

The art of spiritual care

Implications for the use of instruments and tools

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In the development of spiritual care, there is an increasing interest in the role of instruments and tools. After having sketched good reasons for using instruments and tools, we discuss five side-effects that give food for thought. Subsequently, we offer a critical reflection on the use of instruments and tools in spiritual care against the background of an articulated view on spiritual care as an art. We discuss the hermeneutic nature of spiritual caregiving, the role of the practice of spiritual caregiving, and the importance of tacit and intuitive knowledge. We use empirical data from interviews with Christian and Muslim chaplains to illustrate our analysis.

Introduction

In the last decades, a slow transformation has taken place in many European countries in the field of spirituality and health care. After having been framed in a religious context for many centuries, from the 1960s on, interest in and practices of spirituality have been developed more and more outside religious structures such

as churches (Cadge, 2012). In the last two decades, spirituality increasingly has become a phenomenon that is seen as an important dimension of health care (Cobb, Puchalski & Rumbold, 2012). Both researchers and health care professionals have contributed to what is now known as spiritual care, as an interdisciplinary part of health care contributing to the well-being of patients and their families (Balboni 2022).

As the interest in spirituality moved from the religious context to the health care context, the phenomenon was approached in new ways. Religious language was replaced by more secular language, and much discussions have been spent on how to define a phenomenon that seems to be both elusive and important to both caregivers and care receivers (Pulchalski, 2009; 2014). With the shift from religion to health care, implicitly a shift took place from the paradigm of the humanities (including theology) to the paradigm of natural and social sciences. A shift in paradigm includes a shift in what is considered to be scientific knowledge, bringing new methodologies to the scientific study of spiritual care. Since a methodology shapes our understanding of the object which is studied, these developments have also impacted the way spirituality and spiritual care have been viewed upon.

One of the typical developments following the introduction of spiritual care to the health care sector is a growing number of instruments and tools for spiritual care that have been developed, tested, and validated (Balboni et al., 2017). From the perspective of practitioners and researchers in healthcare, there is a number of reasons why this is necessary and useful. Researchers need validated instruments for measuring spirituality and spiritual care in order to produce knowledge that is considered to be scientific according to the criteria of the natural and the social sciences. Within medical science, there is a clear hierarchy of evidence that guides the attempts of researchers to produce a type of knowledge that is free from subjective interpretation and preferably quantified (Sackett et al., 1996). Attaining such knowledge is considered to be a moral imperative since it will allow patients and families to have access to equal standards of spiritual care, and it will prevent society to finance forms of spiritual care that are not effective or beneficial to the well-being of patients and families.

Healthcare practitioners may benefit from tools and instruments because it helps them to screen, monitor and assess spiritual needs (or better: the spiritual dimension of patient and family needs) (Steinhauser et al., 2017); in education, it helps them to grasp what the phenomenon is about (Best, Leget, Goodhead & Paal, 2020); it supports spiritual caregiving by structuring and delineating their attention (Van de Geer et al., 2017); and it is helpful for working with patient files

that secure the continuity of care (Best, Leget, Goodhead & Paal, 2020). Moreover, in contemporary health care systems, the funding of spiritual care asks for a clear scientific basis and forms of accountability that are easier when quantifiable. All these benefits for healthcare professionals indirectly also benefit patients, as we might expect that spiritual care will be better if those who provide it are better educated and monitored and continuity of care is guaranteed.

Five side effects of the use of instruments and tools

Looking at recent developments in both research into and provision of spiritual care, spirituality is increasingly seen as a relevant part of health care, being included in new definitions of 'health' (Huber et al., 2016), honoring the strong interest patients display in discussing this dimension in medical consultations (Best et al 2015) as well as family expectations (Heinke et al 2020). At the same time, one can observe that the instruments and tools that have been developed in the field of spiritual care, have an impact both on the way we provide spiritual care and the way we look upon spiritual care. However, critically reflecting on the development and use of instruments and tools in the area of spiritual care, we see five side effects that may need attention.

