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The presence of religion in three hospitals in the region of Groningen: How do these hospitals encounter religious diversity?

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Abstract

In the last decade, researchers studied the governance of religion in public institutions extensively. Due to both the growing multicultural society and secularization in Western societies, it is interesting and relevant for researchers to examine the governance and presence of religion in the public sphere. In this research, I will give a complete overview of the presence of religion in three hospitals in the region of Groningen by looking at spiritual care, religious facilities and services, the knowledge of religion among health-care providers and religious needs and wishes of patients. Based on theoretical assumptions, I argue that the church-state relationship, the growing multicultural society, the framing of religious minorities, secularization and the hospitals' understanding of religion affect religion in the hospitals. I used a qualitative research methodology by conducting in-depth interviews with spiritual caregiver and nurses. In addition, I analyzed documents and websites. Based on the findings, I argue religion is present to a limited extent due to, among others, secularization and the dominance of the biomedical model. However, religion disappeared not entirely in the hospitals. There are religious facilities and services which are mainly based on patients' requests. The number of religious requests of patients is related to the demographical data of the region. In the region, the majority have a Christian background, but people with an Islamic background are growing. Finally, the priority of the biopsychosocial model is growing since spiritual caregivers try to create awareness, and hospitals provide education among health-care providers.

Keywords: governance of religion, public institution, hospitals, religiously diverse patients, spiritual care, multicultural society, secularization.

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1. Introduction

Since the rise of several extremist attacks in the United States and Europe in the 21st century, the role of religion has become increasingly important in international relations and societies. Suddenly, there was more awareness and attention to people's religious background. At the same time, societies became increasingly multicultural, causing a growth of religious minorities. Consequently, religion in public institutions and organization has become a much-debated topic in society in which the role of the government is discussed. Jehovah's Witnesses' refusal of blood transfusions, for example, continues to be discussed in hospitals because it can result in severe consequences for people's health. Another example, in 2017, was the discussion in The Netherlands if Muslim women are allowed to wear a headscarf under a police hat. Proponents argued that governmental organizations should be a reflection of the multicultural society. However, opponents argued that governmental organizations should take a neutral position to be impartial (Fogteloo, 2017). These examples show the different views on the role of religion in governmental organizations in the Netherlands. In the Netherlands, but also in Europe, there are various views on the role of religion in governmental organizations (Cadge, Griera, Lucken, & Michalowski, 2017).

Due to these societal developments, interest in research about the role of religion in public institutions in Europe increased. Public institutions are semi-governmental organizations that need to follow state regulations, are supported by state funds, and are publicly accountable (Cadge et al., 2017, p. 227). Hospitals, prisons, the military or educational institutions belong to public institutions (Religion & Public Institutions, 2015). The governance of religion takes mainly place at the institutional level resulting in more interest in the role of religion in specifically public institutions (Bader, 2009; Mattes, Permoser & Stoeckl, 2016). Additionally, the governance of religion is shaped by the church-state relationship, which varies per country (Cadge et al., 2017). In the context of the Netherlands, the church and the state have been separated since the revision of the Constitution in 1848 (Knippenberg, 2007; Ministry of the Interior and Kingdom Relation, 2019). The separation is strongly connected to the prohibition of religious discrimination and the right of religious freedom (Habermas, 2006, p. 4), written down in Article 1 and 6 of the Constitution respectively (Constitution, 1848). These articles of the Constitution (1848) indicate that no religion is favoured by the state, which indicates a mandate of the government's neutrality.

Another development is the increasingly multicultural society, which makes research on the role of religion in public institutions even more interesting (Triandafyllidou & Modood, 2017). After the Second World War, immigrants from countries such as Indonesia, Bosnia, Suriname, Turkey, Morocco and Syria arrived in the Netherlands (Van der Bie, 2009; Knippenberg, 2007; VluchtelingenWerk Nederland, 2019). Due to the growing multicultural society, the religious landscape in the Netherlands changed and became more religiously diverse (Van der Bie, 2009; Van Herten, 2009). Religious diversity is the coexistence of multiple different religious communities (Lindsay, 2015). The presence of religion in society is connected with multiple areas in society, such as education, integration, social exclusion, rights of minorities, tensions between and within religious communities. Thus, religion is not isolated from social life and society. Consequently, the government cannot function separately from religion. This relation results in cooperation with religious communities by providing, for example, financial support.

Besides, tolerance between and towards different religious communities is desirable. Tolerance implies that civilians make it possible for others, even if they disapprove, to have their own beliefs, lifestyle and practices (Slijper, 1999). To maintain tolerance in society, communication and cooperation between the government and religious organizations or communities are necessary (Habermas, 2006). Moreover, findings of Kaya's (2019) study indicate that in countries without a national church, the institutionalization of religion results in tolerance. The connection between religion and facets of social life, and the tolerance between the government and religious communities show no strict separation of church and state. The approach of the church-state relationship is variable (Ministry of the Interior and Kingdom Relation, 2019).

The separation of church and state based on the prohibition of religious discrimination and the right to religious freedom, and the communication and cooperation between state and church, seem contradictory. Due to these fundamental ideas, it is interesting to examine how public institutions encounter religious diversity. This research will specifically focus on hospitals as a public institution. The growing religious diversity in society also results in the growth of religious diversity among patients in hospitals. The growing size and complexity of religiously diverse patients have specific health-care implications (Vertovec, 2007). Moreover,

hospitals are confronted with new and different religious needs and wishes of patients. At the same time, hospitals want to provide the best quality of health-care for every patient.

Previous studies looked into the role of religion in public institutions (Cadge, Freese & Christakis, 2008; Gilliat-Ray, 2011; Griera & Martínez-Ariño, 2014; Reimer-Kirkham, Sharma, Pesut, Sawatzky, Meyerhoff & Cochrane, 2012; Sargent & Erikson, 2015; Willander, Bradby, Torres & Jonsson, 2019). However, these studies have mainly been conducted in countries such as the United States, Canada, Spain, France, Germany and Sweden. Research in the Netherlands on the role of religion is limited to more specific health-care, such as mental health-care or palliative care (Pieper & Van Uden, 2005; Van de Geer & Leget, 2012). Overall, few studies have been done in hospitals in the Netherlands, especially studies in the province of Groningen are lacking. Demographically, Groningen differs from Western regions in the Netherlands, such as in cities as Rotterdam and Amsterdam: there is more religious diversity in Western regions with the result that no research has been done in the region of Groningen. However, there is religious diversity in Groningen, which makes it still relevant and interesting to examine the presence of religion in hospitals in the region of Groningen. The research question is as follows:

"To what extent and in what ways is religion present in hospitals in the region of Groningen?"

The research question is further elaborated into the following four sub-questions: "*Which religious facilities are present and which are restrained?*". "*Where is religion physically visible, and what does it look like?"*. *"How do hospitals respond to the presence of religion?" and "Which policies do the hospitals have about religion?".* To answer the research questions, I analyzed websites and document, and conducted interviews with spiritual caregivers and nurses in the following three hospitals: "The University Medical Center" (UMCG) in Groningen, the "Martini Ziekenhuis" in Groningen and the "Ommelander Ziekenhuis Groningen" (OZG) in Scheemda.

First, I will give an overview of previous literature about religion in public institutions and show how this research is an addition to the existing literature. Second, in the theoretical framework, I will show that the following factors might affect the presence of religion in hospitals: the separation of church and state, the growing multicultural society, the framing of religious minorities and secularization, and the institution's understanding of health-care. Next, based on the theoretical framework, I will formulate the expectation of the research

outcomes. After, I will discuss the methodology in which I explain the methods I use to conduct and analyze the data. Subsequently, I will work out the research results based on the interviews, websites and documents. Finally, I will discuss the results in a broader context, mention the implications of the research and make recommendations for further research. In the end, I clearly state the argument of the research.

Based on the research outcomes, I show the complexity of religion in hospitals. I argue that religion is present in the hospitals through spiritual care, prayer rooms, facilities, services or the way of responding to religious issues. Overall, the main argument is that the presence of religion in hospitals is limited due to secularization and the dominance of the biomedical model. Religious factors are not the priority in health-care. Consequently, hospitals try to neutralize religion through the use of “universal” elements. Religion is present but mainly related to Christianity, Islam or general spiritual or philosophical beliefs. This can be explained by demographical data of the region in which Christian people are the majority and the number of Islamic people is growing. Religious accommodation seems to be present mainly on the request of the patient.

2. Literature in the field of religion in public institutions

Religious diversity in public institutions has been studied extensively (Cadge, Lucken, Griera & Michalowski, 2017). Before discussing the various studies, it is essential to clarify the concepts used in the studies. In a broad sense, Hodgson (1998, p. 179) defines institutions as "general regulations in social behavior" or "the rules of the game in society". More specifically, Cadge et al. (2017, p. 227) define public institutions as "those institutions that need to follow state regulations, are publicly accountable and are supported (totally or partially) with state funds". In short, institutions have the power to regulate the social behaviour of individuals through their public institutions (Mattes, Permoser & Stoeckl, 2016). Within those institutions, religion can play a role or function (Cadge et al., 2017). Many scholars tried to define the concept of religion. For example, Durkheim (1912) defined religion as "an unified system of beliefs and practices relative to sacred things". Another well-known scholar in the field, Geertz (1973, p. 90), describes religion as "a set of symbols which acts to establish powerful, pervasive, and long-lasting moods and motivations in men". More scholars try to define religion but have been confronted by its complexity (Bende & McRoberts, 2012; Hodgson, 1998). Therefore, Cadge et al. (2017) argue to approach concepts such as religion broadly and inductively. Moreover, Beckford (1999) explains that defining religion can have concrete political consequences and might affect the research outcomes. In this research, I approach the concept of religion also broadly so that there is no strict way of what belongs to religion or not.

As mentioned before, the governance of religion takes mainly place at the institutional level, which makes research on the role of religion in public institutions interesting. The interest in the governance of religion increased due to the growth of multicultural societies and religious minorities resulting from global migration processes (Beyer, 2012; Willander, Bradby, Torres & Jonssen, 2019). Due to the growing multicultural societies, public institutions are challenged by the growth of religious diversity (Mattes et al., 2016). Hence, the question is: "How do public institutions encounter this growth of religious diversity?". The growth of religious diversity in society results in growing visibility of religion in which public institutions are increasingly confronted with different religious needs, wishes or issues (Sargent & Erikson, 2015). Besides, public institutions are expected to guarantee religious freedom and recognize religion in a diverse society. Consequently, public institutions cannot ignore the presence of religion in their institution. In addition to the right of religious freedom, public institutions

should consider the prohibition of religious discrimination by providing equal services and facilities for every religious group. These religiously based challenges for public institutions make it interesting for researchers to examine and understand the governance of religion in public institutions.

Existing studies on religious diversity in public institutions examine religious diversity in different public institutions (Mattes et al., 2016). The most common types of public institutions studied in research are the military, prisons, educational institutions or hospitals (Cadge et al., 2017; Religion & Public Institutions, 2015). For example, Ajouaou and Bernts (2015), and Beckford (2005) chose, on the one hand, for prisons as their primary level of analysis, because of the growing religious diversity among prisoners and the fact that prisoners show high levels of religious activities and practices. Stoeckl and Roy (2015) decided, on the other hand, to examine Western militaries with the reason that military officers are more conservative than the rest of society and that their strong identification of the national identity is mainly related to religion. Examining the governance of religion in hospitals is relevant since the presence of different hospitalized patients. This makes hospitals a place of cultural and religious encounter (Sargent & Erikson, 2015). Differently is the choice of scholars to study, for example, both prisons and the military, or prisons and hospitals with the reason to compare the presence of religion and examine if specific characteristics of each public institution affect the accommodation of religion (Furseth, 2000; Griera & Martínez-Ariño, 2014).

Next to the type of public institution, studies vary by country. Research has mainly been conducted in Germany, France, Britain, Spain, Sweden and Italy (Religion & Public Institutions, 2015). Interesting are the differences in countries' national context, such as politics, culture, the religious background of citizens or norms and values that might affect the governance of religion in public institutions. As with public institutions, comparative studies have been conducted into the presence of religion across countries. Soper and Fetzer (2007) include Britain, France and Germany in their research, while Furseth and Van der Aa Kühle (2011) compare the Scandinavian countries Denmark and Norway.

Looking at previous studies, the authors often describe multiple factors, both from outside and inside the institutions, which might affect or determine the governance of religion in public institutions. The external factors which are extensively discussed in previous research

are the church-state relationship, the current political debates about religious minorities or processes of secularization (Cadge, 2012; Cadge et al., 2017; Engelhardt, 2003; Furseth & Van der Aa Kühle; 2011). Internal factors might include the financial situation or policy of an institution. In this research, I discuss both the influence of internal and external factors on the governance of religion in hospitals. Below, I will first engage with the existing literature and arguments described, explain to what extent this research fits into it, and how it is an addition.

First, multiple scholars discuss the influence of the church-state relationship on the governance of religion in public institutions (Cadge et al., 2017). In their research, Griera and Martínez-Ariño (2014) emphasize the importance of the national context of the church-state relationship concerning both prisons and hospitals. Similarly, Soper and Fetzer (2007) argue that differences in the governance of religion in public institutions across countries as Britain, Germany and France, can mainly be explained by the church-state relationship. Minkenberg (2003) divides the church-state relationship into three types of relations: strict separation of church and state, a close church-state relation, and both separation and cooperation between church and state. According to Soper and Fetzer (2007), strict separation of church and state, such as in France, is likely to restrict religion in public institutions. In a country with a close church-state relationship, such as Britain, it is plausible that the country is more open to incorporate religion in public institutions. In countries with both separation and cooperation between church and state, such as in Germany and the Netherlands, religion is present to a limited extent. In his study, Beckford (2005) first expected a different influence of the church-state relationship than described by Soper and Fetzer (2007). He expected that Muslims receive better treatment in prisons in France, a country with a strict separation of church and state, than in Britain, a country with an establishment. The strict separation of church and state would create a situation in which no other religion, such as Christianity, exercise influence on religion in the public sphere. In Britain, the establishment of the Church of England would be influential concerning other religions in the public sphere resulting in less freedom and visibility of other religions. However, the results of Beckford's (2005) study show that they are in line with the arguments of Soper and Fetzer (2007) because Britain provides active support for the Islamic identity of Muslim inmates in prison, while France does not encourage the Muslim identity in prisons. Similar results are found by Furseth and Van der Aa Kühle (2011) about prison chaplaincy in Denmark and Norway. They show that in Denmark imams are paid by the state, whereas in Norway the Muslim community is responsible for

employing and paying imams, a difference caused by the fact that Denmark has a closer church-state relationship than Norway. The expected importance of the church-state relationship on the governance of religion in public institutions is crucial to examine further and theoretically apply the results to the context of the Netherlands. There is both separation and cooperation between church and state in the Netherlands, which makes it also interesting to examine how both separation and cooperation affect the extent in which religion is present in public institutions and how public institutions encounter the growth of religious diversity.

Similar to the previously mentioned studies by Beckford (2005) and Soper and Fetzer (2007), scholars focus on, specifically, the governance of Islam (Abu-Ras & Laird, 2011; Amiraux, 2016; Gilliat-Ray, 2011; Kaya, 2019). Due to, among others, the increase of immigrants with an Islamic background many scholars chose to focus on the governance of Islam. Scholars such as Engelhardt (2003) focus specifically on Christian hospital chaplaincy to examine the effects of current secularization processes. The consequence of focusing on one religion is that results do not show information concerning the presence of other religions. Hence, other researchers chose to approach religious diversity more broadly by not focusing on one or two religions (Davidson, Boyer, Casey, Matzel & Walden, 2008; Sargent & Erikson, 2015; Willander, Bradby, Torres & Jonsson, 2019). Willander et al. (2019) found results about Christian, Muslim and Buddhist chaplaincy in Sweden. Findings show that, despite the principle of religious freedom and the intention to include more of Islam and Buddhism, Christian hospital chaplaincy remains overwhelmingly dominant. Wright (2001) found similar results which show spiritual care is mostly performed in the Christian context. Additionally, Davidson et al. (2008) found results about the religious needs of the following subgroups: Muslim, Baha'i, Catholic, Protestant, Jewish, Buddhist, Mormon, Latino, Filipino, Chinese, African American and Jehovah's Witness. They show that the way religion is present in the hospital does not represent all subgroups' religious needs. They argue there are several gaps in the knowledge, available resources and practical issues.

Scholars, as Puchalski (2001) and Abu-Ras and Laird (2011), also highlight the role of spirituality, especially in health-care. Puchalski (2001) argues that spirituality involves the whole person, the physical, emotional, social and spiritual. In this case, there is no focus on one or multiple religions, but on spirituality in general. Moreover, Bender and McRoberts (2012) explain that the reason for examining spirituality is the social shift of growing numbers

of people with no religious affiliation but believe in some kind of divinity. Hout and Fischer (2002) refer to it as growing numbers of "religious nones" due to demographical changes, secularization and politics. Concerning the role of spirituality in health-care, Puchalski (2001) argues that patients with spiritual beliefs tend to have a positive outlook which positively affects health-care areas of mortality, coping and recovery. Another study by Van de Geer and Leget (2012), for example, showed the importance of cooperation between medical professionals and spiritual caregivers to serve both the religious and spiritual needs of patients. Koenig (2007) explains that not all hospitals are aware of the importance of serving both religious and spiritual needs of patients and describes a lack of knowledge among health-care providers about the spiritual needs of patients. Therefore, he recommends more training and education about spirituality.

The governance and presence of religion and spirituality are studied in different ways. Alpers (2019) focuses only on hospital food, while scholars like Willander et al. (2019) focus on chaplaincy only (Ajouaou & Bernts, 2015; Carey & Davoren, 2008; Engelhardt, 2003; Furseth & Van der Aa Kühle, 2011; Reimer-Kirkham et al., 2012). Additionally, Cadge et al. (2008) also focus on hospital chaplaincy, but they acknowledge that the presence of religion consists of more than only hospital chaplaincy. According to Cadge et al. (2008), religion in hospitals is also about pastoral care, religious services, the possibilities for nutritional practices, pain concerns, dilemmas within patient-care, end-of-life issues, and the treatment and responsibilities of health-care providers. Moreover, Griera and Martínez-Ariño (2014) looked at the accommodation of religious diversity in which they include daily religious practices, such as food or dress requirements. Similar, Davidson et al. (2008) focus on religious items, dietary needs, modesty, blood, birth and death, and visiting. To create a complete overview of religious diversity in hospitals, I will include spiritual care, religious facilities and services, the knowledge of health-care providers, and religious needs and wishes of patients in this research.

