in essence as false as the contrast between charismatic and non-charismatic services in the congregation” (Ridderbos, 1978, p. 496). Ridderbos, referring to Bultmann en Kümmel, goes as far as to say that he believes there is only one possible conclusion, “namely that the ministry, according to Paul, is itself also a charisma” (Ridderbos, 1978, p. 498). Martin Bucer, reformer from Strasbourg who can be considered the founder of the structure of the reformed church and the offices, also believed that the correlation between office and charisma is essential (van’t Spijker, 1971). He leaves no room for a contrast between ministry and charisma. The goal of the charismata is to build up the Body of Christ. Depending on the position that an individual occupies in the body of Christ, he is granted a spiritual gift to enable him to answer his calling. Justice can be done to the special charisma of the bearer of the office only when each and every one takes his own place in accordance with the gift he is given.

The office is not above the congregation nor opposite to it. But neither does it originate in the congregation. The dilemma either from above or from below, is no longer an issue as a result of Bucer’s use of the correlation between office and charisma (van’t Spijker, 1971, p.34).

Calvin, strongly influenced by Bucer (Berkhof, 1985, p. 374; van’t Spijker, 1992, p. 99), also relinquishes the concept of the apostolic succession. In the church “puny men risen from the dust” (*Institutie*, IV.3.1) are called to service in the

congregation of Christ. From the congregation of the Lord individuals are called to a (ministerial) task. In his explanation of Ephesians 4: 11 and 12, from which he concludes that the charisma is the basis for office, Calvin adopts Bucer's ministerial theology. In his eyes, too, charisma and office cannot be separated.

The relationship between charisma and office remains a topic of discussion in (Protestant) church history. In 1937, for example, there was a heated discussion between the theologians Noordmans and Brouwers about the office of ministry. Referring to Calvin, Brouwer wanted to understand the positions of ecclesiastical professor and visitator as new ministries. In modern terms, he approaches the office from a functional perspective. Noordmans, like Brouwer, refers to Scripture and Calvin, but argues that office has mystical traits that exceed Brouwer's historical arguments. Noordmans arrives at the conclusion that you cannot simply transform different 'services' into offices (Noordmans, 1937). Although the exact meaning of the 'mystery of the office' remained unclear (Graafland, 1999, p. 143), there is no doubt that for Noordmans office included more than simply executing a task. The dispute in 1937 was primarily a discussion between two theologians. The synod of the Dutch Reformed Church [*Nederlandse Hervormde Kerk*] also regularly held heated discussions on the office of ministry. In 1949 the subject of the discussion was granting sacramental authority to non-ordained pastoral workers. In 1959/60 the same issue became relevant again when the synod considered granting authority to administer the sacraments to ministerial candidates awaiting a call. Both times the sacramental authority was restricted to ordained ministers. In 1962 the discussion centred around the question whether office-bearers are strictly necessary for the administration of an 'open and oecumenical Lord's supper', for example in so-called 'house churches' [*huishgemeenten*]. The synod asserted in a letter dated 13 February 1962, that the offices are part of the order of Christ's church, and that non-ordained clergy are allowed to administer the Lord's Supper only in cases of extreme emergency (war, captivity) (Lekkerkerker, 1971, p. 27). In 1969 the office of ministry was again a point of dispute within the Dutch Reformed synod. The 'Committee for the Office of Ministry', also known as the Van Ruler Committee, was commissioned to reflect on the office. Within the committee "relations were very tense" (van Ruler, 1958). The report was discussed and critically evaluated by the Council for the Affairs of Church and Theology [*Raad voor de Zaken van Kerk en Theologie*]. The council decided finally not to present the report to the synod. The synod subsequently asked professor Berkhof from Leiden to prepare a report on the office of ministry. In his report "What is going on with the office of ministry?" [*Wat is er aan de hand met het ambt?*] (Berkhof & Zanten, 1970) Berkhof chooses a functional approach to office in which the ministries, which in principle are equal, serve the organization. After two rounds

of discussions by the General Synod, the report was not approved in 1969, but was presented to the churches for consideration, with an additional appendix that included the critical questions asked by both the consultation committee and the General Synod. The synod was of the opinion that the report contained sufficient considerations and arguments to serve as a starting point for a new and in-depth reflection on the office of ministry (Gosker, 2000, p. 234).

Reflection on the issue of the office of ministry was not a priority in the Reformed Churches in the Netherlands [*Gereformeerde kerken in Nederland*]. They traditionally emphasized the independence of the local congregation, and base the position of the minister much less on the office than, for example, the Dutch Reformed Church (Gosker, 2000, p. 262).