One side effect is the idea of the indispensability connected to the role tools and instruments play in providing spiritual care. The idea of indispensability is typically connected to the presupposition that only standardized and evidence-based approaches can guarantee good quality care. This presupposition, however, does not hold, since most of the care done in this world is done unpaid, by non-professionals, in private settings (Tronto 1993), and if this care is not of good quality it does not seem to be so because it is not standardized and evidence-based. Moreover, even standardized and evidence-based care can be very problematic if it is not connected to human qualities like empathy.

A second side effect is too high expectations about the use of tools and instruments, connected to a misunderstanding of what spiritual care is. Since Donabedian's landmark paper about measuring the quality of care, it is common to make a distinction between process, outcome, and facilitating structure of care (Donabedian 1966). Tools and instruments are instrumental by their nature and related to the outcome of care. In spiritual care, however, much of its quality is dependent on the process of a spiritual encounter, which is largely based on the professional and personal competencies of the spiritual caregiver. This does not

mean that tools and instruments can have no place in such an encounter and everything depends on the right way of being present (Adams 2019). It means that the quality of the spiritual care process is largely dependent on the way tools and instruments are used in such a process.

Another side effect is that there seems to be a growing gap between the scientific knowledge of spirituality produced in research on the one hand, and the practical knowledge and wisdom of spiritual care experts and chaplains on the other. Talking to spiritual care experts, it turns out that often they are not even interested in tools and instruments because they consider it either not fitting to the phenomenon, or not fitting in their way of working (Boelsbjerg, 2013). They rely on other sources and modes of knowledge, that fall outside of the scope of interest of the researchers. Although providing spiritual care can be seen as a shared responsibility for the entire multidisciplinary team of health care professionals, it seems a questionable development if knowledge about spiritual care produced in research is isolated from, or not speaking to the professional discipline who has it as its primary task and has developed most expertise as a discipline.

A fourth side effect is that some forms of knowledge are privileged over others, reflecting structures of power and exclusion in health care (Carel & Kidd, 2014). Research done in the interdisciplinary field of spiritual care is higher ranked the more it is designed and done according to the paradigm that is least fit to study the phenomenon: the paradigm of the natural sciences dominant in medical science. Although in the world of chaplaincy, there is an increasing interest in research, the majority of chaplains and spiritual caregivers are hardly trained in doing research, and if so, hardly familiar with quantitative research methods that are standard in the medical sciences (Damen, Delaney & Fitchett 2018; Damen, Schuhmann, Lensvelt-Mulders & Leget, 2020). At large international and interdisciplinary conferences, chaplains are a minority, and many of the big names in spiritual care research have medical backgrounds.

In line with what already has been said, a fifth side effect is the risk of limiting research to what can be measured, the goal following the methodology instead of the other way around. Research funding is highly competitive, academic careers are built on getting research money, and because the chances of being funded are much easier for medical research than research in the humanities, it is highly rewarding to choose research topics and methodologies in such a way that successful output is guaranteed (cf. Edgar, 2019).

A critical reflection on the use of instruments and tools

Discussing the side effects of using of tools and instruments, it becomes clear that in spiritual care tools and instruments have to be seen within the context of the practice they are part of. This presupposes a view on what spiritual care is. The aim of this contribution is to offer a critical reflection on the use of instruments and tools in spiritual care against the background of an articulated view on spiritual care as an art. Viewing spiritual care as an art is based on a specific understanding of the phenomenon of spiritual care as a hermeneutic practice. Therefore, we will begin with discussing the hermeneutic nature of spiritual caregiving. Subsequently, we will elaborate on the role of the practice of spiritual caregiving. And finally, we will pay attention to the importance of tacit and intuitive knowledge for spiritual caregiving.

The argument we develop in this contribution aligns with insights from the profession that has the provision of spiritual care as its primary task in healthcare: chaplaincy. Being rooted in the humanities paradigm, chaplains are often less inclined to work with tools and instruments, but rather display a deep familiarity with the phenomenon of spirituality that enables them to freely engage in professional encounters using the practical wisdom they have been developing during their life and career (Grevbo, 2018). Our methodology is to present a philosophical analysis and interpretation of the practice of spiritual care as performed by chaplains, using empirical data to illustrate our analysis. The empirical data are taken from interviews with Christian and Muslim chaplains. The interviews were held in Denmark in the period between 2009-2011 in relation to a larger medical anthropological study about palliative care needs among patients with advanced cancer in Denmark, which ran until 2016 (Boelsbjerg, 2017). The main focus of the study was concerned with patients' coping strategies when confronted with death but included the perspectives of healthcare providers, relatives, and spiritual caregivers.