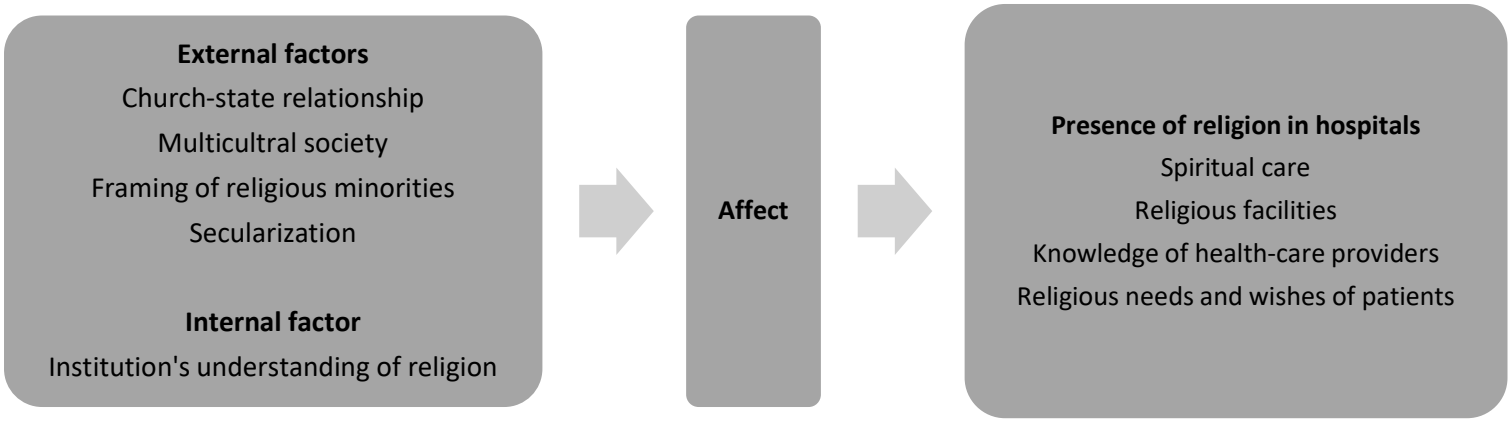
Few studies examine the presence of religion in hospitals in the Netherlands. Pieper and Uden (2005) examine religion in, specifically, mental health-care in the Netherlands and emphasize, just as Puchalski (2001) describes, the importance of religion in mental health-care by using the coping mechanism. In short, the coping mechanism implies that religion positively affects the treatment period and recovering of physical and psychological health problems.

Similar to Koenig (2007), they argue that professionals should have knowledge of religion and spirituality, and recommend a more prominent role of religion and spirituality in health-care. Van de Geer and colleagues (2018) emphasize the importance of spirituality in, specifically, palliative care in the Netherlands. All in all, these studies show the importance of the presence of religion and spirituality in health-care. However, as religion appears to have an essential role in health-care, the question is to what extent is religion present in hospitals in the Netherlands.

3. Theoretical expectations about the presence of religion in hospitals

In this chapter, the theoretical framework, I will examine arguments and hypotheses about the presence of religion in hospitals and how hospitals encounter religious diversity. I continue to explain what religion in hospitals means through the following concepts: spiritual care, religious facilities, knowledge of health-care providers and religious needs and wishes of patients. Next, I will discuss specific factors that might affect the presence of religion hospitals and might affect how hospitals encounter religious diversity. These factors are divided into external and internal factors. External factors are influences from outside the institution. The following external factors will be discussed: the separation of church and state, the multicultural society, the framing of religious minorities in the public debate, and secularization. Internal factors are influences from inside the institution. The following internal factor will be discussed: the institution's understanding of religion. In Figure 1, the conceptual framework shows the influence of external and internal factors on the presence of religion in hospitals figuratively.

Figure 1. Conceptual framework of the influence of external and internal factors on the presence of religion in hospitals



3.1 Explanation of concepts

To examine the presence of religion and if external and internal factors affect the presence of religion, I first explain how I conceptualized and operationalized the presence of religion in hospitals. The presence of religion is divided into the following themes: spiritual care, religious facilities, knowledge of health-care providers and religious needs and wishes of patients.

3.1.1 Spiritual care

Spiritual care is professional guidance, support, and counselling for people about life's meanings and philosophies, based on their religious or spiritual beliefs (VGVZ, 2019; Doolaard, 2015). Spiritual caregivers are experts in dealing with fundamental questions of life, meanings of life, spirituality and ethical considerations. The presence of spiritual caregivers can take place in various fields, such as rehabilitation centers, youth care, prisons, psychiatry and hospitals. Currently, The Dutch Association of Spiritual Caregivers in Healthcare Institutions (VGVZ, 2019) includes spiritual caregivers of the following eight different types of beliefs: Protestant, Catholic, Humanist, Islamic, Jewish, Hindu, Buddhist and the "Institutioneel Niet Gezonden" (SING). Next to these types of beliefs, spirituality is also included in the work of spiritual caregivers. The concept of spirituality refers to everyday sources of inspiration such as nature, music, art or meditation (Van de Geer & Leget, 2012). At the moment, spiritual care takes place in 167 hospitals in the Netherlands, including 45 academic hospitals.

Situations of illness, suffering or death can disturb the process of giving meaning to life and raise questions about life (Maagdelijn, Verkoulen, Meerding, Van Steenveldt, & De Bekker, 2018). Spiritual caregivers support and help with the meaning of life during these situations in which they often have direct patient contact. In the Netherlands, the concept of spirituality and spiritual care is integrated into health-care since the development of palliative care (Van de Geer & Leget, 2012). Before, only Catholic and Protestant clergy were integrated into health-care. Nowadays, spiritual caregivers have different backgrounds. According to Liefbroer & Berghuyijs (2017), their study, patients prefer spiritual caregivers with the same religious or philosophical background. The growing multicultural society and the growth of religious diversity create a challenge for spiritual caregivers in hospitals to help patients of various religions or spiritualities. Doolaard (2015) argues that this growth determines spiritual caregivers' positions. Spiritual care has to adjust to the religious and spiritual needs of

patients. The philosophical and religious identity of spiritual caregivers became, therefore, increasingly important.

In short, the extent to which religion is present in a hospital is related to the accessibility of spiritual caregivers and the possibility of personal contact with a spiritual caregiver with a specific religious or philosophical background. Due to the growing religious diversity among patients, it might be challenging for spiritual caregivers in hospitals to respond to this growth. All in all, looking at spiritual care is essential for examining the presence of religion in hospitals.

3.1.2 Religious facilities and services

Next to spiritual care, facilities and services are also related to the presence of religion. Facilities and services in hospitals create an opportunity for patients to perform their religious or spiritual practices or rituals. In daily life, the performance of religious practices or rituals is the responsibility of the people themselves. However, during hospitalization, the connection between the home situation and the church or community is severed. In addition, practices or rituals which people usually performed at home, need to be performed in the hospital. Therefore, a hospital might provide facilities or services so that religious practices or rituals can still be performed by patients (Maagdelijn et al., 2018).

Concerning the performance of rituals or practices, Muslims usually go to a mosque, Jews to a synagogue and Christians to a church to attend services or pray. In addition, Muslims use a washing room before praying. The services in Islam take mainly place on Friday and in Christianity on Sunday. Hindus, for example, often have a special place or room where they can worship their gods. All these practices are no longer possible when people are hospitalized unless the hospital provides religious facilities and services so that patients can still perform their religious practices or rituals. According to the study of Davidson et al. (2008), patients like to have access to religious books such as the Bible or the Quran. Further, patients with a Catholic background requested the presence of holy water, rosaries and crucifixes. Patients with an Islamic background requested mainly prayer rugs and prayer compasses. Other facilities and services are the availability of a prayer room, washing room and (church) services.

All in all, the extent to which religion is present in a hospital is related to the religious facilities and services hospitals provide. More precisely, the question is to what extent hospitals provide prayer rooms, washing rooms, religious items and (church) services and the reasons for whether or not it is present.

3.1.3 Knowledge of health-care providers

The presence of religion is also related to the knowledge of health-care providers about religion in relation to health-care. The religious background and beliefs might affect a person's identity, way of life, traditions or health (de Diego Cordero, Lucchetti, Fernández-Vazquez, & Badanta-Romero, 2019). It also affects the norms, values and perceptions of people. These norms, values and perceptions are, subsequently, related to the way people interpret processes of illness, health, medical treatment and death. Religion or spirituality might, for example, affect decisions about medical treatments, nutritional practices, medicines or the preference for a health-care provider of the same gender. Also, religion and spirituality might positively affect a person's health, such as coping with health issues, mortality, or recovery (Puchalski, 2001). All in all, religion and spirituality seem to be important factors for patients in health-care. Therefore, health-care providers should take religious beliefs into account. Knowledge about religious beliefs among health-care providers might improve patient quality care and health-care outcomes (Swihart, Yarrarapu & Martin, 2020).

The growth of religious diversity creates challenges for health-care providers to provide competent care for every patient with different religious beliefs (Swihart, Yarrarapu & Martin, 2020). Competent care for every patient with different religious beliefs consists of health-care providers meeting in the religious needs of patients and become aware of the importance of religion for patients so health-care providers can understand patients better (Van de Geer et al., 2017). To meet the religious needs of patients and understand patients better, knowledge about religion in relation with illness, health, medical treatment and death, among health-care providers is necessary (Alpers, 2019; de Diego Cordero et al., 2019). Education and training are necessary to achieve this level of knowledge. By way of contrast, the lack of knowledge can lead to misunderstandings or obstacles in providing competent health-care (Davidson, Boyer, Casey, Matzel, & Walden, 2008).

In short, the extent to which religion is present in a hospital is determined by, among other things, the knowledge of health-care providers in hospitals about religious beliefs that might be revealed among hospitalized patients. To gain knowledge among health-care providers, hospitals might, for example, provide education, workshops or training for health-care providers to increase the knowledge with the result of improving competent care for all patients with different religious beliefs.

3.1.4 Religious needs and wishes

At last, the extent to which religious needs and wishes are taken into account by health-providers is related to the presence of religion. Religious rituals, traditions or practices might be revealed during hospitalization (Penn Medicine, 2012). As described before, hospitals might provide facilities and services so that patients can perform religious rituals or practices. However, patients might also have specific needs or wishes based on their religion. For example, the preference for health-care providers of the same gender or having roommates of the same gender. Moreover, patients might ask not to disturb their ritual of praying, request the visit of members of their community, request the visit of a pastor, priest, rabbi or imam, or have specific wishes concerning religious holidays (Davidson et al., 2008). Also, patients might have religiously-based wishes regarding medical treatments, such as circumcision of Jewish or Muslim boys or the refusal of blood transfusion of Jehovah Witnesses. The extent to which religious needs and wishes are taken into account might improve patients' quality of care with religious beliefs (Swihart, Yarrarapu & Martin, 2020).

One common religious wish is the request for specific nutrition based on religious beliefs. Nutritional practices can be defined as "the which individuals select, consume and utilize the available food supplies" (Rani, Reddy, & Sreedevamma, 2003). It is strongly related to social and cultural pressures, such as beliefs, traditions and religion. Multiple religions have specific nutritional practices. For example, Muslims might follow the dietary regulations of Halal, which means that they are only allowed to eat expressly permitted foods. Besides, Muslims might fast during the holy month of Ramadan and only eat and drink between sunset and sunrise. Furthermore, Jews might follow the dietary rules of Kosher, which means that the food derives from plants or permitted animals and is prepared in a specific way according to the regulations of Judaism (Nederlands-Israëlitisch Kerkgenootschap, 2010). A less known

nutritional practice is the prohibition of beef and veal in Hinduism. Next to these nutritional practices, Catholics might fast forty days before Easter.

Due to the growing religious diversity among some patients, hospitals might be confronted with these kinds of nutritional practices. It might be challenging to fulfil the various needs and wishes of all patients. All in all, the presence of religion in hospitals is related to the extent to which hospital take religious needs and wishes, including nutritional practices, into account. Hence, the question is how hospitals respond to the specific religious needs and wishes of patients.

3.2 The influence of factors and contexts outside the institution: External factors

Above, I described how I operationalized the presence of religion in hospitals. Through these four aspects, I clarified how religion could be present in hospitals. According to the literature, I will further elaborate on factors or contexts that might affect the governance of religion in public institutions and, in particular, the presence of religion in hospitals. I distinguish between the following external and internal factors: the separation of church and state, multicultural society, the framing of religious minorities, secularization, and institution's understanding of religion.

3.2.1 The separation of church and state

According to the literature, I expect that the national context of the church-state relationship affects the presence and reaction of public institutions towards religious diversity (Cadge et al., 2017; Furseth & Van der Aa Kühle, 2011; Griera & Martínez-Ariño, 2014; Koenig, 2009; Mattes et al., 2016; Minkenberg, 2003; Soper & Fetzer, 2007). According to Soper and Fetzer (2007), the presence and reaction to religious diversity is strongly connected to the church-state relationship and varies significantly from among countries. Moreover, this church-state relationship affects the governance of religion, especially visible in public institutions in which religious diversity is involved (Mattes et al., 2016).

In his study, Minkenberg (2003) makes a distinction between three general types of church-state relationships. First, a religious establishment in which the church and state are strongly connected, such as in Denmark or the Church of England. The state recognizes a

church by law as the official state church supported by civil authority. Miller (2019) argues that a religious establishment might benefit both religious and non-religious people. Moreover, a religious establishment might be beneficial for all religious groups, including religious minorities. The close link between public policy and the church creates more accessibility to the government for religious minorities. Consequently, religious minorities are more likely to look for public recognition of their religious rights and needs, for example, in the accommodation of their religious needs (Soper & Fetzer, 2007). Besides, Beckford (2005) argues that Britain, a country with a religious establishment, recognizes these religious rights and needs because it is a community where religious minorities play a large role. Based on these assumptions, it is more likely that religion is present in public institutions in countries with a religious establishment compared to countries with no religious establishment.

The second type of church-state relationship is the separation of church and state, such as in France (Minkenberg, 2003). In France, the concept of laïcité is integrated into politics and society. Laïcité is interpreted as state neutrality and discouraging religious involvement from the state, especially in public institutions. Religion is limited to the private sphere, and expressions and symbols of religion in the public sphere is restricted and sometimes prohibited. Also, public recognition of religious rights and practices of religious minorities are mainly restricted. For example, wearing religious clothes or pray in public all contravene the principle of laïcité. The strict separation of church and state is related to secularism. Secularism represents the shift from religious visibility in the public sphere to the private sphere (Soper & Fetzer, 2007). The state also argues that there should be no distinction between ethnic and religious identities in the public sphere (Beckford, 2005). Therefore, public institutions should represent the neutral attitude of the state. The strict separation of church and state does not indicate that there is no religion in the public sphere. Institutions, such as hospital, should maintain a private domain for patients in which institutions accommodate religion to a limited extent (Tassy, Polski, Banet, & Gorincour, 2004). Compared to countries with no strict separation of church and state, religion in countries with a strict separation is present to a lesser extent in public institutions.

The third type of church-state relationship implies both separation and cooperation between church and state, such as in the Netherlands or Germany (Minkenberg, 2003; Soper & Fetzer, 2007). The idea is that the state wants to emanate neutrality, but is at the same time

flexible in cooperating with the church or religious communities. Churches or religious institutions receive, for example, (financial) support. According to the Dutch government, there is a separation of church and state (Ministry of the Interior and Kingdom Relations, 2019). The separation of church and state is based on the principle of religious freedom and the prohibition of religious discrimination written down in, respectively, article 1 and 6 of the Constitution (1848). These Constitution articles imply the neutrality of the state so that no religion is favoured by the state. Consequently, the state's neutral attitude might shape the accommodation and regulation of religion in public institutions, including hospitals. Neutrality creates the expectation that the presence of religion is limited in public institutions. However, there is also cooperation between state and church. Cooperation creates the ability for religious minorities to look for public recognition of their religious rights and needs through, for example, the accommodation of religion. Thus, cooperation also affects the extent and ways in which religion is present in public institutions. The expectation is that the state accommodates religion in public institutions, but selects which religious accommodations are included. The religious accommodation of religious minorities might, for example, be restricted compared to the accommodation of the dominant religion in society.

While there is much academic literature in which authors use these three types of church-state relationships to explain the governance of religion in public institutions, this model also has implications (Bader, 2003; Bader, 2007). More specifically, dividing the church-state relationship into three types might be too simplistic because church-state relationships are highly diverse and complex. In addition, church-state relationships might change in a country over the years or vary in different branches of society. In short, the governance of religion in society and public institutions is not homogenous. Therefore, it is necessary to be flexible and critical when using the three types of church-state relationships for explaining the governance and presence of religion in public institutions. In this research, the focus is on the Netherlands. Consequently, I cannot examine and compare the influence of different types of the church-state relationship on the presence of religion in hospitals. However, I expect that religion is accommodated in hospitals in the Netherlands, and I will further examine which religious accommodations are present and which ones are restricted.

3.2.2 Multicultural society

The second external factor which might affect the extent and ways in which religion is present in hospitals is the growing multicultural society. Societies in Europe have changed over the last few decades into more multicultural societies due to, among other things, global migration (Becci, Burchardt & Giorda, 2016; Griera & Martínez-Ariño, 2014; Koenig, 2009). Dutch society has also become increasingly multicultural with people from different religious and cultural backgrounds (Central Bureau for Statistics, 2019). Because of the growing multicultural society, the religious landscape in the Netherlands also changed and became more religiously diverse (Van der Bie, 2009; Van Herten, 2009).

More religious diversity in society might build up pressure for the state to respond to this growth by accommodating religious diversity in public institutions (Koenig, 2009). The growing religious diversity in society creates a situation where religious groups and minorities might expect and look for public recognition of equal rights and practices from the state (Furseth, 2000). Equal rights and practices are strongly related to the right of religious freedom and the prohibition of religious discrimination (Constitution, 1848). To guarantee and protect these rights, public institutions might provide equal opportunities for religious groups and minorities to practice their religion in public institutions (Furseth, 2000).

All in all, multiculturalism is strongly connected to religious diversity in society. To guarantee the right of religious freedom and the prohibition of religious discrimination in a religiously diverse society, hospitals might feel the pressure to accommodate the religious diverse needs and practices of patients (Mattes et al., 2016). Hence, the expectation is that various religious accommodations are present in hospitals. In this research, I examine the influence of the growing multicultural society by looking at demographical data of the population living in the region of Groningen and how the demographical data affect the accommodation and presence of religion. Moreover, I will explore if patients' requests result in the accommodation of religion or if the religious accommodation is caused by the degree of religious diversity in the region.