In the recent history of the Protestant Church [PKN] in the Netherlands – the church in which in 2004 the Dutch Reformed Church, the Reformed Churches in the Netherlands and the Evangelical Lutheran Church united – the office of ministry has also regularly been on the agenda. The ministry issue was addressed at the synod in connection with discussions about church workers. In the synod meeting of April 2012 there was a sense that the issue was being discussed without a clear vision of a ministerial theology. That resulted in a motion in which the synod board was asked to initiate the formulation of a clear theology of ministry within the Protestant Church in the Netherlands. At the November 2013 meeting the subject of ministries was addressed. “Ministries are gifts from God to the church, yet we don’t know what to do with them”, as the secretary of the general synod of the PKN, Arjan Plaisier stated in his introduction. After the introduction the working paper “The office of ministry under discussion” [*Het ambt in discussie*] was presented and discussed. The aim of the discussion was to prepare for an in-depth report. Instead of a report the secretary of the general synod composed seven letters on ministry for the synod meeting of April 2014. The letters were addressed to the congregations, church sessions, elders and deacons, ministers, classes, the catholic bishop’s conference and missionary workers (but not to spiritual caregivers). In revised form the letters were sent on to the congregations for discussion and response. In April 2016 the subject will again be on the agenda of the general synod.

Ministry in Spiritual Care

Ministry in spiritual care in the public domain is not primarily about building up the church in its institutional manifestation, which since Bucer has been the context for the question of the nature and meaning of the ministries in the churches. Rather, the office-bearer is delegated to a health care institution. And yet almost

500 years later Bucer's theorem that charisma and ministry cannot be separated seems again to be very relevant in the field of spiritual care. A parallel can be found in discussions on official affiliation of spiritual caregivers and the relationship between the terms 'ministerial' and 'professional'. By some the ministerial aspect is considered outdated; others argue that professional and ministerial aspects cannot be separated.

The bipolarity in the definition of spiritual care, i.e. professionalism and official endorsement, is rooted deeply in the concept of the office, even in its New Testament origins. Twice the polarity led to so much dissension in the Reformed synod that reports on the subject by the committees led by Van Ruler (1958) and Berkhof (1969) could not be adopted. Similarly, at the 2006 general meeting of the VGVZ, the tensions around the board proposal regarding religious affiliation prevented the proposals being put to a vote.

After space was created for "free", i.e. non-affiliated spiritual care in June 2013, the VGVZ established the Sector 'Not Formally Affiliated' on 12 May 2014. In that decision the bond between the poles of the bipolarity of the office seems to have been severed. A polarity is characterized by the tension between two inextricably linked poles. Ton Hanrath in his role as chairman of the VGVZ (a role he held from 1995 to 2003) emphasized along with others that the two poles of professionalism and official endorsement are inextricably linked in the field of spiritual care (Hanrath, 1997, 2000, 2002). He pictured the link in a triangle whose base is formed by the person of the spiritual caregiver. The left side is formed by the position/profession/professionalism and the right side by the ministry/the community/the religious or worldview tradition.

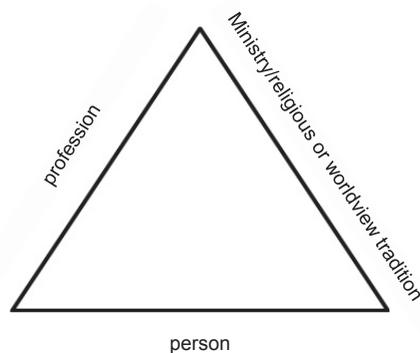


Figure 1 Triangle of Hanrath

Because the discussion on the office of ministry focused increasingly on functionality, the pole of professionalism received increasing emphasis, while official endorsement tended to be reduced to the status of relic. That process, which is

remarkable within an association that originally enjoyed strong church affiliation and with a large majority of members who are office-bearers in a religious institution, was apparently facilitated by a lack of reflection on the meaning of the ministry from which the profession of spiritual caregiver developed. The question that needs to be asked is whether the spiritual caregiver has also fallen victim to medicalization and increasing managerialism in the healthcare field. Has the temptation of becoming a professional among professionals resulted in embarrassment regarding one's own identity?

Because the discussions on church workers had been limited to the functional pole of the ministry, the PKN synod decided in 2012 to initiate a process of fundamental reflection on the nature of ministry. It is unfortunate that the process was not paralleled in the field of spiritual care, despite years of discussion. For although the discussion on official endorsement was concluded in 2013, reflection on the meaning of the office is still very much needed.