In this part of the study, 14 chaplains were recruited via hospitals, hospice, and the local faith community. 12 Christian and 2 Muslim chaplains participated. Most (n=10) worked full- or part-time as hospital chaplains; one of these was a Muslim imam. The remainder worked at a hospice (n=1), visited the local hospital (n=1), were on call for Muslim patients (n=1), or focused on supervision of chaplains (n=1). Purposive sampling was used to ensure diversity in terms of location (urban, rural, and suburban areas), care setting, religion, and gender.

The interviews were conducted in Danish by the second author, who included questions about the chaplain's personal background and experiences of providing spiritual care to severely ill patients and their relatives. The chaplain was also asked to characterise patients' spiritual needs and the challenges encountered in spiritual care provision. Interviews were audio-recorded and transcribed verbatim. All participants gave written, informed consent before participation, adhering to the original ethical approval obtained from the Danish Data Protection Agency (2013-41-1712).

1) The hermeneutic nature of spiritual caregiving

Spirituality as we approach it in this paper, can be defined as "the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred" (Nolan, 2011). The processes of experiencing, expressing, and seeking meaning, purpose, and transcendence are not limited to rational and conscious processes. Human beings start to develop a meaningful relation with their life-world from the moment they are born. Meaningful structures are connected to the way we learn to inhabit and use our bodies and are deeply rooted into our corporeality (Merleau-Ponty, 2013). This is the reason why it takes some time after we have moved out of our house before we can begin to experience the new place we live in as our home. And this is also the reason why it has such a huge impact if older people are forced to move from a house they have been living in for 60 years to a nursing home (van der Leer, 2020).

Once we try to give words to the meaning structures that enable us to inhabit the world and define our life world, we will discover that the processes of thinking and speaking are discursive processes, in which meaning is tentatively articulated at the very moment of being in conversation (Gadamer, 2013). Understanding spirituality, therefore, is a fundamentally hermeneutical enterprise focusing on the discovery of meaning structures as they emerge in lived experiences. Instruments and tools that depart from fixed categories and thus can only very tentatively and superficially contribute to an understanding of spiritual processes. And even then, an instrument is only working well to the extent that it is embedded and used in a good way. In that regard, the scientific language and endeavor can be seen as a challenge in regard to understanding and providing spiritual

care. The language used can be of high importance as it also defines the topic that can be discussed, like one of the respondents points out:

I think religion is 'a language game' to use Wittgenstein's expression; it is a language game that plays with the questions of life and of course does not do so in an exact scientific language, but it is very exact when it comes to tinkering with the big questions of life. [...] I actually think that a lot of people, even if they do not consider themselves religious, use this language to play or fight with, because it is the language that you can use when you stumble into existential questions. It is probably also the competence that is expected of the chaplain, not that he is an expert, nor that he comes up with the finished answers, but that he can be a partner in the language game, where we stumble into these questions. (Charles, Christian chaplain)

Because the discovery and articulation of meaning structures in spiritual care are so much dependent on the context of a conversation and the quality of the encounter, experienced chaplains are aware of the creativeness of the hermeneutic process that takes place in the encounter. One of the respondents phrases this as follows:

I come with my horizon, and that person comes with another, and when we meet, something new happens that affects both of us in some sense. So, it requires some openness and imagination, and I have to draw on all my experience and my responsiveness as a human being. In one or another sense, it is about empathy. But also, tenderness and respect for the other person because one is enormously naked. The ones I talk to, they get so exposed, and sometimes I completely feel like literally getting a thick blanket around that person and just cuddling the person because that person is so naked. (Peter, Christian chaplain)