3.2.3 Framing of religious minorities

Another external factor which might affect the presence of religion in hospitals is the framing of religious minorities. The public opinion and ideas conveyed by the media and politics about

religion can affect the extent and ways in which religion is present in hospitals. Since, among other things, the rise of several extremist attacks in Europe and the United States at the beginning of the 21st century, the understanding and perception of religion changed in both Europe and the United States (Bosco, 2014; Cesari, 2010; Triandafyllidou, 2017). Perpetrators of most extremist attacks used their religious beliefs to "justify" their actions. Religion became, therefore, gradually a concept related to terrorism and radicalization, especially concerning Islam. Islamic terrorist groups like the Islamic State and Al-Qaida reinforced these ideas of Islam being dangerous and violent by committing increasingly more deadly and brutal attacks in Europe. Interpreting religion as a threat is often referred to as the 'securitization of religion' (Bosco, 2014; Cesari, 2010; Mattes et al., 2016). According to Mattes et al. (2016), securitization of religion can be identified as a dominant frame that influences the discourse on religious diversity internationally. Moreover, religion and religious practices might be experienced as a threat to the peace, stability and democracy of Western societies (Bosco, 2014).

Consequently, both politics and the media increasingly present Islam as a threat and problem to Western societies (Cesari, 2010; Koenig, 2009). An example is the statements of the Dutch PVV party leader Geert Wilders. He expresses several negative statements about the consequences of the presence of Islam in Dutch society. Politics and the media can be very influential because people in society might take over these ideas. Moreover, politics and media sometimes convey the idea that religious beliefs, values and norms clash with the "modern" and secular beliefs, values and norms in Western societies (Bosco, 2014). In addition, religion might be considered as "backwards" and "conservative", because of the assumption that religious beliefs are the opposite of modern and secular ideas. As religious diversity is growing, people become more afraid of losing their own "modern" beliefs, values and norms. They argue that religious beliefs are culturally dangerous and fear that it becomes the new norm (Triandafyllidou, 2017, p. 33). The fear increases when religion becomes more visible. Since the governance of religion mainly takes place at the institutional level (Bader, 2009; Mattes, Permoser & Stoeckl, 2016), religion is especially visible in public institutions. For example, the presence of separate prayer rooms for Muslims, the presence of religious symbols and the refusal of blood transfusions by Jehovah's Witnesses, might reinforce the idea that religion becomes more dominant than secularity in Western societies. Hence, the state might be careful in supporting and accommodating religion in the public sphere (Cesari,

2010). Increasingly visibility of religion might cause negative reactions from the media, politics or society. These reactions might be related to negatively framing religious minorities as a threat. Consequently, the support and accommodation of religion might be restricted in public institutions, which, subsequently, affects the presence of religion in hospitals.

All in all, the framing of religious minorities might affect the extent and ways in which religion is present in hospitals. To examine the framing of religious minorities, I look at which religious accommodations are restricted and determine the reasons for these restrictions. The reasons can explain more about how health-care providers approach specific religions and if there are any prejudices about particular religions.

3.2.4 Secularization

The last external factor are secularization processes, mainly present in Western societies. According to Rutjes (2017, p. 426), secularization is "the confinement of religion to its own sphere and even the (discursive) marginalization of that sphere". Additionally, Berger (1990, p. 107) refers to secularization as "the process through which parts of society and of culture are subtracted from the domination of religious institutions and symbols". In short, secularization is the process in which religion and its practice play a less critical role in the public sphere and are more limited to the private sphere (Kuru, 2008; Norris & Inglehart, 2011; Soper & Fetzer, 2007). It became a private matter, separated from state affairs. Consequently, religion is less visible in the public sphere. In almost all European countries, there is a rise of secularization (Cadge et al., 2017; Habermas, 2006).

The shift of religion being less present in the public sphere and limited to the private sphere has consequences for the governance of religion in public institutions. Engelhardt (2003) argues that secularization in public discourse can cause implications in public institutions, such as in hospitals. It affects how religion is regulated (Cadge & Sigalow, 2013; Cadge et al., 2017). Nowadays, hospitals in the Netherlands are no longer strongly intertwined with religion. There are almost no Christian, Islamic or Jewish hospitals anymore. Hence, secularism is also reflected in hospitals and might create the assumption that religion should be restricted to the private sphere with the result of a less prominent role of religion in hospitals.

All in all, the expectation is that secularization affects the presence of religion in hospitals. Religion is restricted to the private sphere, and the visibility of religion is limited in the public sphere due to secularism in society. In this research, the influence of secularization processes is examined by looking at the visibility of religion in hospitals, such as religious symbols or the way prayer rooms look.

3.3 The influence from within the institution: Internal factor

3.3.1 Institutions' understanding of religion

Above, I discussed four external factors which might affect the presence of religion in hospitals. The last factor I consider in the research is the internal factor: institutions' understanding of religion. The institutions' understanding of religion might affect the policy towards religion and religious diversity in a hospital and how health-care providers approach religion. Hospitals tend to clearly distinguish between a medical perspective of health and a religious perspective of health, in which they approach the body and mind separately (Martínez-Ariño & Griera, 2016). Moreover, health-care is in this approach related to the body in which the mind, related to religion, does not play a significant role. Thus, hospitals approach health as biomedical in which there is only focus on the physical process (Taylor, 2007). In this approach, health-care providers aim to make the patient physically better or healthy. The biomedical approach focuses on biological factors and not on psychological, social or environmental factors (Engel, 1977; McDaniel, 2013). In short, in the biomedical approach, there is no room for considering religious factors. Taking psychological, social or environmental factor, such as religion, into consideration might affect a person's health situation positively. Consequently, hospitals might not see the importance of religion for some patients. All in all, the role of religion is restricted in health-care or for example, in making essential medical decisions.

In addition, health-care providers understand health based on the biomedical approach, but patients might understand health differently. Understanding processes of health, medical treatments, recovery or death can vary based on one's approach. The different approaches can, subsequently, lead to different decisions, misunderstandings or conflicts within health-care. For example, from the biomedical approach, health-care providers might advise continuing the treatment if it will improve a patient's health, or health-care providers

might advise stopping treatment because there are no possibilities anymore. However, religious reasons might result in the decision of a patient to stop the treatment. In short, hospitals might overlook the importance of religion in health-care because religion is seen as extrinsic to health-care (Martínez-Ariño & Griera, 2016). Therefore, the dominant frame of the biomedical model might affect the extent and ways in which religion is present in hospitals. To examine the influence of the institutions' understanding of religion, I look at how health-care providers approach health-care and if they seriously take the function of religion into account. Thus, I examine the extent to which health-care providers involve religion in the medical process of a patient and if it is prior in health-care.

In summary, in the theoretical framework, I explained how to operationalize the presence of religion in hospitals divided in spiritual care, religious facilities, knowledge of health-care providers and the religious needs and wishes of patients. After, I discussed the external factors that might affect the extent and way religion is present in hospitals. I referred to the church-state relationship, the (growing) multicultural society, the framing of religious minorities and secularization processes. Finally, I discussed the influence of the following internal factor: the institution's understanding of religion.

4. Methodology

In this chapter, I will describe how I conducted the research by explaining the research design. The research design includes the selection participants, the method of interviews, operationalization, and coding process. In the end, I will discuss the trustworthiness and ethical dilemmas of the research. The interview guides for the interview with both the spiritual caregivers and nurses are attached in appendix 1. The transcription of the interviews is attached in appendix 2, and the codebook is attached in appendix 3. Overall, this chapter underpins the methods I used to find an answer to my research question.

4.1 Research design

The main question in this research is about the extent and ways in which religion is present in hospitals and how hospitals encounter religious diversity among patients. The research question is further elaborated in four different sub-questions, namely: "*Which religious facilities are present and which are restrained?*". "*Where is religion physically visible, and what does it look like?". "How do hospitals respond to the presence of religion?" and "Which policies do the hospitals have about religion?".* To answer these questions, I used a qualitative research methodology. The choice for a qualitative research methodology is mainly based on the aim to understand the motivations, reasons and preferences of hospitals' actions, policy and behaviour towards religion. It also creates the possibility to examine factors that might affect the presence of religion and to gain a detailed understanding of the complexity of religion in a hospital (Hennink, Hutter & Bailey, 2015).

The data for this research is collected through in-depth interviews with spiritual caregivers and nurses working in hospitals. In addition to the interviews, I used public documents and website pages of all three hospitals for the analysis, listed below in table 1. During every stage of analysis, I used the program ATLAS.ti for coding and systematically analyzing the interviews and relevant documents to interpret the data and answer the research questions eventually. This program provides an efficient way to store, organize, code and analyze the data (Hennink, Hutter & Bailey, 2010).

Table 1. Documents, website pages and a book used for the analysis

Hospital	Document/website	Name of document/website
UMCG	Document	Hospitalization (University Medical Center Groningen, 2017)
UMCG	Document	Project "Als niet alles is wat het lijkt" (ZonMw, & Reyners, 2019).
UMCG	Website	Church services (University Medical Center Groningen, n.d.-a)
UMCG	Website	Circumcision (University Medical Center Groningen, n.d.-b)
UMCG	Website	Prayer room (University Medical Center Groningen, n.d.-c)
Martini Hospital	Book	"Ruimte voor geestelijke verzorging in het Martini Ziekenhuis" (Holsappel, Jutte & Zock, 2010)
Martini Hospital	Document	Patient information spiritual care (Martini Ziekenhuis, n.d.-a)
Martini Hospital	Document	"Zin op zondag" (Martini Ziekenhuis, n.d.-a)
Martini Hospital	Document	Room for emotions in the prayer room (Stichting Vrienden van het Martini Ziekenhuis, 2020)
Martini Hospital	Document	Art (Martini Ziekenhuis, n.d.-b)
Martini Hospital	Website	Prayer room (Martini Ziekenhuis, n.d.-c)
Martini Hospital	Website	Treatment policies (Martini Ziekenhuis, n.d.-d)
OZG	Document	Information in case of hospitalization (Ommelander Ziekenhuis Groningen, n.d.-a)
OZG	Website	Prayer room (Ommelander Ziekenhuis Groningen, n.d.-b)

4.1.1 Selection of cases and participants

This research includes the following three hospitals in the region of Groningen: the Martini Hospital, the University Medical Center Groningen (UMCG) and the Ommelander Hospital Groningen (OZG). I have chosen to focus on hospitals in the region of Groningen and not to include hospitals in other regions of the Netherlands. Religious diversity is most common in the Western regions of the Netherlands, such as in Rotterdam and Amsterdam, but there is also religious diversity in Northern regions such as in Groningen. No less than 31.6 per cent of the residents in the region of Groningen indicate a religious affiliation, including Roman-Catholic, Dutch-Reformed, Reformed, Protestant, Islamic, Hindu and Buddhist (Schmeets, 2016). Since there is religious diversity in the region of Groningen, it is interesting to examine the presence of religion in hospitals. Besides, I chose to include the UMCG and Martini Hospital because these are the two most prominent hospitals in the region of Groningen, both with specialist care possibilities. I chose to include the OZG because many people who live in North-East of Groningen go to the OZG for hospital care, including many Turkish people with an Islamic background. Finally, I included not more than three hospitals due to the limited time available.

In total, I conducted four interviews, of which two with spiritual caregivers and three with nurses. I interviewed two nurses at the same time. In qualitative research, the sample size is not predetermined. The best is to reach the point of saturation, which means additional interviews do not result in new information (Sargeant, 2012). The point of saturation is not entirely reached because of the limited time to do many in-depth interviews. However, the depth of the interviews and the richness of information are more relevant than the number of interviews (Burmeister & Aitken, 2012).

For the selection of participants, I used the targeting selection method (Sargeant, 2012). Based on the research questions and theoretical framework, I expected spiritual caregivers and nurses could both best provide information about the research topic. Spiritual caregivers have much knowledge about the presence of religion in a hospital, especially about spiritual care, and the way hospitals encounter religious diversity. In addition, they are mainly in direct contact with patients, some of whom with a religious or spiritual background, in which they often have in-depth conversations about, for example, the meaning of life or patient's religious and spiritual issues. Next to spiritual caregivers, nurses provide relevant information since they are responsible for the daily care of patients in which religion can play a role as well.

Via information on the website, I contacted them by email or phone. Due to the lack of time of spiritual caregivers and nurses, and the expectation that they will provide broadly the same information, I interviewed one spiritual caregiver of the UMCG, one spiritual caregiver of the Martini Hospital, two nurses of the UMCG of which one works in intensive care and the other in oncology, and one palliative care nurse of the OZG. No spiritual caregivers are working at the OZG.

4.1.2 Method of interviews

The reason for choosing a qualitative research methodology is to understand and examine the behaviour and actions of people, groups or institutions. There are different data collection methods in qualitative research, including in-depth interviews, observations or focus groups (Hennink et al., 2015). The most informative method for this research is in-depth interviews with all five participants. An in-depth interview aims to create a conversation in which the interviewer receives as much information about the research topic as possible (Hennink et al.,

2015). This type of conversation requires a semi-structured interview, a relationship of trust between the interviewer and the participant, and motivation of the participant to tell their story (Hennink et al., 2015). Moreover, a semi-structured interview contains naturally open questions creating opportunities for a discussion (Adams, 2015). Effectively conducted in-depth interviews provide insights and information about the research topic. In this research, the general purpose of the interviews was to examine the extent and ways in which religion is present in hospitals.

Finally, it is crucial to note that there were limitations for conducting the interviews due to the current situation of COVID-19. Especially in hospitals, there were strict rules concerning COVID-19. It was not possible to do observations in the hospitals due to the limited accessibility. Additionally, it was not possible and safe enough to conduct all the interviews face-to-face, especially not in the hospitals. Therefore, I conducted three interviews digitally and by phone and one at the home of the participants.

4.1.3 Coding process

To create textual data for the analysis, I made non-verbatim transcripts of the recorded interview, first, in Dutch and, after, I translated it into English. The anonymized transcripts are written out in appendix 2. Next, I developed codes to use in the analysis. Developing codes and carefully coding the texts is the foundation for the analysis (Hennink, Hutter & Bailey, 2010). I used both deductive and inductive codes in the analysis. The deductive codes were based on the theoretical background and interview guides which makes them closely related to the topics and issues of the research. The inductive codes are based on the data by active reading and noticing connections. All deductive and inductive codes are listed, categorized in themes, in the codebook with explanation and examples in appendix 2. Subsequently, I started the coding process involving multiple times of reading the data, interpreting the meanings and reviewing the codebook.

During the coding process, I first selected all relevant and essential quotations in the interviews and documents without giving them a specific code or label. In total, I selected 227 quotations. After, deductive codes were connected to the quotations. In total, there are eighteen different deductive codes. There were also interesting and relevant quotations for which there was no code yet. Therefore, I made new inductive codes.

4.1.4 Operationalization

Before conducting the interviews, I made a semi-structured interview guide, with a combination of structure and flexibility, customized on each participant (Hennink et al., 2015). The interview guide was based on the theoretical framework. It covered the following topics: the presence of religious facilities, the physical visibility of religion, the reaction of hospitals to the presence of religion and the policy of hospitals towards religion. These topics were divided into the following categories: spiritual care, nutritional practices, religious facilities, knowledge of religion among health-care providers and the religious needs and wishes of patients. At the beginning of the interview, I shortly introduced the research topic, what the participant could expect and the duration of the interview. During and after the interview, the participants always had the possibility to stop the interview or ask questions. I also told the participants about anonymity and confidentiality, and I asked them permission to record the interview (Hennink et al., 2015). In the end, all participants received the report of the research.

I operationalized the research questions by asking specific questions to the spiritual caregivers and nurses. The first sub-questions is about the presence or restriction of religious facilities. Therefore, I asked spiritual caregivers and nurses questions about the facilities related to spiritual care, such as the accessibility of spiritual caregivers, the religious or spiritual background of spiritual caregivers, and the reasons for not having spiritual caregivers with other religious backgrounds. In addition, I asked about the availability of (religious) dietary requirements, the celebration of holidays such as Christmas or Eid al-Fitr, the presence of a prayer room or church services and possibilities for medical treatments motivated by religion. Documents and websites provided extra information about religious facilities.

The second research sub-question is about the visibility of religion. In the interviews, I asked spiritual caregivers and nurses about the presence of a prayer room and the way they look. Also, I asked them about the presence of washing rooms or religious symbols in hospitals. Documents and websites also provided information and visual images of the visibility of religion, such as visual images of prayer rooms.

The third research sub-question is about the reaction of hospitals to the presence of religion? In the interviews, I asked spiritual caregivers and nurses how they respond to patients' specific religious-based wishes. For example, about the possibilities for patients to get a nurse of the same gender or having roommates of the same gender. In addition, how do

hospitals encounter and respond to the daily religious practices of patients or how do hospitals respond to religious-based wishes concerning medical treatments? A well-known example is the refusal of blood transfusion by Jehovah Witnesses refuse a blood transfusion. Another example is that Jews or Muslims do not want to slow down or speed up the process of dying because of religious reasons.

The last sub-question is about the policy or protocols of religion in hospitals. Therefore, I asked spiritual caregivers and nurses about prescribed protocols and rules about religion. Also, I used documents and websites for information about policies or protocols in hospitals. All in all, the presence of religion is operationalized by spiritual care, religious facilities, knowledge of health-care providers and religious needs and wishes.

4.2 Trustworthiness and ethical considerations

The trustworthiness in qualitative research indicates the degree of quality of the research. Four factors determine the trustworthiness. The factors are credibility, transferability, dependability, and confirmability (Elo, Kääriäinen, Kanste, Pölkki, Utriainen & Kyngäs, 2014; Shenton, 2004). The degree of credibility, which means internal validity, is about the truthfulness of the research. Truthful results should reflect reality as well as possible by using standard research methods such as in-depth interviews. To obtain truthful information of the participants, they can refuse the interview and are not obliged to answer the question. Finally, participants have the opportunity to read and check the transcripts of the interview.

Second, transferability is about external validity. External validity means that findings can be applied to other contexts, situations or circumstances. By explaining the context, situation and circumstances of this research in detail, findings can be applied to similar contexts. However, this research focuses specifically on three hospitals in the region of Groningen, making it complex to apply it to other contexts. The expectation is that the factors that affect the presence of religion in hospitals might affect the presence of religion in other hospitals.