Reflecting on the concept of the office of ministry we can redefine the elements of Hanrath's triangle in an attempt to connect the poles of professionalism and official endorsement. In our version the triangle as a whole does not symbolize professional identity, but rather the office of ministry. The dimension of the divine is essential to the concept of that office. The office-bearer feels called by the Other. On the one hand that is what makes the office extraordinary. The minister is called to the ministry by the Divine. (This is not to deny that, following Calvin, every person may believe he or she is called to his or her profession or task.) The person who is called by God to the work of ministry, including his complete biography, forms the base of the triangle. At the triangle's vertices (that were left open by Hanrath) we now place, in addition to the calling (at the top), charisma and position (see figure 2). All sides and vertices are indispensable for the existence

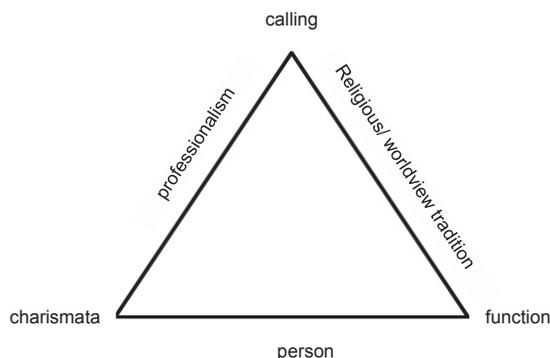


Figure 2 Office triangle

of the triangle. Only in this totality is the spiritual caregiver able to function fully and in an integrated way, to quote Heitink, personally suitable, officially endorsed and professionally competent (Heitink, 2006, p. 168). In this way he becomes a representative of the sacred, the divine, God, not as a substitute – in our view no human can be that – but as one who is called to (re)present the sacred, in the Christian tradition the God and Father of Jesus Christ.

The independent spiritual caregiver

Now that unaffiliated spiritual care is a reality, professional reflection is needed on the role of the unaffiliated spiritual caregiver. At least reflection is needed for those functions in which (sacramental) authorization is connected to ministry. The administration of Word and Sacrament as elements of the Christian liturgy⁵ is a case in point. Although the number of hospitals that do not organize a weekly religious service is increasing, the large majority of care institutions do provide the opportunity to gather for worship. The free spiritual caregiver is not authorized to lead gatherings in which, along with the proclamation of the Word, the sacraments are celebrated. In ecumenism sacramental authorization is always the prerogative of ordained clergy, that is: those persons who through ordination (confirmation) by God and man are appointed and authorized (Kronenburg & Gosker, 2009, p. 145). The liturgy of the Word also requires ministerial authority. The Catholic as well as the Protestant churches have always maintained that Word and Sacrament are inextricably linked. Therefore, the administration of both is part of the responsibility of the single ministry of Word and Sacrament (Kronenburg & Gosker, 2009, p. 146). Organizing weekly religious gatherings, but not calling them church services, as some institutions do, is an inappropriate solution to this problem as long as in fact they are meant to replace a Christian church service.

In addition to the authority of the independent spiritual caregivers to conduct these gatherings, competency is another point requiring attention. Whereas homiletic skills naturally receive considerable attention in ecclesiastical educational programmes, this is not so self-evident in the “free” study programmes.

The requirement of ordination for the administration of the sacraments in community worship, also applies to the administration of the sacraments to individual patients. Free spiritual caregivers are not authorized to administer them; their task is to ensure the availability of ordained pastors from the institution or outside it to take their place. As early as 2006 Smeets called for reflection on how the sacraments fit in to spiritual care practice. So far this reflection has not taken

⁵ This will also apply increasingly to rituals in other religions.

place (Smeets, 2006). (There are parallel examples in the case of Hindu rituals, Islamic recitation of the Quran, Jewish prayers, etc.).

These questions regarding the authority of the general spiritual caregiver are related to the functionality of the ministry. It is, however, equally important to remember that ministry – as stated above – is also charismatic, or a gift from God. Ministry therefore also represents the sacred, the transcendent⁶, even God himself. This central notion from Nieuwenhuis' theology of ministries (Nieuwenhuis, 2004) is essential to spiritual care. The person who holds the office does not refer to himself, but rather to what he represents, "This also implies that he is aware of, and receptive to that which is beyond human understanding. In the service he provides, the person of the office-bearer is subordinate to his function" (Nieuwenhuis, 2004, p. 33). This representation was self-evident to many spiritual caregivers, but, as it turns out, not to all of them. And it proves to be of some importance to care recipients also.⁷ In connection with the representation of the sacred, the office also represents the religious community that endorses the spiritual caregiver. The general spiritual caregiver is unable to provide dual representation of the transcendent and the religious community. The effects of this are difficult to predict. It would be interesting to conduct more research on this subject.