The process of making sense again of what has happened to you can be a long and difficult process. In processes like that, there hardly seems to be a fixed methodology that can be followed, because the chaos asks for attempts to bring fragments together in stories, so gradually larger meaning structures may reappear. One of the respondents uses a helpful metaphor for this process:

You have to systematize your destiny, because if you are in a situation where your life is like an overturned bookshelf, and everything has collapsed, then you are forced to place some of the fragments in order, which are floating in chaos on the floor. There is probably something about the fact that as you get it articulated and inserted into a

narrative, you get a certain overview and can see certain possibilities. So, just telling the story can sometimes be enough. (Charles, Christian chaplain)

And just as finding meaning is a process in which one can not really do, produce or effect anything, the art of making sense of what has happened in a conversation, is a delicate interplay of doing and undergoing, being open and receptive, and having confidence that meaning will appear again, sometimes against all odds. During this conversation meaning structures will appear and be reconnected as they develop during the presence of the spiritual caregiver:

I have to console myself with the fact that fortunately, it is not me who has to invent the grains of gold, they actually have them themselves. Because when we start talking, their experience and their memory and their ideas about God, e.g., their image of God, often show that there is a way out of the feeling they have. And then we often end up having to pray together, and it does not provide any solution, but it does provide a calmness, not necessarily a clarification, but some kind of peace in the midst of the clarity anyway. (Thomas, Christian chaplain)

This last fragment also highlights another important dimension of spiritual care: the role of the practice of spiritual care, creating a space that enables certain meanings to appear. That will bring us to the second point of our argument.

2) The role of the practice of spiritual caregiving

Where does providing spiritual care begin and end? One way to answer this question is to not look upon spiritual care as a series of intentional actions by an individual actor, but consider it as a morally charged practice composed of many actions, which is constituted by the interaction of people involved, their backgrounds, biography and contextual situatedness (Rouse, 2007). Looking at spiritual care as a practice makes it possible to honor the fact that not only human actors are decisive for the quality of a process, but also the professional role of the partner in conversation, which can transpose what is said in a different key:

Conversations about these [spiritual] matters arise in a contact where one is present [...]. My agenda is not first and foremost religious, but I think, by virtue of the archetype that the pastor is, [my role] calls on certain definitions and a language that other people will not [evoke]. Even though the nurse might be equally able to talk with

patients about the same things, it gets a different tone, even if they are the same words that are used, it gets a different tone from the fact that now it is the priest that you talk to. (Mathew, Christian chaplain)

Instruments and tools can play a useful role in this practice, but only if they are well embedded in and useful for the development of the transformative process of spiritual caregiving. And as this example shows: sometimes meeting with an open agenda and being a minister in a church can create a space in which a spiritual process can take place that is only to a limited degree the result of the intentional actions of the spiritual caregiver involved.

In the following fragment, we see another example of how the encounter between a priest and a patient will have a different quality because of the religious practices it is embedded in. In fact, in this fragment the Lord's Prayer almost becomes an important actor itself, carrying both the priest and the patient:

I was called over to the unit where they said there was an old man who was terminally ill and he was very anxious and very restless. When I came over and talked to him, it was something like just quietly sitting down, then we talked very briefly about his life situation and [what] was [happening] here and now. I also said to him: "Now that I am also a priest, is there anything I can do for you?" To which he then replied: "Well, I really would like us to pray the Lord's Prayer together, and if you would then bless me?". I have tried this together with others and it can really loosen up. [...] He became much calmer, he actually did, and it was not so often, we had those long conversations [as chaplains], but it actually came to take place over a period of time, so little by little he told me his life story. [...] Every time I was there, we finished with the Lord's Prayer and the blessing. He became visibly calmer, he did, and I know others who experienced that too. Because [praying together] tells a much, much bigger story than the one we are involved in ourselves. (Linda, Christian chaplain).