Thirdly, the dependability indicates the opportunity for other researchers to replicate the research. Therefore, I described the research design in detail and made clear how I obtained and operationalized the data. In the end, I will mention the limitations of the

research so that other researchers can take this into account. The last factor, confirmability, is about the objectivity of the research. The researcher should prove that the results are based on data and not on presuppositions. This can be done by first describe the expectations based on previous literature and refer outcomes back to the literature. In addition, I will explain the choices and methods made in research and mention the shortcomings.

Next to the trustworthiness, it is crucial to mention the ethical dilemmas related to this research. Research ethics provide the guideline for responsible research, and research should ensure a high ethical standard. First, participants should not experience any disadvantages as a result of participating in the research. Respect for participants is essential. That is why I made clear to the participants that they are taking part in research and that their participation is entirely voluntary (Hennink et al., 2015). Next, I informed the participants about the research aim, who is taking part in the research and the duration of the interview and, finally, asked explicitly for permission to record the interviews.

Also, social, physical and emotional risks should be minimalized. That is why I guarantee the anonymity of the participants by not making it possible to identify them. The information that can identify the participant is not included in the transcripts. Lastly, it is important to be careful with the data obtained. Only the supervisor and second assessor have access to the data, and I will store the data on my computer, which I will remove after finishing the thesis.

5. The presence of religion in hospitals in the region of Groningen

The aim of the results chapter is to present and explain the outcomes of the data collection by providing a complete overview of the presence of religion in hospitals. First, I describe findings discussed in the interviews and documents and identify the context and depth to understand their meanings. Precisely, health-care providers' reaction to religious wishes and practices in the hospitals is singled out in the thick description because of the extensive findings of this issue. Next, I categorized the topics into specific themes related to the research question and theoretical background. After, I describe and explain which factors affect the presence of religion. The way of subdividing and analyzing the results is based on Hennink, Hutter & Bailey's (2010) extensive explanation of qualitative research.

5.1 The reaction towards religious wishes and practices: Thick description

First, I emphasized the reactions towards religious wishes and practices in hospitals in the thick description in table 2. The reaction towards religious wishes and practices is a broad concept and therefore used in the thick description to make it more concrete. The thick description creates the possibility to get a deeper understanding of this topic by explaining the depth, context and nuances (Geertz, 1973). In all interviews and documents, this topic is extensively discussed. I divided the reaction to religious wishes and practices into different kind of religious wishes and practices. It is related to the following issues: medical treatments, same-gender wishes, rituals, nutritional practices and spiritual care. Moreover, I examine the context and look at the similarities and differences between the three hospitals. The way health-care providers in hospitals react to religious wishes and practices give insights into how hospitals encounter the presence of religion and religious diversity among patients. Interesting is the notion of patient-centered care, which seems to play a role in all issues below.

5.1.1 Medical treatments: Patient-centered care vs family-centered care

Requests concerning specific medical treatments are one of the recurring religious wishes or practices of patients. The following medical treatments are discussed: the refusal of blood transfusions, tube feeding, euthanasia, family members' request not to tell the patient any

bad research results, and religiously based circumcision. According to protocols and policy in the hospitals' information documents, the refusal of blood transfusion by Jehovah's Witnesses is generally accepted. In a public information document of one of the hospitals, they describe: "You may have fundamental objections to certain medical procedures, such as a blood transfusion. We ask you to report this as soon as possible in a letter to your attending physician. There will be plenty of time to look for alternatives together" (Ommelander Ziekenhuis Groningen, n.d.-a).

Similar to the reaction to the refusal of blood transfusions is the reaction to the wish of patients to continue tube feeding or not to use euthanasia. Moreover, specialists in the hospital advise the patient about the best medical treatment and discuss the consequences of the refusal or the choice for alternative medical treatments. However, in the end, it is the patient's decision to accept it or not. Thus, it is about shared decision-making. One of the nurses describes the following about tube feeding: "Especially Islamic patients want to continue medical treatment as long as possible. For example, they want to continue the tube feeding; otherwise, they interpret it as stopping someone's life" *(Hospital 1)*. According to the nurse, it is the patient's right to decide about their treatment, as long as it is medically and legally possible. This shows the importance of the autonomy of patients for hospitals and health-care providers in which the patient is central in health-care (Entwistle, Carter, Cribb & McCaffery, 2010). Especially in Western societies, patient-centered care is dominant in health-care (de Pentheny O'Kelly, Urch & Brow, 2011; Franzen, 2017).

Family members of the patient might have a wish based on religious beliefs concerning the medical situation of the patient. For example, family members might request to not tell the patient about negative research results so that the patient will not lose hope. The dominant principle of the autonomy of the patient in health-care, shared in Western societies, do not all people in society share. In other (religious) cultures, illness might be approached as a family affair in which the family is central, instead of the patient only. In case of not telling the truth about medical research results, the autonomy of the patient is at risk. Since the autonomy of patients is essential and applies as the ethical standards for health-care providers, the request of family members creates conflicting feelings and values among health-care providers. Therefore, health-care providers do not feel comfortable when they would not discuss the results with the patient without knowing if they would agree on this. In

addition, it is also not allowed by law to not tell the medical research results without discussing this with the patient beforehand. Consequently, health-care providers will not accept the request of family members. They try to tell it in another, more subtle, way. One of the nurses explains: “The family does not want to tell the patient that he or she is terminally ill, because the patient will lose hope. So, this is not exactly told the patient in this way. You cannot say: “You are going to die”. The situation will always be explained; it is necessary. For example: “We cannot do anything for you, you will probably die soon. Doctors need to be fair about the situation because it is established by law. Another option is to say that the disease has been increased with many complications with the result nothing more can be done. They cannot say: “You will die”, because it will take away the hope of the patient” *(Hospital 1)*. All in all, religiously based wishes tend to be accepted, only if the patient’s autonomy is not at risk.

The last wish based on religious beliefs is about circumcision, mainly performed in Islam and Judaism. In the information document of one hospital, they explicitly refuse it and refer to special clinics for the circumcision: “At hospital 1, circumcisions are only performed for medical reasons” *(Hospital 1)*. Hospitals’ refusal of religious-based circumcision is also related to the principle of the autonomy of patients in which patients should decide about their own medical treatment. When circumcision takes place, boys are still underaged because they do not have the full competence to make important medical decisions independently (KNMG, 2017). Consequently, parents decide about the religiously-based circumcision of their child. However, the religious performance of circumcision is in contrast with the principle of autonomy of patients. Therefore, hospitals decide not to accept religiously-based circumcision. Next to the autonomy, circumcision of underaged boys is also in contrast with the right of a person’s physical integrity (KNMG, 2017). The right to physical integrity is established in article 11 of the Dutch Constitution (1848). Circumcision of underaged boys is, in this case, an irreparable intrusion of the boy’s body.

To conclude, based on these hospitals’ reaction to specific religious wishes or practices, it is more likely a religiously based wish will be accepted by the hospitals if the autonomy of the patient is not at risk. In hospitals, patient-centered care is the ethical standard compared to family-centered care.

5.1.2 Same-gender wishes: Availability and logistic reasons

Next to the reaction of religious wishes or practices concerning medical treatments, I will discuss the reaction to patients' wish to have roommates, nurses, or doctors of the same gender. Generally, in all three hospitals, there is no separate room for women and men. The hospitals' principle is to mix the rooms with both women and men to keep the waiting time for hospitalization as short as possible. If patients have any objections to this, they can discuss it with one of the health-care providers working in the department in the hospital. Health-care providers will, subsequently, look if it is logistically possible to accept the wish. There are logistic reasons for rejecting the wish to stay in a room with people of the same gender. In its information document about hospitalization, one of the hospitals describes the following: "In all departments, it happens that both men and woman stay in the same room. If you really have any objections to this, please discuss this with the specialist on the department" *(Hospital 3)*. In one of the hospitals, most of the rooms are single or double rooms resulting in fewer requests of patients for separate rooms.

Similar is the reaction to the wish for a nurse or doctor of the same gender: if the availability allows it, it is possible to get a nurse or doctor of the same gender. However, in general, there are more female nurses than male nurses. Consequently, the wish for a male nurse is more difficult to accept than the wish for a female nurse. A spiritual caregiver explains the following about this: "One time there was a male patient who did not want to get care from a female nurse … I think they always try to take this into account. However, most of the people who work here are women" *(Hospital 1)*. In short, the acceptance of same-gender wishes based on religion might seem to relate to patient-centered care, as discussed before concerning medical treatments. In this case, the patient is central in health-care and the hospitals. Logistic reasons or limited availability might result in wishes not being accepted.

5.1.3 The performance of rituals

Another wish based on religion is the performance of specific rituals. The performance of rituals is a broad concept. To be more specific, spiritual care-givers and nurses discuss the following rituals: praying, rituals of saying goodbye and sickness blessings. Patients can perform the ritual of praying in a prayer room which is present in all hospitals. The spiritual caregiver of one of the hospitals indicates that they will soon get a new prayer room with

more facilities. According to the spiritual caregiver, the reason for the new prayer room is the following: “Before, we had a prayer room which was small, dark and had little privacy. There were little corners and almost no possibilities for religious diversity” *(Hospital 1).* The room will be larger so that it can be decorated in an attractive way for all religions. For example, the hospital will implement universal elements that do not refer to a specific religion. Later, I will further elaborate on the concept of universal elements.

Next to the larger space of the new prayer room, there will be a separate room for Muslims with the availability of using prayer rugs. According to the spiritual caregiver, many Islamic employees pray in the prayer room. Also, the spiritual caregiver mentions that Muslims pray with more noise. Therefore the hospital decided to create a separate room for Muslims. The idea that Islamic prayer is noisy seems to be connected to the (Protestant) perspective of the spiritual caregiver. There is one shared prayer room in the other two hospitals in which there are no religious symbols. According to the spiritual caregiver and nurses, the prayer room is as neutral as possible to be accessible for every religion. Later in this chapter, I will discuss the universality and neutrality of symbols and elements in detail.

Besides, hospitals have the intention to accept and help with rituals of patients. No hospital indicates that they refuse the performance of specific rituals. In practice, most of the rituals in which health-care providers or spiritual caregivers are involved, are related to Christianity, such as praying together or do sickness blessings. This might result from spiritual caregivers with mainly Christian background or background related to no specific religion. A spiritual caregiver explains: “We do not do only conversations but also rituals. Explicitly, a sickness blessing or rituals for saying goodbye” *(Hospital 1).*

5.1.4 Nutritional practices

The possibilities for nutritional wishes or practices based on religion is in all hospitals similar. Patients can indicate which nutritional practices they have so that the hospital offers food according to patients’ religion. The hospitals mention in their information documents about hospitalization the following: “Specific dietary requirements based on culture, religion or belief can also be communicated to the assist” *(Hospital 1)*, or “If you are not allowed to eat certain products because of your religion or if you are vegetarian, for example, you can report this to the facility service employee” *(Hospital 3)*. Similar are the findings of Alpers’ (2019)

study in which eighty-one per cent of the nurses argue that the hospital offers food to religious patients based on their religion, such as halal food. Serving food that meets patients' religious needs is related to patient-centered care (Alpers, 2019). Meeting religious dietary requirements also has positive effects on the health outcomes, such as their recovery. In practice, spiritual caregivers and nurses indicate there are not many patients with dietary requirements. Finally, concerning the month of fasting, many patients do not fast during hospitalization because of their medical situation.

5.1.5 Spiritual care: Religious or spiritual background

There are some differences concerning spiritual care among the hospitals. In hospital 3, there is no spiritual caregiver because of financial reasons. Moreover, the hospital does not think spiritual care is a priority or crucial in health-care. Due to the absence of spiritual caregivers, palliative nurses feel responsible for taking care of patients with questions about the meaning of life. In hospital 2, there are spiritual caregivers, mainly with a Christian, Humanistic or general background. In hospital 1, there is, next to the Christian, Humanistic and general spiritual caregivers, also an Islamic spiritual caregiver. Due to multiple requests of people asking for an Islamic spiritual caregiver, the hospitals decided to meet their needs. There are no spiritual caregivers of other religions, such as Hinduism or Buddhism.

If patients need or request a spiritual caregiver with a specific background not present in the hospital, spiritual caregivers try to contact people outside the hospitals. Visits from, for example, pastors, imams or humanist counsellors are allowed. However, one of the spiritual caregivers mentions "If necessary, we try to make contact with philosophical societies from the city or outside the city. However, we have to know them to be sure we can trust them, and that they will not try to convert the patient" (Hospital 1). This statement indicates that the hospitals and spiritual caregivers want to control who is talking to the patients about spirituality, religion or the meaning of life. If spiritual caregivers do not know people outside the hospital, they have no control and fear proselytism. The findings of the study of Furseth and Van der Aa Kühle (2011) show that employing spiritual caregivers is a way to control and prevent proselytism and radicalization. Especially since the rise of extremism and radicalization, exaggerated by media and politics, hospitals might want to control spiritual

care. It can also be related to securitization in which religious beliefs, especially Islamic beliefs, might be experienced as a threat (Bosco, 2014; Cesari, 2010; Mattes et al., 2016).

Table 2 Analytical notes for the thick description of the 'reaction to religious wishes and practices'

Breadth	**Depth**	**Context**	**Nuance**
Medical treatment	Jehovah's Witnesses' refusal of blood transfusion, circumcision, tube feeding, no use of euthanasia, or not telling the patient about negative research results.	The acceptance of religious wishes or practices concerning medical treatments is related to patient-centered care. The principle for hospitals is the autonomy of the patient. In situations where the autonomy is at risk, hospitals tend to not accept the wish, for example, about circumcision or not telling the truth about medical research results.	Some Jehovah's Witnesses do not refuse blood transfusion but want their family not to know this. Next, in an emergency, it is impossible to first ask for any religious wishes or practices.
Same-gender	Nurses, doctors or roommates of the same gender	The wish for roommates, doctors or nurses of the same gender tends to be accepted because of patient-centered principles. Only logistic reasons or the limited availability might result in not able to accept the wishes.	One hospital only has single or double rooms and no triple or quadruple rooms resulting from fewer requests to be in a room with people of the same gender.
Rituals	Praying, saying goodbye rituals and sickness blessings	The possibilities to perform rituals vary per hospital. One hospital wants in the new prayer room a separate room with prayer rugs for Muslims. Spiritual caregivers want to do rituals, but in practice, they mainly perform rituals related to Christianity. Some health-care providers are not familiar with specific rituals.	No performance of rituals because of the medical situation of a patient
Nutrition	Halal food, nutrition during religious holidays and fasting periods.	In general, all hospitals mention that patients can indicate their dietary requirements to serve food according to their religion. This is related to patient-centered care.	Not much religious dietary requests because of the medical situation. Most of the patients who usually fast do not fast during hospitalization because they have medical reasons.
Spiritual care	The religious background of spiritual caregivers. Visits from a humanist counsellor, pastor or imam.	The background of spiritual caregivers is related to the extent to which patients request spiritual caregivers with a specific background. Contact and visits of pastors, humanist counsellors, imams or others is possible, but only if spiritual caregivers know them to prevent proselytism.	There is not much awareness of the presence of spiritual care among Islamic patients which might affect the request of a spiritual caregiver with an Islamic background.

5.2 Findings in relation to the theoretical framework

In the thick description above, the reaction to religious wishes and practices of health-care providers and spiritual caregivers was singled out to gain a deeper understanding of the topic. Next, I categorize all issues into specific themes to better understand the underlying meanings in relation to the theoretical framework. In the theoretical framework, I described how the presence of religion is operationalized by the following concepts: spiritual care, religious needs and wishes, religious facilities and knowledge of health-care providers. I use these concepts in classifying all the issues (figure 2). These categories identify the extent to which and ways in which religion is present in hospitals. In addition, two other concepts were discussed: the hospital's understanding of religion and demographics. These concepts identify factors which might affect the presence of religion.

Figure 2 Classifying codes into categories

Spiritual care	Religious facilities	Knowledge of health-care providers	Religious needs and wishes	Hopsital's understanding of religion	Demographics
•Religious background •Accessibility •Awareness	•Religious services •Religious holidays •Prayer room •Washing room •Religious books •Prayer rugs •Nutritutional practices	•Education •Knowedge religious practices	•Reaction religious wishes and practices •Reaction medical treatment •Rituals •Requests of patients	•Understanding of health-care •Vision spiritual caregivers •Patient-centered care •Policy •Symbols •History	•Religiously diverse patients

5.2.1 Biomedical model vs biopsychosocial model: What is the priority?

As described in the theoretical framework, the expectation was that the institutions' understanding of religion affects the presence of religion. Based on the findings in this research, the hospitals' understanding of religion is related to the biomedical model. Hospitals tend to clearly distinguish between a medical perspective of health, in which they approach the body and mind separately, and a religious perspective of health (Martínez-Ariño & Griera, 2016). Thus, the biomedical approach focuses on biological factors rather than psychological, social or environmental factors (Engel, 1977; McDaniel, 2013). Findings show that the biomedical model is still dominant in hospitals. One of the nurses explains, for example: "The

hospital is very physically orientated" *(Hospital 3)*. Reimer-Kirkham et al. (2012) describe that biological and medical factors are prior in health-care. Services not related to biological or medical factors are more sidelined. In hospital 3, there are no spiritual caregivers that indicate the lesser extent of this service's priority. Palliative care nurses feel responsible for the spiritual care and try to help the patients. Sometimes they contact spiritual caregivers in primary care outside the hospital. In hospital 1 and 2, there are spiritual caregivers. It seems spiritual care is also not the priority in these hospitals since most of the patients are not aware of the possibilities of spiritual care, especially among Islamic patients. The concept of spiritual care is not familiar in Islamic communities, and therefore health-care providers try to create awareness by calling the spiritual caregiver also Imam. One nurse explains: "Often, the patient does not know there are spiritual caregivers" *(Hospital 1)*. Consequently, patients do not indicate that they need spiritual care, but nurses working in the department need to recognize if they need spiritual care. In one of the hospitals, spiritual caregivers try to increase awareness among health-care providers at the departments. Especially in palliative care, there is awareness of the service of spiritual care. The lesser extent of awareness among both patients and not all departments in the hospital show that the biomedical model is still dominant and spiritual care is not seen as a priority in health-care.

The low awareness of spiritual care among patients also affects the accessibility of spiritual care. Since patients are not aware of spiritual care, they will not request a spiritual caregiver with a specific background. No requests from patients, especially religious minorities, might result in no spiritual caregiver with a specific background. One spiritual caregiver explains the following: "If there is a large group with the request for a spiritual caregiver with a specific religious background, you have to do something about it. We do not get these questions often, too little to take this into account with the applications" *(Hospital 2)*.