Official affiliation is relevant in contexts other than the immediate contact with patients. The officially endorsed spiritual caregiver represents the religious community within the field of healthcare, thereby making a unique contribution to healthcare practice (Cobb, 2004). In the hospital he is the interpreter of 'the silent uprising of the soul' (Borgman, 2000) and it is his duty as a representative of the religious community within the institution to stand up for all things religious and the 'divine'. The significance of affiliation with a religious or worldview institution for this representation within the healthcare institution will have to be investigated.

⁶ The terms transcendent and sacred are used interchangeably. I personally prefer the term sacred, because it is more comprehensive and it is also a term that humanists are familiar with. The term commonly used in the literature is transcendent.

⁷ Personal experience (unexpectedly) taught me that this representational aspect of official affiliation is significant to the patient. I started wearing a white clerical collar six months ago to be more recognizable within the hospital. I was most surprised by the effect the collar has on conversations with the patients. When we first meet many patients appear to be "taken aback" when "the collar" comes to visit them. I frequently have to explain that I am a "normal" minister/spiritual caregiver and that I wear the collar so I am more easily recognized. After this introduction the collar, and what it represents, instills extra confidence and invites the patient to talk about "higher things". This is true of secular care recipients as much as the churchgoing care recipient.

The results of the reflection proposed here should be recognized by the VGVZ and the *Quality Register of Spiritual Caregivers Foundation*, (SKGV) in determining the position and the functioning of the free spiritual caregivers. It is important that a professional standard formulate the distinction between endorsed and unaffiliated spiritual caregivers, and that a register take into account the differences in education and the distinctive qualities connected to endorsement.

At the same time a devaluation of ministerial spiritual care for the sake of general/generic spiritual care is certainly not justified. The suggestion is that general spiritual care might serve everyone while ministerial/Christian spiritual care is an outmoded differentiation of spiritual care of value only to an increasingly smaller group (Vreeman et al., 2009; Morice-Calkhoven, Smeets, & Lammers, 2013; vgl. de Boer, 2014; Hanrath, 2000;) -. It would be more correct to say that ministerial spiritual care can be deployed on a broader scale than so-called general spiritual care. Based on his professionalism the ministerial caregiver is able to provide spiritual care to all people; based on his religious/worldview tradition he can provide pastoral care to believers. As office-bearer ministerial spiritual care can administer the Sacraments.

It is therefore important to clearly communicate the results of the process of reflection on official endorsement and its implications for the unaffiliated spiritual caregivers, both within the VGVZ and outside it and to clearly communicate the subsequent understanding of the competencies of the free and the affiliated spiritual caregiver, and how the two relate to each other.

Conclusions

In the concept of office there is a tension between functional aspects and mystery. Official endorsement lends added quality to spiritual caregiving. Not only is office a prerequisite for ecclesial rituals, the officially endorsed spiritual caregiver also represents a community and the transcendent in a manner that the unaffiliated spiritual caregiver cannot.

Recommendations

The decision has been made and implemented that office is no longer a requirement for the spiritual care profession and that membership in the professional organization and inclusion in the quality register are open to both endorsed and non-endorsed spiritual caregivers. Therefore it is time that the spiritual care profession should cease questioning and discussing its identity over and over again. It is high time that all spiritual caregivers together confidently take their place as

trustworthy professionals within the field of healthcare (Vlasblom et al., 2014). This chapter is intended as a contribution to that future.

An important element of this professionalism is evidence-based practice (Fitchett, Nieuwsma, Bates, Rhodes, & Meador, 2014; Vlasblom et al., 2014), which involves the continuous investigation of what the 'best practice' is. An important research question will be how the care recipients value the official endorsement of spiritual care. Such research may be difficult because the valuation of the care recipient is not based only on rational arguments, but primarily concerns experience. The majority of care recipients will have no idea what the office of the ministry entails, which is not necessarily related to how they value it. This does not make that form of care less necessary.

Apart from this reflection on the meaning of the ministerial office for spiritual caregiving, it will also be necessary for the churches to reflect on the official endorsement of spiritual care. This process of reflection should also address the requirement of academic education in order to be admitted to the office of minister inside and outside the congregation. The observation that such a requirement cannot be legitimized on a strictly theological basis, does not rule out the importance of further theological reflection.

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