Another Christian chaplain puts a similar idea in different words when he points to the fact that a spiritual encounter between two people who belong to the same church is always at the same time also an encounter with the one who founded this church, and who is said to be working through this encounter:

So, it is also like, as Christians, as a church, we are under the promise that Jesus gave His disciples, when 2 and 3 are gathered in His name, then He himself is present, and it is for sure, when we stand and pray to Him and sing and put our lives in His hands, then He is with us too. It is a very important aspect to include when you are

in that situation in a hospital. I think I have many good experiences with that. (Ian, Christian chaplain)

In relation to being a Muslim chaplain, the role as a religious expert is something that is often called for, as well as being a practical guide for arranging a funeral or the like.

Sometimes you have a function where you have to pray, where you have to read the Qur'an, where you create a ritual space in the (hospital) section or in the patient's room. This indeed resonates with the role of being a spiritual care provider as you take care of those people, who are there. Other times it's very remote. It may seem very impersonal. It's just some information [you deliver], and then that's what you use an imam for. At other times, the patients and relatives have a different expectation, e.g. that you can use an imam to pray, »Please, will you pray for us? And when you go home will you remember us in your daily prayers«. So, there might also be a request for this. (Karim, Muslim Chaplain)

As the Islamic tradition has accentuated the plight of every practicing Muslim to deliver spiritual care to others from the faith community (in the form of visiting the sick, encouraging hope, patience, and trust in God during crisis), it is not seen solely as the imam's area of responsibility. Nevertheless, the Muslim chaplain also has the role of a spiritual counselor and as a person who can support the healing process.

It is not uncommon to have engaged imams in something that we would nowadays characterize as healing, where one is offering prayer; something that would be experienced as soothing. Also, amulets with writings from the Quran that people would wear around the neck. These elements are very close to how one would traditionally practice spiritual care within an Islamic context. (Karim, Muslim Chaplain)

Practices can be composed of many elements. The examples we just gave were religious of nature, but also in secularized practices of spiritual care it is helpful to think about spiritual care not in terms of an intervention from a spiritual caregiver to the spirituality of a patient (like a surgeon entering the body of a patient to set things right), but a practice in which a space is opened for processes that are bigger and more comprehensive than the participants are aware of and can account for. Poems, pieces of music, paintings, and stories, can all speak to us in a way that opens up new perspectives and they do have such an effect independent from the one presenting them.

This brings us to our third point, which refers to the way in practices of spiritual care one is sensitive to what is working in an encounter, beyond what the two conversation partners are aware of.

3) *The nature of tacit and intuitive knowledge*

Similar to the creative process of meaning emerging in the process of thinking and speaking in the experience of the patient, also on the side of the spiritual caregiver a creative process is at stake in which there is no clarity about the way the encounter will develop. By most chaplains, this condition was compared to improvisation, like in this excerpt:

You could say that there's a lot of improvisation in it and it's new situations all the time. So, to improvise must also be something you like. It is rarely so that you have time to prepare for an encounter or know what you are going to meet. So, you have to be turned on, because you are aware that you can not prepare to the situation, you just have to be present and feel in the moment exactly what is being said and respond to it. (Charles, Christian chaplain).

In providing good spiritual care many forms of knowledge are involved, comparable to the knowledge involved in performing music or painting. Although technical mastering and high quality of instruments like a violin or a brush are helpful, they are not decisive for the quality of the resonance that is achieved by the artwork (Rosa, 2016). Since spiritual caregiving to a large extent is similar to non-rational practices in the arts, the importance of tacit and intuitive knowledge in spiritual care should be put more in the center. This point is made very clearly by one of the respondents who reports about being open to what happens in the uniqueness of each encounter:

Because [establishing] contact is so important. Every time it's like creating a piece of art. Every time I walk in the door, there really has to be humility around my approach, and every time it's THE TRUTH, and every time we have to find the melody, see if we can follow each other along. Can I make myself available in a proper way for that person? (Peter, Christian chaplain)

A different way of putting this is understanding the process of attunement as a way of listening in order to hear 'what is behind what is being said'. This way of listening is not a mode of making sense of words, but being open towards the processes that are not yet articulated in words and perhaps not even in clear thoughts.