The dominance of the biomedical model is also reflected in the knowledge of health-care providers about the importance of religion in the health-care and religious practices of patients. Despite the findings from studies which indicate the importance and positive outcomes of social, psychological, environmental or religious factors in health-care (Cohen & Koenig, 2003; Puchalski, 2001; Swihart, Yarrarapu & Martin, 2020), hospitals do not explicitly include these factors in the education of health-care providers. One of the nurses describes

her education as follows: “We had ethics on school, but not specifically about the role of religion” *(Hospital 1)*. Consequently, health-care providers do not have enough knowledge about the importance of religion and religious practices. This is in line with the results of the study of Davidson et al. (2008), which shows the gap between the religious needs of patients and the knowledge of health-care providers. Therefore, some religious practices might not be familiar to health-providers and might be considered “strange”, which sometimes results in misunderstandings or conflicts. As one of the spiritual caregivers explains: “Yes, sometimes you need to explain about the importance of rituals and try to understand people. Some nurses or doctors do not know this and think it is something strange” *(Hospital 1)*. According to Cohen and Koenig (2003), it might be helpful to be aware of religious practices so that the patient can be better understood.

Although the biomedical is dominant, there is more attention to the biopsychosocial model in hospitals. In the biopsychosocial model, social, psychological, environmental and religious factors also play an important role in health-care (Engel, 1977). One of the nurses explains that the hospital started with some education about intercultural sensitivity: “At the beginning of this year, the hospital did invest in education about intercultural communication in health-care giving by someone from the Hanze University of Applied Sciences” *(Hospital 3)*. Also, spiritual caregivers try to create as much awareness as possible among health-care providers with projects or education: “We work towards this and put much effort in education, to explain what spiritual care is, what we contribute and how this connects to other disciplines” *(Hospital 2)*. In addition, there is more attention for the approach of seeing the patient as a total human being including the social, psychological and religious factors: “In these meetings, we sit together with doctors, speech therapists, physiotherapists and people from other disciplines who are involved, so that everyone gets a good perspective of the total human being and the different facets of care”. The increasing attention for the biopsychosocial model in the hospital results in more attention for religion in health-care.

5.2.2 Universality of religion: God leaves the building

Findings show that hospitals try to “neutralize” religion by emphasizing universality related to secularization. There is secularization in Dutch society (CBS, 2018). Alidadi and Foblets (2012, p. 414) note about secularization that: “in the public space there is the (contested) idea that

religion is to be confined to the private sphere". This is in line with the definition of secularization. Religion and the performance of religion play a less important role in the public sphere and are more limited to the private sphere (Kuru, 2008; Norris & Inglehart, 2011; Soper & Fetzer, 2007). Consequently, religion becomes less visible in public institutions, such as in hospitals. Meanwhile, religious diversity is growing in a secular society. As a reaction to the growing religious diversity, hospitals emphasize universal elements of religions to incorporate in health-care. In other words, hospitals try to neutralize religion to make it accessible to everyone. Neutralizing religion can be referred to as emphasizing what religions have in common or what is not related to religion in particular (Cadge & Sigalow, 2013).

The limited visibility and universalization of religion are also reflected in the current activity of spiritual caregivers. Before, one of the hospitals was Roman-Catholic orientated with mainly Protestant and Catholic chaplains. Currently, the hospital is not religiously oriented, and the concept of chaplaincy is neutralized to spiritual care. This is in line with the findings of Becci (2015) which show the universalization of Christian chaplaincy into the concept of spiritual care, as a consequence of secularization. According to Wright (2001), spiritual care has been described as a universal activity. In addition, spiritual caregivers believe that all people have a spiritual or philosophical background. One spiritual caregiver explains: "We assume that everyone, every human being so every patient, have a philosophy, so a specific way of living" *(Hospital 1)*. The idea of neutralizing spiritual is related to the spiritual caregiver's following statement: "We have two colleagues who are general spiritual caregivers with no specific religious or philosophical background. They can connect with many philosophies" *(Hospital 1)*. The spiritual caregiver indicates they can help many people with different philosophies. Also, both spiritual caregivers and nurses explain that they do not speak about religion, but more about spirituality or philosophy: "I am used to talk about the meaning of life instead of religion. We never use the word religion in the hospital" *(Hospital 3)*. They feel like religion is a restricted concept which does not apply to everyone. Consequently, spiritual caregivers do not mention their religious background in the first place, because they indicate that they want to be accessible to everyone.

Next to spiritual care, hospitals try to neutralize prayer rooms by using universal elements (Furseth & Van der Aa Kühle, 2011). As one spiritual caregiver notes: "It was a choice, if we want to get rid of the chapel kind of room, we need to look at universal things. Much

light for example" *(Hospital 2)*. The study of Gilliat-Ray (2005, p. 304) also shows that hospitals want to change from chapel space to prayer space, open to all people from all religions. Therefore, religious symbols are restricted both in the prayer room as in the hospital in general. In one of the hospitals' information documents, they describe the following: "The prayer room is for everyone. There are deliberately no religious symbols present" *(Hospital 2)*. Instead of religious symbols, hospitals decorate the prayer room with, according to them, universal elements not related to any religion. One spiritual caregiver explains: "What we find very important, is the centrality of the light. In many religions, the centrality of light is important. Also, when you do not have a religion, light can be attracted, next, with primordial elements, such as water and fire" *(Hospital 1)*. All hospitals indicate that the centrality of light is a universal element.

However, Gilliat-Ray (2005) argues that the neutral intention of universal elements is not entirely neutral. Behind every decision, there is an unconsciously individual preference. Also, "universal" elements might refer to one or several religions. In the end, "universal" elements or the "neutral" service of spiritual care might appeal more to a particular (religious) group. For example, spiritual caregiving is inherently related to Christianity and was called chaplaincy before. Consequently, spiritual caregiving is more familiar with Christian patients than patients with another religious background. To conclude, the growing religious diversity created challenges for hospitals to decorate the prayer room and provide services in other ways (Cadge & Sigalow, 2013).

5.2.3 The dominance of Christianity

Before, I described that secularization and the growing religious diversity in society result in hospitals trying to neutralize religion. However, religion has not entirely disappeared. Moreover, Christianity seems to be still dominant in hospitals. When looking at religious facilities and services, the majority of them are related to Christianity. Most spiritual caregivers with a religious background are Catholic or Protestant. Even if spiritual caregivers intend to offer spiritual care to every patient, Catholic or Protestant spiritual caregiver is the default option. Therefore, spiritual care seems to be more accessible for patients with a Christian background and more restricted to other religious minorities, especially when patients want to do rituals. One spiritual caregiver explains: "We do not only conversations,

but also rituals. Explicitly, a sickness blessing or rituals for saying goodbye" *(Hospital 1)*. From a historical perspective, chaplains in hospitals were also dominantly Christian (Abu-Ras & Laird, 2011; Becci, 2015). In addition, according to Carey and Davoren (2008), spiritual care is not a common practice in other religions than in Christianity. In one of the hospitals, the Islamic spiritual caregiver can offer spiritual care to Islamic patients. However, most Islamic patients are not aware of this because spiritual care is not a common practice in their religion, resulting in not many requests of patients for Islamic spiritual caregivers.

Next to spiritual care, facilities and services are also more Christian related. In two hospitals there are church services on Sunday but no services related to other religions. There is also only a Bible and no other book related to religion in one of the hospitals. Similar is the finding of Davidson et al. (2008), where patients indicate that they prefer the presence of books related to more than just the Christian religion. Also, while Christmas is celebrated, other religious holidays are not. Only in one hospital, they celebrated twice the festival of breaking the fast for Muslims. Thus, concerning religious facilities and services, Christianity seems to still be dominant in hospitals.

5.2.4 Demographical data: Religious diversity in the region

The dominance of Christianity in hospitals might be the result of demographical data of the region of Groningen. As described before, processes of secularization result in less visibility of religion in hospitals. Consequently, religious facilities and services are mainly provided on the request of the patients. The requests of patients are related to the extent of religious diversity in the region of Groningen. Findings of Conway's (2016) study also shows that the growth of religious minorities results in more requests for religious accommodations in hospitals. In this research, table 3 shows there is religious diversity in the region of Groningen, but the majority are Christian, subdivided in different Christian affiliations, or Islamic. There is a small group of people who are Buddhist, Hinduist or who indicate another religion.

Also, in the hospitals, spiritual caregivers and health-care providers describe that most of the patients are Christian or Islamic. Hence, most of the requests for facilities or services are Christian or Islamic related. The majority of the religious patients are Christian what might result in more facilities and services related to Christianity, such as church services, the availability of the Bible or spiritual caregivers with a Christian background. The spiritual

caregivers mention: “There may be a selection in the spiritual care, but I think as I said before, it is related to the demographical statistics of the region of Groningen” *(Hospital 2)*. The presence of an Islamic spiritual caregiver in one of the hospitals is, for example, the result of requests of patients. One of the spiritual caregivers describes: “That is also the reason for having an Islamic spiritual caregiver, because there were requests from patients, and we could not help them” *(Hospital 1)*. In the other hospital, there are not many requests of patients for spiritual caregivers with a specific background and the spiritual caregiver explains the following about this: “If there is a large group with the request for spiritual caregivers with a specific religious background, you have to do something about it. We do not get these questions often, too little to take this into account with the applications” *(Hospital 2)*.

Other facilities, services or religious items also refer mainly to Christianity or Islam. Like spiritual care, most of these facilities and services are related to Christianity, such as celebrating Christmas or church services. However, in one hospital, there are also several facilities and services related to Islam. There is a separate space in the prayer room for Muslims to pray, and prayer rugs and the Quran are available. About the prayer room, one spiritual caregiver explains: “Our Islamic colleagues mainly used it to pray several times a day” *(Hospital 1)*. In addition, the hospital celebrated twice the festival of fasting. Due to the presence and requests of patients, mostly with a Christian and Islamic background, the hospitals provide mainly religious accommodations related to Christianity or Islam for patients.

Besides the growing religiously diverse society, people in Dutch society are less strictly religious. According to the CBS (2018) statistics, more than half of the Dutch population consider themselves not religious compared to 40 per cent at the end of the 1990s. Thus, more people consider themselves as not religious. As a spiritual caregiver notes: “I think the group of patients with a strict view of religious identities becomes smaller” and “I also speak to many people who do not associate themselves with, specifically religion, in that way, but they tell me a lot about what is important for them” *(Hospital 2)*. Consequently, there are fewer patients with strictly religious beliefs.

Table 3 Demographic data about religious diversity in the region of Groningen in percentages (CBS, 2015)

	No religion	**Roman Catholic**	**Dutch Reformed**	**Reformed**	**Protestant**	**Islam**	**Judaism**	**Buddhism**	**Hinduism**	**Other**
Groningen	68.4	4.9	5.1	6.1	7.5	1.3	0.0	0.3	0.3	6.1

6. Conclusion

In the results chapter, I described and explained relevant and interesting findings concerning the presence of religion in hospitals in the region of Groningen. In the concluding section, I will discuss these findings and explain how they relate to a broader perspective. In the theoretical framework, I discussed the concepts: spiritual care, religious facilities, knowledge of health-care providers and religious needs and wishes. These concepts show to what extent religion is present in hospitals. I will answer the research questions and explain which underlying factors affect the presence of religion. The questions central to this research is: *"To what extent and in what ways is religion present in hospitals in the region of Groningen?"*. Finally, in the discussion, I describe the research's strengths and weaknesses and make recommendations for further research.

6.1 The influence of internal and external factors on the presence of religion

Based on the theoretical framework, I first expected that the church-state relationship affects the presence of religion. In the Netherlands, there is one type of church-state relationship. Therefore, I could not compare the influence of different types of church-state relationships on the presence of religion in hospitals in this research. However, in the Netherlands, there is both separation and cooperation between church and state, which might result in religion is not entirely excluded, but also not explicitly present. Based on the results, I found out that religion is accommodated, so religion is not entirely excluded. Religion is also not explicitly present and is limited to specific accommodations, which I will discuss later. Further research is necessary to examine to what extent the church-state relationship affects the presence of religion.

Next to the church-state relationship, I expected that the growing multicultural society affects the presence of religion. As described in the theoretical framework, the growing religious diversity in society creates a situation where religious groups and minorities might expect and look for the public recognition of equal rights and practices from the state (Furseth, 2000). Outcomes show that the demographical data of the region of Groningen affect the presence of religion. The majority of the religious people living in the region of Groningen have a Christian background. Also, the facilities and services are mainly Christian related, such as church services or spiritual caregivers with a Christian background. Based on these findings, I

conclude that Christianity is dominant in the hospitals (Abu-Ras & Laird, 2011; Becci, 2015). There is also a growth in the number of Islamic people due to the growing multicultural society. One of the hospitals responds to this growth by providing facilities and services for Muslims, such as hiring a spiritual caregiver with an Islamic background, celebrating the festival of breaking the fast, the presence of a separate space to pray, the presence of prayer rugs or the availability of the Quran. In the other two hospitals, facilities and services for religious minorities are limited. They are mainly related to Christianity and not to other religious minorities. All in all, the growing multicultural society affect the presence of religion, especially in one of the hospitals.

Since there are more religious minorities, I also expected that the framing of religious minorities affects the presence of religion in hospitals due to the changing, more negative, perception of religion (Bosco, 2014; Cesari, 2010; Triandafyllidou, 2017). The growing negative perception of religion seems to affect the presence of religion. Spiritual caregivers provide spiritual care to patients with whom they can also discuss religious issues. When patients ask for someone with a specific background that is not present in the hospitals, spiritual caregivers contact people outside the hospitals. In this situation, they do not contact others outside the hospital whom they do not know because they fear proselytism. As Triandafyllidou (2017) and Bosco (2014) also described, religion can be related to the idea that religion might be "dangerous" or "radical".

Another factor discussed in the theoretical framework is secularization, resulting in religion being less present in the public sphere and restricted to the private sphere. Therefore, I expected that the visibility of religion is limited in hospitals (Engelhardt, 2003). Based on the outcomes, religious symbols are restricted. It is also interesting that all hospitals try to "neutralize" religion through the use of universal elements in the prayer room such as light or elements of nature (Furseth & Van der Aa Kühle, 2011). Gilliat-Ray (2005) argues that universal elements are not always entirely neutral. Chaplaincy is also "neutralized" into spiritual care. However, Becci (2005) argues that spiritual care is inherently a Christian service. To conclude, secularization affects the presence of religion. It results in the limited visibility of religion and hospitals' intention to neutralize religion by emphasizing "universal" elements among different religions.

Next, I expected that the hospital's understanding of religion in health-care affects the presence of religion in hospitals. Reimer-Kirkham et al. (2012) argue that the biomedical model is dominant in hospitals in which biological factors in health-care are more important than social, psychological or religious factors (biopsychosocial model). Findings of this research are in line with the study of Reimer-Kirkham et al. (2012). Knowledge of health-care providers is mainly related to biological and medical factors. In one of the hospitals, there is also no spiritual caregiver and religious services are limited. However, the biopsychosocial model seems to take an increasingly important role in hospitals. Hospitals provide more education about social, psychological or religious factors in health-care and spiritual caregivers try to create as much awareness as possible among patients and health-care providers through the use of projects. All in all, the dominance of the biomedical model in health-care affect the presence of religion in hospitals, since religion is not considered as important in health-care.

Lastly, a surprising outcome was the influence of patient-centered care on the presence of religion. The patient is central in health-care and patients should remain their autonomy. Consequently, hospitals mainly accept the religious needs or wishes of patients. However, if the autonomy of patients is at risk when accepting religious needs or wishes, hospitals tend not to accept these religious needs or wishes. Thus, the principle of patient-centered care affects the presence of religion in the hospital, especially in the reaction to religious needs or wishes.

6.2 Providing answers to the research questions

The research question central to this research is: *"To what extent and in what ways is religion present in hospitals in the region of Groningen?"*. This research question is subdivided into three questions which I will answer below.

The first sub-question in this research is as follows: "*Which religious facilities are present and which are restrained?".* Based on the findings, religious facilities and services are restricted in all hospitals due to secularization in which religion largely disappeared from the public to the private sphere. Also, since the biomedical model is dominant in health-care, religious facilities and services are not a priority in the hospitals. Consequently, hospitals try to provide "universal" facilities and services for patients apart from their religion. Especially

the demographical data in the region of Groningen determines to what extent religion is present. Christian patients are the majority, and there is a growth of Islamic patients. Consequently, most religious facilities and services are limited to Christianity and some to Islam resulting in religious facilities and services, mainly related to Christianity and Islam. This seems to be related to the dominance of Christianity in hospitals and society more broadly. In one hospital, there are also some Islamic facilities and services due to the growth in the number of Islamic patients in the hospital related to the growing multicultural society. In the end, hospitals incorporate religious facilities and services mainly based on requests from patients. There are no religious facilities or services present related to other religions than Christianity and Islam.

The second sub research question is: "*Where is religion physically visible and what does it look like?".* The visibility of religion is restricted, which seem to be affected by secularization. No religious symbols can be found in hospitals. Only in one hospital, there is a separate space for Muslims to pray with prayer rugs and religious books (the Bible and the Quran) as a reaction to the growing number of Islamic patients in the hospital. As religion is almost not visible in the hospitals, the hospital tries to incorporate what it considers to be "universal" elements or symbols. This is the hospitals' reaction to the religiously diverse society in which they intend to respond to every patient despite their religion. However, according to Gilliat-Ray (2005), universal elements cannot be completely neutral.

The third sub research question is: *"How do hospitals respond to the presence of religion?"*. The hospitals have in common that the respondence to the presence of religion is related to patient-centered care. Patients should remain their autonomy. If the autonomy of the patient is not at risk, hospitals tend to accept religious needs and wishes. Overall, the respondence of health-care providers is minimal. The priority of the biomedical model can explain this. Biological and medical factors are the priority in health-care. Health-care providers are not always aware of the important role of religion in health-care. There is a lack of attention for the biopsychosocial model. Besides, religious minorities are growing, and the religious background varies among patients. Hospitals react to this by "neutralizing" religion and intent to use "universal" elements.

The fourth sub research question is: *"Which policies do hospitals have about religion?".* The hospitals describe in information documents their policy towards religious issues.

Beforehand, hospitals indicate that they accept the refusal of blood transfusion by Jehovah´s Witnesses, which is related to patient-centered care. Circumcision for non-medical reasons is not accepted because the autonomy of the patient is at risk. Moreover, in the first place, rooms in the hospitals are mixed with both women and men, similar to the gender of the health-care providers. Patients can always request if they have objections but are depends on availability and logistics. Overall, there are not many rules or policy document concerning religion in the hospitals.

To conclude and answer the research's central question, I argue that religion is present in hospitals in the region of Groningen but to a limited extent. Secularization processes can explain the limited extent of the presence of religion. Due to secularization, there is less religion present in the hospitals, and the visibility of religion is limited. However, due to the multicultural society and growing religious diversity, there is some religion present in hospitals. Hospitals' reaction to the presence of religion is to neutralize religion through universal elements in the hospital. The dominance of the biomedical model is also an explanation for less religion in the hospital because religious factors are not the priority. Religion is especially present through facilities and services in the hospitals, but these are mainly affected by the dominance of Christianity. The majority of the patients are Christian resulting in facilities and services which are mostly related to Christianity. The growing number of Islamic people in the region resulted in the incorporation of some facilities and services related to Islam in one of the hospitals.

6.3 Discussion

In this research, I focused on hospitals in the region of Groningen. During the research, I encountered some weaknesses and strengths of the research. Therefore, I will make recommendations for further research. First, religious diversity in the region of Groningen affects the presence of religion in hospitals. In the Netherlands, religious diversity differs among the several regions. Consequently, the religious background of patients in hospitals varies among the regions. Therefore, it might be interesting to examine the presence of religion in other regions in the Netherlands and examine how religious diversity in other regions affects religion in hospitals. As described in the theoretical framework, the church-state relationship might affect the presence of religion in hospitals. For further research, I

recommend how different church-state relationships affect the presence of religion among countries.

Next to these recommendations, I want to notice the restrictions of the situation of COVID-19 while writing the research. Especially hospitals do experience the consequences of COVID-19, because of the growth of patients diagnosed with COVID-19 due to more pressure on health-care. Therefore, hospitals became an extra isolated place to prevent the risk of infections as much as possible. Due to these measurements, I could not do observations in hospitals or conduct interviews physically with most of the participants.

In the end, this research shows a complete overview of the complexity of religious diversity in hospitals. Hospitals are challenged by growing religious diversity among patients. Therefore, I examined the presence of religion by including spiritual care, religious facilities and services, the knowledge of health-care providers, and religious needs and wishes of patients in this research. Outcomes are in line with theoretical findings and showed that underlying factors affect the presence of religion in hospitals in the region of Groningen. As religious diversity is still growing in society, research into the presence of religion in public institutions is increasingly important. This research is the first step in gaining a complete overview of how public institutions encounter growing religious diversity and examining the extent to which religion is present in hospitals in the Netherlands.

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Appendix 1

Interview guide spiritual caregivers

Introduction

- First of all, thank you for your time for this interview. My research is about religious diversity in hospitals. Due to, among other things, the growing religious diversity in society, I am curious about how hospitals encounter the growing religious diversity among patients. I think it is useful and informative to talk to spiritual caregivers who work in a hospital. I will ask questions about spiritual care, but also about nutritional practices, religious facilities, knowledge of religion among personnel in hospitals and the religious needs and wishes of patients.
- The interview will take about one hour, and during the interview, you always have the opportunity to stop the interview or ask questions. Furthermore, the information discussed in this interview will be kept confidential, and only my supervisor and second assessor can access the information. Finally, anonymity is guaranteed by not mentioning your name in the research. I would like to record the interview to analyze the data, do you give permission for that? I will start the interview with some general question for the background information.

Background information

- Can you tell me/explain about spiritual care in the hospital?
- What is an average day look like for you? What are the main tasks?
- You often have direct contact with patients. Can you describe how this contact look like and what kind of patients you have frequent contact with?
- Can you tell me about the religious or spiritual backgrounds of these patients?

Spiritual care

- At some point, patients may need contact with a spiritual caregiver. How does this work? How can patients come into contact with spiritual caregivers?
- How long does it take for a patient to have an appointment with a spiritual caregiver?
- On the website of the hospital, it is mentioned that there are working spiritual caregivers. How many? Do all spiritual caregivers have a religious or spiritual background, and if so, what is the religious or spiritual background. Can you tell more about it?
- What are the reasons for having spiritual caregivers with a background in the hospital?
- What are the reasons for not having spiritual caregivers with other backgrounds?

- What religious or spiritual background do patients mainly have?
- How does it work when a patient has a religious or spiritual background other than the available spiritual caregivers?

Nutritional practices

- Can you tell me about the religious dietary requirements? Which religious dietary requirements are there and what are the reasons for it?
- Are there specific religious dietary requirements not possible for patients? What are the reasons for it?
- What are the possibilities for dietary requirements concerning religious holidays, such as during Ramadan or Christmas?

Religious facilities

- Are religious holidays been celebrated? If so, which ones? Why are these religious holiday been celebrated?
- What are the reasons for not celebrating other religious holidays?
- Can you tell me about the available religious services, such as church services or prayer services, in the hospital? Why these specific religious services?
- What are the possibilities for patients when they want to pray or seclude themselves for religious reasons?
    - How does this prayer room or quiet room look like?
- What if people want to wash before praying, such as Muslims normally do?
- Why are there (no) washings rooms?

Knowledge of religion

- How is the situation concerning the knowledge of doctors and nurses about the combination of religion and health care? Can you tell me about it?
- To what extent are doctors and nurses informed about religious habits, rituals, norms and values which may be revealed in health care? What is the reaction?
- What is the situation concerning knowledge about specific medical treatments based on the religious background of a patient? What is the reaction? Do conflicts occur? How does the hospital deal with conflicts?

To what extent do doctors and nurses know the religious background of ethical issues? For example, if health professionals are approached by family members of the patient with the

request not to tell the patient, he or she will not recover and eventually die? With the reason that the patient will not lose hope instead of being confronted with the harsh reality.

Religious wishes and needs of patients

What is the policy concerning religious diversity among patients?

- By whom and how is this policy established?
- What is the reaction of the hospital or personnel towards specific religious wishes or needs of patients?
    - To what extent are these religious wishes or needs accepted?
- What is the reaction when, for example, a patient prefers a doctor or nurse of the same gender? Or do not want to be in the same room with a patient of the opposite sex?
- How are religious wishes concerning medical treatments been handled? For example, the refusal of blood transfusion by Jehovah's Witnesses?

Conclusion

- Do you have questions or comments in response to the interview? If you want to, I can send the transcribed interview so you can check it by yourself. Would you like that?
- I want to thank you for your participation in the interview. If there are any questions afterwards, you can always contact me.

Interview guide nurses

Introduction

- First of all, thank you for your time for this interview. My research is about religious diversity in hospitals. Due to, among other things, the growing religious diversity in society, I am curious about how hospitals encounter the growing religious diversity among patients. I think it is useful and informative to talk to nurses who work in a hospital. I will ask questions about spiritual care, nutritional practices, religious facilities, knowledge of religion among personnel in hospitals and the religious needs and wishes of patients.
- The interview will take about one hour, and during the interview, you always have the opportunity to stop the interview or ask questions. Furthermore, the information discussed in this interview will be kept confidential, and only my supervisor and second assessor can access the information. Finally, anonymity is guaranteed by not mentioning your name in the research. I would like to record the interview to analyze the data, do you give permission for that? I will start the interview with some general question for the background information.

Background information

- What is an average day look like for you? What are the main tasks?
- You often have direct contact with patients. Can you describe how this contact look like and what kind of patients you have frequent contact with?
- Can you tell me about the religious or spiritual background of these patients?

Spiritual care

- I understood that since last year there is no spiritual caregiver anymore. Do you know the reasons for this?
- Last year, when there was still working a spiritual caregiver, did he or she have a specific religious or spiritual background?
- What if a patient needs to talk about the quality of life or religious issues concerning their health? What are the possibilities?

Nutritional practices

- Can you tell me about the religious dietary requirements? Which religious dietary requirements are there and what are the reasons for it?
- Are there specific religious dietary requirements not possible for patients? What are the reasons for it?

- What are the possibilities for dietary requirements concerning religious holidays, such as during Ramadan or Christmas?

Knowledge of religion

- Have you ever had workshops or training from the hospital related to religion?
- How is the situation concerning the knowledge of doctors and nurses about the combination of religion and health care? Can you tell me about it?
    - To what extent are doctors and nurses informed about religious habits, rituals, norms and values which may be revealed in health care? What is the reaction?
- What is the situation concerning knowledge about specific medical treatments based on the religious background of a patient? What is the reaction? Do conflicts occur? How does the hospital deal with conflicts?
- To what extent do doctors and nurses know the religious background of ethical issues? For example, if health professionals are approached by family members of the patient with the request not to tell the patient, he or she will not recover and eventually die? With the reason that the patient will not lose hope instead of being confronted with the harsh reality.

Religious wishes and needs of patients

- What is the policy concerning religious diversity among patients?
    - By whom and how is this policy established?
- What is the reaction of the hospital or personnel towards specific religious wishes or needs of patients?
    - To what extent are these religious wishes or needs accepted?
- What is the reaction when, for example, a patient prefers a doctor or nurse of the same gender? Or do not want to be in the same room with a patient of the opposite sex?
- How are religious wishes concerning medical treatments been handled? For example, the refusal of blood transfusion by Jehovah's Witnesses?
- What are the possibilities when people want to pray or be alone for personal, religious or spiritual reasons in their room?

Conclusion

- Do you have any additions, perhaps something I have not thought of myself?
- Do you have questions or comments in response to the interview? If you want to, I can send the transcribed interview so you can check it by yourself. Would you like that?

- I want to thank you for your participation in the interview. If there are any questions afterwards, you can always contact me.

Appendix 2

Transcription interview – spiritual caregiver

Hospital 1

Duration: 37 minutes

I: interviewer / P: participant

Before recording the interview, I introduced myself and explained in short the aim of my research and why I think it is informative to interview the participant. Before the interview, I send an interview set-up so that the participant knew about the topics we were going to discuss. Next, I explained that the information of the participant will be kept confidentially, and only my supervisor and second assessor can see this information. The name of the participant and the name of the hospitals will not be mentioned in the final thesis report. Further, I told the participant about the possibility to ask questions during the interview or stop the interview whenever they want to. Finally, I asked if I could record the interview to analyze the data. The participant agreed to this.

I: Can you tell me about spiritual care in the [name hospital], to have some background information?

P: We are with a team of six people with various philosophical backgrounds, deliberately chosen. And there are some people next to us, such as interns or trainees. We are in the [name hospital] focused on patient care. Other hospitals do emphasize on education and care for employees. This is also more developing in here, but we focus on the role of patient care. In the [name hospital] is the philosophical dimension of being human, the meaning of life, recognized as an essential element of being human. If you adhere to the holistic view of human, it is crucial to give attention to this. We are the experts in this area. We assume, this is all the ideal vision, that everyone in the hospital, because everyone is working with the whole human being so with the whole patient, contributes to spiritual care, as we called it, at a basic level. When it gets more specifically, difficult, complicated, or people cannot do it from their philosophical vision, we try to help. Every spiritual caregiver had their departments to introduce spiritual care, emphasize the importance, ask attention for it and give education about spiritual care. We try to organize it this way in the hope that it works. People know what spiritual care is and when they have to ask us for help, or they can do it independently. Most

of the colleagues have a meeting in their department every week with the coordinating nurse, or sometimes with doctors, it depends on the department. To discuss which patients there are and which patients would probably benefit from a conversation with a spiritual caregiver. We work territorial, but if there is a specific philosophical question, I have a Catholic background, if someone wants a sickness blessing or talk to a Catholic pastor. The other way around, if there is an Islamic patient, I will send my Islamic colleague, or in another situation, my Protestant, Humanistic or non-believer colleagues. We try to work in this way. We do not only make conversations, but also rituals. Explicitly, a sickness blessing or rituals for saying goodbye. Due to COVID-19, it has been stopped in the hospital, but we have every Sunday a meeting, also called a church service or inspiration service. We think it is an essential part of our offer. Next to this, we try to work on awareness in several projects. Next year, we do a big project. I can tell you about this later.

I: Yes, that sounds interesting. I noticed spiritual caregivers are working in the [name hospital] with different backgrounds; for example, you have a Catholic background. I was wondering why chosen explicitly for these backgrounds?

P: What do you mean exactly?

I: Well, I saw there are spiritual caregivers with a Catholic, Protestant, Humanistic and general background. I was wondering, what if a patient wants an Islamic spiritual caregiver, is that possible?

P: We have this now

I: I did not see that on the website, that is interesting to know.

P: We have this since half a year, actually already for a longer time, but they leave every time. Hopefully, we have now someone who stays longer. The Islamic spiritual caregiver tries to be there for Islamic patients, next to the general spiritual care that everyone needs to do. We have chosen this consciously, that we first give general spiritual care to all patients, as part of the health-care. When it gets specifically, we can offer more specifical spiritual care. We only have no Buddhist and Hindu spiritual caregiver. If we notice by our patients there are requests for this, we will discuss this. That is also the reason for having an Islamic spiritual caregiver because there were requests from patients, and we could not help them.

I: Yes exactly, so over the time there were more requests and needs for an Islamic spiritual caregiver?

P: Yes, and also questions about culture, it is not entirely related to Islam, but sometimes it is, in which different views and perspectives come up in health-care. Thus cultural differences. We notice our colleague can help for being a bridging function in this; between the health-care provider and family from the patient, for example. We cannot do this with our Western background.

I: Yes, because I am wondering, what if there are any specific needs or wishes from, for example, an Islamic patient. Perhaps, the wish for having a nurse or doctor of the same gender, all these kind of things based on religion. How is this handled? Do you know anything about this?

P: Not a lot, it is not that I see these problems every day. One time there was a male patient who did not want to get care from a female nurse. It can also be related to sickness. I think they always try to take this into account. However, most of the people who work here are women. There are some male nurses, but most of them are women.

I: What if a patient wants contact with a spiritual caregiver. How does this work?

P: It will come up quickly when a patient directly asks for a spiritual caregiver. This morning, I heard that Islamic patients do not know at all about the possibilities of spiritual care; this concept is unknown in their community. They often speak about an Imam. We have learned to call the Islamic spiritual caregiver 'Imam'. What for us create a blockade, for the people with a Christian background, but for the Islamic patients, it is important to call him the Imam. Most departments know there is an Islamic spiritual caregiver, but we have some work to bring demand and supply together. It does not happen naturally. Officially, the best way is that a nurse asks at the intake, when a patient will be hospitalized, if the patient wants to have contact with a spiritual caregiver, or asks some questions suggesting someone needs spiritual care. It happens in some departments, actually in more and more departments. However, still not in many departments.

I: Thus, the contact often emerges when a nurse notice or indicates the need for spiritual care.

P: Yes, they are educated in recognizing spiritual questions. We have documents about it and gave education about the meaning of a question of life and when someone needs help with that, or how you can see if someone needs spiritual care. Most of the time, these questions of life are hidden. A patient will not say: "I have a question of life, can I speak to a spiritual caregiver?". Questions are much clearer with a dietician or physiotherapist. You need to listen with three ears to patients to understand these questions. That requires a doctor or nurse to

make time and space for what the patient cares about. Just as a nurse observes that a patient is losing weight and contact a dietician, they might also think to contact spiritual caregiver when a patient, for example, makes many jokes about death. Perhaps there are problems or issues behind it. This is the way we want it to be. In addition, patients have the right to have contact with a spiritual caregiver. So the people can always directly ask for spiritual care themselves, it occasionally happens, but not that often.

I: And I am also wondering, the patients who are in contact with spiritual caregivers, do they often have a specific religious background, or does this vary a lot?

P: It varies a lot. We assume that everyone, every human being so every patient, have a philosophy, so a specific way of living. Certain norms and values, or essential things which turn upside down when someone is sick and need to be hospitalized. As soon as something happens there, we come in. People often think it is about religion, but it is not. Sometimes there are specific religious questions, many Christians who want to pray, but often there are no specific religious questions.

I: We talked about when a patient requests a spiritual background with a specific religious background. There is an Islamic spiritual caregiver now. What about Hinduism and Buddhism?

P: We have two colleagues who are general spiritual caregivers with no specific religious or philosophical background. They can connect with many philosophies. That is what most people have these days, that you feel connected with nature, something bigger or something that transcends. However, there is no specific name, scripture or image of this. So they are outstanding in having contact with those people. We are all, but that is their specific philosophical background. We do have agreements to help health-care providers with this: “What if you have such a patient, what can you do?”. For example, try to think together what can help this patient, are there, for example, people of their network who can do something? Actively keep on asking if some specific texts or images can support the patient, ask about rituals which may be important. In this way, you can try to think together with the patient actively. If necessary, we try to make contact with philosophical societies from the city or outside the city. However, we have to know them to be sure we can trust them, and they will not try to convert the patient.

I: Concerning facilities, I understood there is a church service?

P: Or an inspiration service, the services are not all Christian.

I: So, an inspiration service and a church service. Are there more services?

P: Well, the idea is to celebrate the festival of breaking the fast. We did it twice, and we would also celebrate it this year, but it did not happen because of COVID-19. There were plans for celebrating it. What we also wanted to do was broadcast live The Passion on television. We always have the 4 and 5 May commemoration. We also organize a commemoration for people who passed away in our hospital, for adults and children.

I: You did celebrate the festival of breaking the fast before, or would it happen this year for the first time?

P: I think we celebrated it twice, but it was in the time I did not work here.

I: And there is a prayer room? I saw it on the website. How does it look like, and what kind of room is it? For what can people go there?

P: Well, actually, I have to tell you three things. Before, we had a prayer room which was small, dark and had little privacy. There were little corners and almost no possibilities for religious diversity. Nevertheless, we noticed many people used the prayer room: a dark room with some light, a bench, a writing table, a bookshelf and a small corner to put lights on. Our Islamic colleagues mainly used it to pray several times a day. We are now very far in creating a new prayer room, a larger prayer room where we can decorate the space in a way that is attracting for people with several philosophies, so that I, as Catholic, can pray there but also my non-believing Humanist colleague can find a place there. What we find very important is the centrality of the light. In many religions, light is important. Also, when you do not have a religion, light can be attracted, next, with primordial elements, such as water and fire. A place to commemorate, so a commemorate tree: a quiet side and a playful side. Within the room, there is an Islamic prayer room, in the middle but still separated. Because Islamic people often pray more active than others and so that they have more privacy. Building a new prayer room is postponed due to the COVID-19. We noticed in the COVID-19 situation that the prayer room became important for employees. We have rushed to create a prayer room, next to the old one, in a big room. It is a room with many windows, several corners where people can write or meditate and light a candle with beautiful nature images.