It is the spiritual caregiver reaching out towards the patient, trying to be sensitive to and in resonance with that which is slowly emerging:

I'm listening. Listening is almost always the most important thing. Just taking the time to listen, I think, is at least half of what we as humans can do for each other. And that you listen attentively and that you listen in. That is, that you do not just hear the words, but try to hear behind what is being said. Trying to hear what kind of human this is. And then I try to take it from there. (Mahdi, Muslim chaplain)

Then sensitivity needed for interacting with severely ill patients and their relatives also brings a great responsibility to the fore. Most chaplains will describe this as a sense of having to protect one being vulnerable. Like this chaplain explains:

It is a special challenge when you are dealing with people in a very vulnerable situation, as the vulnerability calls for you to be careful that you do not step over the line. Therefore, [I have] a method of saying: I want to listen, I want to hear, and I want to take care of the vulnerability that the person is experiencing, without forcing anything. I want to listen to what is at stake, I want to be part of a dialogue, I want to help and search for something that can help, an answer or a consolation or a story, whatever it may be in the situation. I want to help look for it together with the other but I do not want to take responsibility for the other, I do not want to come up with a story that I need to get rid of, which the other may not need to hear. (Charles, Christian chaplain)

Another feature that the vulnerability can bring up is a heightened sense of the presence of something that enables one to feel loved or cared for. One of the chaplains describes it like this:

I experience that God is most present where [things are really bad], like it is the worst, that is, where there is nothing left to do. To me, the divine is the epitome of presence and care, and acceptance of the whole person and everything that the person contains. (Linda, Christian chaplain)

Tacit and intuitive knowledge play a big role in the art of spiritual caregiving. But what does all this mean for the place and role of tools and instruments in spiritual care? In this contribution, we developed the view that providing spiritual care first and foremost is an art in which tools and instruments are subordinate to practical knowledge, experience, and wisdom of the phenomenon. How we see this more concretely will be discussed now.

Conclusion and recommendations

Spiritual care is a process that evolves around the appearance of existential meaning through an encounter between two or more persons, involving multiple dimensions of reality. Our contribution is not a plea for abandoning the developments and use of instruments and tools in spiritual care. We think that both instruments and tools are helpful and important, as long they are put into perspective. Reconsidering what we have said in the introduction in the light of the three dimensions of spiritual care that we just sketched, we come to the following reflections.

As for the hermeneutic nature of spiritual caregiving, we think it is important to acknowledge that tools and instruments can grasp specific aspects of spiritual processes at certain moments in time, but they will always provide a limited and sometimes even reductionistic view on the phenomenon. Interpretation is a never-ending and creative process, and in the case of spirituality, this process has a transformative dimension (Waaajman, 2002). So meanings will evolve, deepen, extend, and new resonances will emerge that may even be the result of entering in a spiritual conversation.

An example of a tool that has been developed to monitor the spiritual dimension of patients in hospice care, and that combines a short questionnaire with a hermeneutic approach is the USD-4D (de Vries et al 2021). The USD-4D is a four-dimensional tool (bio-psycho-social-spiritual) in which the spiritual dimension is represented by 5 questions that patients can answer on a 1-10 scale and give an indication of their spiritual well-being with regard to five themes. Once patient's scores indicate possible spiritual distress, they are invited to a conversation with a healthcare professional. For the conversation a hermeneutical conversation model (the Diamond model) can be used that is based on the same theoretical background the five questions were deducted from (Leget 2017), and that has been validated as a framework for addressing relevant spiritual themes for patients and loved ones (Haufe 2022).

As for the role of the practice of spiritual caregiving, we think it is important to acknowledge that the use of tools and instruments is always embedded in a context to which also moral demands are attached (Leget, 2021). Tools and instruments ask for the right timing, circumstances and competencies to be used, and even then, they are only part of what happens in a practice that is essentially a human encounter full of elements that are beyond measurement and registration (Hansen et al 2023).

As for the nature of tacit and intuitive knowledge, we think it is important to acknowledge that tools and instruments are very rationally and verbally articulated ways of working within a spiritual space that is to a large extent made up by nonrational and nonverbal elements. Although we do not want to suggest a too simple opposition between these dimensions in spiritual care, we hope in this contribution we have developed some reflections that are helpful to critically consider the place that is given to the development of instruments and tools in spiritual care research and practice.

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