I: Often, you think a prayer room is a place where patients go to, but it is also for employees.

P: Yes, for patients and employees. In our new prayer room, we want the possibility that patients who need to stay in bed can also go to the room. Thus, it is accessible for those patients too. The current prayer room is only for employees because, in the hospital, you want to limit any chance of infection of COVID-19. It is not open for patients, but if there is someone

at the door, we will not refuse them. It is a bit complicated because it is such a nice room and we cannot open it for patients. That has its reasons, in the future will welcome the patient in the new prayer room.

I: Good the hear it is decorated in that way so that all kinds of patients can go in the prayer room.

P: It is a choice; you can make several corners for specific philosophies. We have chosen for one prayer room whereas many people as possible feel comfortable. You do not want to be a hospital with just one philosophical background, as is the case in the [name hospital].

I: Yes exactly, do you think it has its effects that the [name hospital] does not have a specific philosophical background?

P: Yes, I think so. I think my colleagues in the [name hospital] have it too, but in here it is clear that religion is not the priority, but what is of value in someone's life. That is the starting point. My colleagues in the [name hospital] have this as well, but I think it is much stronger here.

I: And what about washing rooms? Are there patients who need this?

P: Yes, in our new prayer we have taken into account there is a washing room for people. At the moment, the washing room is in the larger toilet space with a separation between the toilet and washing room. There is a sign that you can go there. It is possible, but it is not ideal.

I: But there is a possibility?

P: Yes, we noticed that people like to do it.

I: Yes, I can imagine, and what about nutritional practices? I am not sure if you can answer the question, perhaps it is more a question for dieticians or nurses. Are there nutritional facilities for religious patients?

P: I suppose so, but I am not sure. Then I should contact one of our dieticians.

I: Yes, maybe at the end of the interview, it is possible to have contact information of a dietician, to ask these specific questions.

P: I think they do a lot to make all kinds of things possible. I cannot imagine they do not.

I: I came across some information on the website, there is quite a lot to be found about facilities and the possibilities.

P: Yes definitely

I: And specific wishes or needs of patients, for example, the performance of rituals. What are the possibilities? Do spiritual caregivers help with that?

P: People need to get the possibility to perform their rituals, which are essential for them. As far as it is possible, patients can perform the rituals. You can imagine it is complicated in a quadruple room, but they always try to figure it out.

I: To what extent is there knowledge of religion among nurses or doctors? Is there, for example, contact with you as spiritual caregivers and the nurses?

P: It depends on the department. I cannot say anything general about this. One department is aware of these things, and the other is not.

I: It might depend on the time patients are hospitalized? Patients stay much longer in specific departments than in others.

P: Yes, sometimes, you need to explain the importance of rituals and try to understand people. Some nurses or doctors do not know this and think it is something strange. We try to intervene in this, but I do not experience it very often.

I: And what about conflicts? For example, philosophical or religious ideas about medical treatments, health-care and sickness, compared with the medical ideas and perspectives about that. Are there conflicts sometimes?

P: Yes, there are sometimes conflicts. In particular, among people with an Islamic background or from the Middle-East and most of the time think different about health-care. As long as someone is well informed and can make an independent decision, then it is okay. That is our value. We are sometimes confronted that it can be hurtful for the patient to tell the whole situation, the patient can lose hope. If you say to someone: “You need to take into account that it may be over for you”. Sometimes it is not possible to say that, and it is searching for the best way to say it.

I: Yes, because I read it sometimes happen, especially among patients with an Islamic background, that, for example, doctors are approached by a family with the request of not telling the patient it can end badly and they find it important that the patient does not lose hope and will not be confronted with the situation. I can imagine it is difficult.

P: Yes, it is. Every situation is different. I can not answer it. In general, it is difficult for doctors to deal with this, because it feels like it is in contrast with their own values. Therefore, we have our Islamic colleague who has a bridge function and understand the medical world of the [name hospitals], doctors and nurses, but also the other world. I can remember that the previous Islamic colleague told us: “You need to say to the patient, we are going to take you

home because we can take better care there". That is different from saying that we cannot do anything anymore for the patient.

I: It is interesting to hear how it works.

P: Sometimes, we miss the tools to do it correctly.

I: It remains difficult, of course. And I was wondering, it is specific questions, about the refusal of blood transfusions by Jehovah's Witnesses. Does this happen?

P: Yes, it sometimes happens, but I have never experienced it myself, so I cannot exactly tell you about it. There are often their pastors; they do not contact us for this. In this hospital, we do not have a significant function; we do with specific patients, but for example, in education about moral dilemmas. It is different in other hospitals; there do spiritual caregivers have a more prominent function in education. We do have expertise in it, we sometimes do it, but it is not the case they ask us for all problems. It is not entirely in the system here. Sometimes it goes wrong.

I: When there is such a situation, they do not directly contact a spiritual caregiver? Before I spoke to a spiritual caregiver of the [name hospital], I think they do more in education about moral dilemmas, and they do ask more often a spiritual caregiver for this.

P: In the past, we had an own group for this, ethicists, who did all kinds of things in this field. However, because of certain circumstances, there are no ethicists anymore. I will not say everyone is just doing something, but some education is needed.

I: I am thinking of contacting a coordinating nurse, so he or she can tell me about their experiences and information.

P: Yes

I: Many things came up until now, but what I like to know, is it possible to contact the Islamic spiritual caregiver to ask if he has some time to answer my questions?

P: Yes, should I ask him?

I: Yes that is possible

P: I will let you know if he is fine with you contacting him

I: Yes, you have my email address. I think I asked all the important questions.

P: That is good

I: I want to thank you for the information

P: Yes, and I want to say, but I am sure you have heard this in my story too. You talk about religious diversity. We do consequently use the word philosophy or spirituality because we do

think if you have no religion, you can still have a philosophy and a way of living. That is the basis for us.

I: Yes, exactly, and I think it will always remain a complex concept, religion. In my research, I mention this about what is religion? Everyone has their interpretation of religion. Probably, most people will name the main religions as religion, but why is a specific philosophy or spirituality, not a religion? It remains complicated.

P: Yes if you interpreted it like this, it is the same as we do. We do not use that concept, because most people think about specific religions and the connections with the divine. At the same time, Humanism is also a philosophy.

I: I check if I asked everything I wanted to ask

P: I can send you a link to the article of one of our directors. From next year, we will start a project in the hospital what is called [name project]. It has already be done in one department in which we educate primary health-care providers about giving spiritual care. It is getting bigger, and many people want to participate in the organization. It is getting more attention and more appreciation.

I: That sounds interesting

P: Should I send you the link?

I: Yes, I will see it in my mailbox. Thank you for the interview and information. In the end, when I have finished my thesis, I can send it to you. I can also send you the transcribed interview?

P: That is not necessary. I assume you write down my words correctly. But I like to know how you finished your thesis in the end.

I: Yes, I will send it to you by that time. If you have any questions about the thesis, for example, you can email me. Thank you.

P: Same for you, good luck with your thesis.

I: Thank you. Bye

P: Bye

Transcription interview – spiritual caregiver

Hospital 2

Duration: 38 minutes

I: interviewer / P: participant

Before recording the interview, I explained in short the aim of my research and why I think it is informative to interview the participant. Before the interview, I send an interview set-up so that the participant knew about the topics we were going to discuss. Next, I explained that the information of the participant will be kept confidentially, and only my supervisor and second assessor can see this information. The name of the participant and the name of the hospitals will not be mentioned in the final thesis report. Further, I told the participant about the possibility to ask questions during the interview or stop the interview whenever they want to. Finally, I asked if I could record the interview to analyze the data. The participant agreed to this.

I: I am wondering, in general, if you can tell me what spiritual care means in the [name hospital]?

P: Yes, that is fine. I have to say, based on your interview set-up, that I cannot answer all the questions. So, you ask me to say something about spiritual care in the [name hospital]?

I: Yes, exactly.

P: I work here since 2016. I started with a small function with the result of coming into the spiritual care team. What I liked about this team, at least at the time I started, was the brainstorming and thinking about how to be a spiritual caregiver in this time. This was in the year 2016. One of the pillars, of which they were highly aware of, was the whole thinking about spiritual care in terms of coming into a sanctuary or safe haven. I do not know if you know what I mean with that concept?

I: Not really.

P: Traditionally, and this is already the case in some institutions where spiritual caregivers are working for example in psychiatry or judiciary, spiritual care and the supply of it, so the fact you can talk to someone about questions of life whether or not related to the religious background, is separate from the medical treatments. Absolute confidentiality is then guaranteed. I think you can imagine the added value of it, especially within the psychiatry.

This means that the client of the patient knows he or she will not get this care in another place or with other therapies. This is something of the patient and remains between the walls. It is also written down in law; it is a right. In the hospital, our vision is, and this is also in line with all the health developments. Concerning the new definition of health from Machteld Huber, it is not only about the somatic side of health, but also about how to deal with health problems. The health problems can be physically but often have a mental component as well. The spiritual well-being is part of it. From our vision, we believe that mental and spiritual care is part of the total range of care in a hospital. We work towards this and put much effort into education, to explain what spiritual care is, what we contribute and how this connects to other disciplines. Next, we are present at multidisciplinary meetings. In this meetings, we sit together with doctors, speech therapists, physiotherapists and people from other disciplines who are involved, so that everyone gets a right perspective of the whole human being and the different facets of care.

I: Yes, exactly, that sounds interesting. Before, I did my bachelor in Sociology, and during my bachelor, I followed a course 'Medical Sociology' where we also discussed this view of health and that health-care is not only physically, but that social aspect can affect health too. Moreover, the interpretation of health can differ enormously. It is interesting to hear this is coming back in your work.

P: Yes, and very different per department. There are contemplative care and other departments. If you come for a simple operation, with a fast recovery, the view of the whole human being will be less necessary. However, at the time, someone is hospitalized for several weeks due to complications, it is more relevant to know more about a patient. For example, what is the patient usually doing in a day and what is important for the patient? Knowing these things can also help with recovery. This strongly differs per patient. What is the quality of life? How important are family and relatives for the patient? How do they help each other? What kind of situations of stress or health-care problems did they experience before? How did they come out of this situation? These type of questions are important and are in line with spiritual care.

I: And has the role of spiritual caregivers increased in recent times, if you compare the past with the current situation?

P: Well, less strictly defined. Traditionally, the [name hospital] was called the [old name hospital] and had a Roman-Catholic section. Thus, a very clear philosophy. Protestant and

Catholic. From this perspective, there was Catholic and Protestant spiritual care, so with a very clear signature. Protestant spiritual caregivers went to Protestant patients, and Catholic spiritual caregivers went to Catholic patients. Very categorically divided. As a team, we said, we will not do this anymore because, in this time, that is not the way to think anymore. Moreover, it does not make sense when you focus on questions about the meaning of life, and it should not be that there is a checkmark in the dossier at the question if a patient is religious or not and when a patient is, they automatically need a spiritual caregiver. Who says the patient has, at that moment, questions about the meaning of life? If there is a strict definition, there is often a reason to think there is contact with religious societies. At the moment, we are over this.

I: Like, it can actually be separated from it [religion]?

P: Yes, the focus is on existential problems.

I: Yes, exactly.

P: The moment someone gets stuck in it when care stagnates in this, it is also a demand for care. We, as spiritual caregivers, will take care of these questions. We think it is really specific to our discipline and therefore distinguish itself from other psychosocial disciplines. We have good contact with, for example, people working in social work or psychology, especially in times of COVID-19 we work intensively together. It helps to define your department and specialities and to be aware of which tasks are for which discipline. So, that is what we also do, the coordination among different disciplines.

I: So that it is adapted as good as possible to the patient, so to say?

P: Yes, exactly.

I: I believe there are, in total, four spiritual caregivers in the [name hospital]?

P: Correct, in September, one of our colleagues will leave.

I: I think I had some mail contact with him because that is what he told me too.

P: Yes, concerning the applications, we agreed on not thinking in categories. We have never searched for someone with a specific signature, but only for qualities. That makes us a mixed team. I studied at the Protestant University, and I am a pastor too. My colleague [name colleague] is a pastor too. [name colleague] did the master spiritual care at the University of Groningen and [name colleague] also did this master but with different courses and from every course they take your own expertise with them.

I: Because I saw a difference, for example on the website of the [name hospital], they added the religious background to every spiritual caregiver, but I noticed at your website there was no religious background as extra information.

P: Yes, we all do have a background. It is part of our profession and education that we reflect on this, like, how did it shape me as a human being, and how can I use it in my contacts? Occasionally, it happens that a patient specifically asks for someone with a specific religious background, such as Catholic. Then, a Catholic spiritual caregiver can go to these patients. It is a well-made choice not to define ourselves beforehand because we notice it restrict people instead of being an addition to people. The existence of figurative boxes, of which we think it does not do justice to the situation of religious diversity, but also not to the new generation who pursue de-pillarization. Summarizing it in boxes does not fit anymore to the current situation. Also, not for us, as spiritual caregivers. However, now it sounds we ignore our background, but that is also not the situation, and I do not experience it in that way. I am a pastor so that I could introduce myself as a pastor and spiritual caregiver. Still, I barely do this because I notice, if someone is Protestants or does have contact with their pastor, it will come forward in the conversation. I can always mention it later in the conversation that I am a pastor. When I immediately position myself and mention I am a pastor, it will close the doors to many people. However, when someone asks if I am connected with the church, I will not lie about it. It is a choice not to emphasize it, because most important is that we are spiritual caregivers and guides in the search to the meaning of life.

I: So that spiritual care is more accessible?

P: Yes, accessibility and professionality.

I: What does contact with patients look like? For example, how does it work when a patient wants a conversation with a spiritual caregiver?

P: That is a general question. I can say something about the routes. There are three routes to contact us. First, a patient indicates they need to talk to a spiritual caregiver. However, relatively not many people do this. Second, a family member asks if a spiritual caregiver can talk to, for example, their mother because they notice the mother is struggling. Themes that are often come up for discussion are, how to deal with sickness, finiteness, relations and the meaning of it, and connection in life. The themes can be religious, for example, that patients search for a God. The third route is the most common one in which health-care providers, most of them are nurses, notice there is something wrong. They notice the patient is struggling

with existential issues and think it will be good for the patient to talk to a spiritual caregiver about these themes.

I: Yes, precisely, so that the nurse indicates the problem?

P: Yes, they will write a consult. We always receive a consult in our digital system. Nurses who are all the time close to the patient, identify a lot of the patient. Every morning there is also a doctor who can indicate problems. It depends, if you know each other better, they ask us more often. Geriatrics asks us a lot and also with Psychiatry we have good contact. Assistant physicians often know where to find us as well. It is very diverse.

I: Is there a large group of patients where you have contact with as spiritual caregivers or relatively a small number of patients? Moreover, how long does it take before an appointment can be made with a patient?

P: These are more logistic questions. Most important is the contact with patients; next to this, we do education. In the current situation of Corona, it is a bit different, because the advice was to have as little contact as possible, only for medical needs. All the time, we have been in contact with patients but most of the time by phone. We had to do it this way. We receive consults via our work number, and we try to make contact the same day to determine the urgency of it. For example, is it necessary to make the conversation the same day or maybe later in the week? The aim is to contact the patient as soon as possible because most of the patients are not that long in the hospital. In any case, it is important to contact the consult applicant as soon as possible.

I: I have a better idea of how it works. What can you tell me about the religious background of the patients? Are there more patients with a religious background or not?

P: That is in line with what I told you before, I think the group of patients with a strict view of religious identities becomes smaller. We have a lot of older patients. It depends on the medical problems and the department. More young people are in the oncology department. Beforehand, we do not fill in the religious or philosophical background of patients. During the conversations, we get to know what is important for a patient and wat the meaning of someone's life is. For example, going to the church every Sunday, or having good contact with the community pastor, or having a lot of useful contacts in the church. You see this, especially in the group of older patients. I also speak to many people who do not associate themselves with, specifically religion, in that way, but they tell me a lot about what is crucial for them. This could be anything, but it is always about the meaning of life. For example, walking with a

dog can make their life very meaningful or a granddaughter yet to be born, which the patient hopefully still can experience.

I: So it often happens it is separate from religion?

P: Yes, it depends on the definition of religion, philosophy and the meaning of life. I try to interpret religion as broad as possible because religion is also related to connections in life.

I: There is always a discussion about the question: what is religion? Spirituality can also be a religion.

P: But I can say that the patients we see are predominantly white. So, no patients with a migration background. There may be a selection in the spiritual care, but I think as I said before, it is related to the demographical statistics of the region of Groningen. Perhaps it is different in the [name hospital] because we are a peripheral hospital with the result of less complex problems. There are exceptions. We have a larger Intensive Care. However, many people from the city or the surrounding villages, and also from the region of Friesland. Not very diverse.

I: No exactly, but do you have patients with other religious backgrounds, such as Islamic patients?

P: Yes, we definitely have sometimes. I work here now for four years, and I think I had contact between five and ten Islamic patients.

I: Very few actually?

P: I think a bit more, but I can remember these patients. Most of the time, with Islamic patients, there is good contact with their own Imam. If there is a question, it is often not religiously based. Once in a while there is no contact with an Imam or the Imam is living too far away and then it is one of our tasks to search for contact with an Imam. We will do this and make the connection.

I: That was also another question of mine, you take care of the contact with others?

P: Yes, recently, I got a question of an Islamic patient if there was a spiritual caregiver with an Islamic background because the patient wanted to pray before going for operation one hour later. In this situation, I had to explain we do not have an Islamic spiritual caregiver and that we could not arrange one in this short period. In this situation, we search for how we can help this patient with the people we have.

I: I can imagine it is more challenging to hire a spiritual caregiver with a specific religious background when not many patients ask for this. For example, in Rotterdam, I assume, there

are more patients with, an Islamic background with the result of more questions for spiritual caregivers with an Islamic background.

P: Yes, I know some of my colleagues from the [name hospital] in Rotterdam. They specifically recruit for Islamic spiritual caregivers. If there is a large group with the request for a spiritual caregiver with a specific religious background, you have to do something about it. We do not get these questions often, too little to take this into account with the applications. What happens sometimes is the questions of health-care providers concerning cultural differences, for example, about the ending of life. The cultural background plays an important role. How do you communicate about this? What is desired or permitted? When a consult is requested for this, it is more a moral reflection. We do this often in which we look which norms and values are behind it. How can these values and norms lead to moral dilemmas? Values can conflict with each other; from a medical perspective, there are questions if it is still useful to continue the treatment or is the treatment harmful to the patient due to too much suffering from pain. However, from the perspective of a family, it feels like being abandoned by the health-care providers, or it does not feel right because of religious reasons. Thus, we, as spiritual caregivers, do a lot of moral reflections concerning the interaction of various value systems. Occasionally, we are asked to be present at a family conversation to help with the various values of both the health-care providers and the family. This also relates to the vision of spiritual caregiving, what I mentioned before, that we speak several 'languages'. We know about the medical terminology and the way of looking at it. Still, we can also imagine how it is for patients to be hospitalized, so more the experiential aspect.

I: So you are being involved in this?

P: Yes, both from the patient and the health-care provider. Health-care providers can sometimes struggle with themselves because they notice this is not the kind of care they want to give, or it is not in line with their own norms and values.

I: I am also curious about the reaction to special wishes of patients, for example, when a patient requests a doctor or nurse of the same gender, or that the patient does not want to lay in a room with patients of the other gender? Does this often happen, and what is the reaction?

P: I find it difficult to answer these questions. I would advise you to contact someone else in the hospital who knows this better. I know it sometimes happens, and it depends on the sources and possibilities if they can accept it. The wish for being alone in a room can be

requested because of religious reasons. Still, a patient can also be very sensitive for stimulus, or the patient can psychologically be very vulnerable, for example, the wish to close the curtains and to turn the light off. If a patient is in a quadruple room, this is not possible. Therefore, it can be a reason to offer a patient a single room.

I: These are questions nurses have probably more to do with.

P: Yes, I think so. Sometimes we notice that a patient is bothered by something or needs something. This can vary from being in a single room or go outside. Some patients are not allowed to leave the room and going outside, for example, for someone who was always outside working as a farmer, this can be very important to be in contact with nature. Moreover, a patient can have the wish to see their dog because it is not allowed in the hospital. This is also about the meaning if life. We do some communication in this to the health-care providers. Something that contributes to the well-being of a patient and to see if it can be facilitated.

I: And what about the facilities, such as a prayer or quiet room. Is saw this is present in the hospital?

P. Yes, if I may interrupt you for a moment, the same question about nutritional practices, I do not know about this.

I: Yes, I thought so, I will first leave out this subject.

P. You can better ask a dietician. I know there are nutritional wishes of patients and that a lot is possible.

I: I already noticed it on the website

P: But I do not know how it exactly works in practice

I: No precisely, do you sometimes have patients who want to wash before praying? Do they pray in the prayer room?

P: Yes, we have this prayer room about eight or ten years now. Previously, there was a chapel, but we said this is too limited. A chapel is religiously very specific where a particular group would feel comfortable in. Then they decided to design the room with the use of universal images. You could say a religiously neutral room. You will not find there arrows towards Mecca, but also no crosses. It was a choice, and if we want to get rid of the chapel kind of room, we need to look at universal things. Much light, for example.

I: More neutral?

P: Yes, but neutral sounds meaningless, and it is certainly not. I would like to invite you to look, but the situation makes this difficult. It is a delightful room and a place to commemorate. There is a place within the room to remember. There are a few chairs where you can listen to music, and you can find different elements, such as water. Also, different senses are stimulated.

I: I read something about this, I thought it would be like this.

P: I do not know if you know the book: space for spiritual caregiving in the [name hospital] in Groningen?

I: Recently, I find this book on the internet. I requested the book at the library. One question, the book is from 2010. Is it still informative?

P: You can say it is a bit outdated, but it gives a good picture of the visions from where work. Gradually, this develops further. The elements are the foundation on which we continue to build further.

I: I think we discussed the most critical topics. I realize it may be interesting and informative to interview a nurse.

P: I can imagine this is interesting too. Religion is part of our professionality. If it is not in someone's work, you will probably get different answers.

I: I got to know more information about spiritual caregiving and that was the most important. If I have transcribed the interview, I can send it to you. In the end, I will also send you the final thesis, if you like?

P: Yes, that would be nice. If you have any questions that come to mind later, you can always approach me again.

I: Thank you. You can also contact me if there are questions about my thesis, for example. Thank you for all the information.

P: Good luck with the research

I: Have a lovely afternoon.

P: Thank you.

I: Bye

P: Bye

Transcription interview – nurse

Hospital 3

Duration: 41 minutes

I: interviewer / P: participant

Before recording the interview, I explained in short the aim of my research and why I think it is informative to interview the participant. Before the interview, I send an interview set-up so that the participant knew about the topics we were going to discuss. Next, I explained that the information of the participant will be kept confidentially, and only my supervisor and second assessor can see this information. The name of the participant and the name of the hospital will not be mentioned in the final thesis report. Further, I told the participant about the possibility to ask questions during the interview or stop the interview whenever they want to. Finally, I asked if I could record the interview to analyze the data. The participant agreed to this.

I: You work in the palliative department, right?

P: Yes, but it is not a department. We are a team in the hospital, not a specific department. We work from the office, and we visit the patients on the departments in response to a request; one of the two nurses.

I: How long have you been working here?

P: About six years

I: So, quite a long time?

P: Yes, a couple of years.

I: First, I will explain in short my research, I think you remember this from the email. My research is about religious diversity in hospitals. Before, I interviewed a spiritual caregiver from the [name hospital] and the [name hospital] and also with nurses from the [name hospital]. Due to the growing religious diversity in society and also among patients in the hospital, I am interested in the extent and way in which the hospital encounter religious diversity. Also, I am interested in the reaction and the way health-care providers deal with it.

P: Did you speak to palliative nurses from the [name hospital] and the [name hospital]? Or with a nurse from another department?

I: No, from the department oncology and intensive care, because I know them via a friend. So, not from the palliative.

P: Why did you decide to contact me?

I: Via the website actually. I approached some of the [name hospital], but I did not receive a reaction to my email. I think that people working in the palliative team encounter more the practice of religion and the growth of religious diversity among patients. Therefore, I think it is informative to interview you.

P: Yes, they take this more into account; that is how I experience it.

I: And that is the most informative for me

P: I am used to talking about the meaning of life instead of religion. We never use the word religion in the hospital.

I: No, I have heard this before; more about philosophy or the meaning of life. I notice that when someone talks about religion, people think about specific religions, but in the hospital, it is also about philosophies.

P: Correct, and at the end of someone's life it can be crucial

I: Do you see many patients with a specific religious or philosophical background?

P: Yes, everyone does, but the patient is not always asked about it. It is not related to the anamnesis; this was the case years ago. As a palliative nurse, I always ask questions about it. Not if someone believes in a religion, but more about what is important in someone's life. Sometimes it is their religion, nature or something what keeps them busy. It can be about the family, the dog or the cat which are very important, or the environment, for example. I come across all kinds of things.

I: Also specific religious backgrounds, such as Christian or Islamic?

P: Yes, not many Islamic patients. You will probably see that more in the city.

I: If there is a religion, especially with a Christian background?

P: Yes

I: What kind of tasks do you have? I do not have much knowledge about the medical world, so for me, it is guessing about the daily activities.

P: I can give you an example. Yesterday we went, as a palliative team what consists of two nurses, several doctors, a social worker and a pharmacist, for a consult to a woman with a lung infection and COPD who is very sick, anxious, stuffy and in much pain. They are still doing research. Her domestic situation is also difficult; her husband is in a depression, and her

children find it challenging to go to the hospital. This woman is around 60 years old. We are asked for advising this woman who is in her last stage of life. We do not know how long this will take. Palliative is often interpreted as working in the last stage of life and the process of dying. However, we like to be involved earlier in the process to make conversations about what is important for people and what they still want to achieve in the time they have left.

I: So, quite a long time involved with the patients?

Yes, we hope so. In general, it is difficult, because we are often asked for patients who are sick and in their last stage of life. Specifically, they ask for a consult with us, because there is a lot of pain, anguish, anxiety, nausea or a complicated domestic situation. Most of the problems emerge in the last stage of life.

I: Yes exactly

P: That is why people are hospitalized. We only work in the hospital

I: Not in the domestic situation?

P: Once in a while, we go for a home visit, but this is rarely happening. Luckily we can pass it on to the palliative nurses who work in the home care organization. Not all home care organizations have palliative nurses, but if they have, we prefer to continue the consult in the domestic situation or a hospice or nursing home. Or they die here.

I: Now I know more how it works

P: Yes, because the good thing about palliative care is that we do not only look at the physical side of care, but also the social and psychological side, and about the meaning of life.

I: So, in a way, you do the same as spiritual caregivers do?

P: Yes, we do a little bit of everything.

I: Yes exactly

P: The hospital is very physically orientated. It is good, and people feel better when they get some attention, to give people time and useful advice. Giving advice is our professionality.

I: You told me there was a spiritual caregiver a year ago?

P: Yes one and a half year ago, because the hospital has some difficulties with the finances there is no new spiritual caregiver. We feel sad about this, also for the patients who have to miss this. They miss something of palliative care. Also, for the people who work there and as a team, we think it is sad there is no spiritual caregiver. Because the people we see will always die. For us, it would be good to have conversations with a spiritual caregiver, but this is not possible at the moment.

I: This is because of the financial situation?

P: Yes

I: And in the time there was a spiritual caregiver, how did it work? Did the patient ask for a spiritual caregiver, or did you ask for the patient?

P: Yes, both, or the nurses or doctors asked the spiritual caregiver.

I: Was it a spiritual caregiver with a specific background?

P: No, just general, for everything.

I: Because you sometimes see, for example, in the [name hospital], they have several spiritual caregivers with a different background. One Humanistic the other Protestant, for example.

P: Yes, I think it is a bit difficult. When I hear about spiritual caregivers in other hospitals, who are involved with their patients and hospitalized, we do not have spiritual caregivers; I think we deprive the patients in this. I feel sorry about it, how much everyone is doing their best, including our team. We always ask the patient if there is a pastor or spiritual caregiver; they know who can come to the hospital. In other situations, we have a list with phone numbers of spiritual caregivers in primary care. I notice it never happens that we call them.

I: Did you experience some patients really need a spiritual caregiver or asked for it specifically?

P: Not that much, it is also because we do not have a spiritual caregiver anymore, but I try to listen extra carefully to the patients because I know it is an important part of human life. What matters, what keeps you busy and what is important?. As a team, we pay much attention to this. I do not know precisely to what extent we deprive the patients; I hope it is not too bad, also because we are more involved.

I: No, exactly. What if you notice a patient really needs a spiritual caregiver. Do you take care of it, or do you contact someone else?

P: We can also ask for a social worker or psychologist. These are possibilities.

I: Several options

P: Everyone has their own professionality. A spiritual caregiver is not a psychologist, just as a social worker. There is some overlap, but I think the hospital deprives the patients by not having a spiritual caregiver.

I: Yes, exactly, do you sometimes see a pastor or something similar?

P: Yes, sometimes

I: I have other questions, I think you saw it in the interview guide I send you before, but I am not sure if you can answer the questions. It is about nutritional practices. Do you know the

possibilities for that? If patients have specific needs or wishes based on their religion. For example, Halal or concerning Jews: Kashrut. I do not know to what extent patients ask these questions? Can you tell me more about this?

P: I saw these questions on your list, and I asked a dietician because I did not know the possibilities concerning nutrition. What I understood is that patients do not participate in the fasting period because they are sick. There are many possibilities. Halal, or something similar, is difficult to arrange it from the hospital.

I: I understand, especially when there are not many requests for it.

P: Almost no requests

I: I think it is different in that situation.

P: I can imagine if you know there is a patient who needs to be hospitalized for a more extended period, the kitchen can do something for this patient. However, it is not the standard.

I: Do you know about what is done with holidays in the hospital? Specifically concerning religious holidays, such as Christmas, which is Christian orientated?

P: Christmas is celebrated, but I have never heard they do something with the festival of breaking the fast.

I: No exactly, and do you have a prayer room?

P: Yes, wonderful and new. If you are here once, I will show you.

I: How does the prayer room look like?

P: There are a couple of benches, not so big. I think it is four by four. When you enter the room, there is, in the middle, a kind of table filled with sand and wood around it. I need to think about how it looks. There are some green and candles. I do not know precisely how often it is used. Last time I have been there was because of the death of a colleague. The room is also used for the condolence book. It is known in the hospital there is a prayer room, but I am not sure how many people go to it. It is close to the central hall of the hospital. People can go there easily.

I: I have an idea of how it looks. I do not think it often happens, because there are not a lot of Islamic patients, but they need to wash before praying. Do you have a washing room?

P: In the mortuary, you mean?

I: In the prayer room, what if people want to pray. Are there possibilities for praying?

P: Yes, but not separated. Not a special room only for praying.

I: Just a shared room?

P: Yes

I: Are there any church services in the hospital?

P: No, you can put on the television or radio

I: A sort of church service on television?

P: Yes. Before, there was a choir who came to sing, for Christmas for example. However, in the last year with the situation of COVID-19, we limit the people coming into the hospital.

I: That is understandable in this situation. About the religious or philosophical wishes or needs of patients? Is there a specific policy, or are there any protocols for the health-care providers?

P: I am not sure. At the beginning of this year, the hospital did invest in education about intercultural communication in health-care giving by someone from the Hanze University of Applied Sciences. She educated 12 to 15 people, including me. It was about getting more sensitive to intercultural communication. That people give attention to this on different departments. Nurses from different departments, nutritional assists and more people followed the two-day training. After this, the situation of COVID-19 came, and it did not succeed in the way they wanted it to be. In October there is another meeting, and we hope to catch it up again.

I: That is understandable. It sounds interesting

P: Yes it is

I: That was also my question if you sometimes have any pieces of training or workshops.

P: Yes, we did e-learning together, also to show it to other colleagues and inform other people about intercultural sensitivity. We use a book for this training, do you know the book. It fits your study; it is called intercultural communication.

I: I do not know the book, but we talk about it in our study, about interculturalism in general.

P: Yes, it is a very interesting book to read and also to take out the most critical points and use it into the work field.

I: Do you sometimes experience any conflicts concerning medical treatments. There is a medical perspective, but some people do have religious reasons for specific medical treatments.

P: Yes sure, a well-known example is the refusal of blood transfusions of Jehovah's Witnesses. It is written down in their dossier. Of course, it will not be implemented.

I: So you are open for the requests of the patient concerning medical treatments?

P: It sometimes happens that children ask us not to tell the father or mother the diagnosis. I think these are difficult dilemmas.

I: It is complicated; how do health-providers or doctors deal with this?

P: Not unambiguous. They check if the patient has been seeing the doctor for a while if so, the doctors know the patient well and know more what to do. They already had several conversations. When a patient is hospitalized, doctors are inclined to tell the results. Agreements have to be made if a patient does not want to know the results. This is possible.

I: I can imagine it is a bit difficult when people ask this

P: Yes, correct. It is the same with life expectancy. We see patients who are seriously ill, or they are diagnosed with cancer, and then it is the question if the patient wants to know their life expectancy. We are cautious about this. Some people do not want to know it, but it can be important for relatives and family. For health-care providers, it is also essential because they can adjust their care to it.

I: Yes, exactly, I can imagine if a patient is in their last stage of life, they have specific religious or philosophical wishes?

P: Yes

I: Can you help or facilitate them with those wishes?

P: In my experience, I always ask the patient about their wishes, what is important for you in the time what is left. At the moment, there is a woman who wants to experience her granddaughter's wedding. If she cannot go by herself, we can ask for an ambulance. These things are often the case as a last wish. From the network, there is a new wish book, and we received a lot of them to be filled in by the patients and let them think about what is important for them in their last stage of life and what needs to be done. There is also information about the notary, for example. Some people want to record a lot, and others do not feel the need to do this. It is good to know where you want to be in the last stage of life. Also, for the general practitioner, it is important to know if they need to send the patient to the hospital or not. Suppose the patient's wish is to die at home, and most of the people want to. In that case, the general practitioner needs to think, in this last stage of life, about what to do: going to the hospital if medical treatments can still be done or is it possible to do a medical treatment at home? Medicines and help them at home.

I: Have you seen any specific religious wishes?

P: Often, the wishes are tiny. Most of the people do not want a balloon flight; they just want to go home and see the people they love: the dog, the cat or the environment, that kind of things. Listen to music. Not many things.

I: And when a patient dies, is there a particular organization who takes care of it further? I have heard of specific rituals of a particular religion or spirituality. With the family, for example? Do you know anything about that?

P: Yes, that is possible. They have talked about it with a nurse if the family wants to help with the last care. Some really want to, and others do not want to. For example, brushing the hair. The organization CMO take care for these kinds of things; bringing the patient downstairs and dress the person properly up for the funeral, for example. I think CMO take care of this in all hospitals.

I: Yes, I forgot the name, but I remember now.

P: The people who work at CMO, they come in many places, and there is no doubt they know of all the possibilities.

I: I think they are specialized in this.

P: Yes, and if it is possible on the department in the hospital, they will facilitate in this.

I: Did you ever get a request from patients who do not want to have a nurse or doctor from the other gender, or do not want to be in a room with patients with the other gender?

P: Rarely, I have to think about it.

I: Do you have a lot of Turkish patients in the hospital?

P: And we only have single or double rooms with the result of not much requests about this. I think it is different when you have triple or quadruple rooms. It rarely happens here, because we have a lot of single rooms.

I: I understand

P: Maybe it happens sometimes on a department

I: And do you have Turkish patients?

P: Yes, we do see them here, but I do not know exactly how much. Not a lot of Turkish patients for which we are asked, we barely see this. It happens sometimes, but not often.

I: Do you have any experiences with them?

P: No

I: I will check my interview guide. We have already discussed a lot.

P: Good

I: Do you have any experiences or additions you want to share, of which you think it may be interesting for me?

P: I enjoy my job to see that every patient is different. We often have examples from books in which there are guidelines for medication or giving advice, but the best thing to see is that every patient is different. We have to adjust our work to each patient separately. This is what I like about my profession.

I: Every patient is different

P: Yes, and the good thing is that we have more time ad attention for a patient to hear what is going on. In those moments, you hear many things what is going on in the domestic situation, what is right or what is not good. What I see a lot with patients are troubled relationships with children or parents; many problems within families, such as no contact.

I: I think it will primarily come up in the last stage of life?

P: Yes correct, and then the question is if people want to do something about it. Do they want to restore the relationship? Do they worry about it? Or maybe they already closed it for themselves. You talk about these kinds of things.

I: Interesting to hear.

P: Good

I: How many people are working on the team?

P: Two palliative nurses

I: I think I have asked everything I wanted to

P: That is good

I: First, I just wanted to include the [name hospital] and the [name hospital] in my research, but I think it is interesting to include the [name hospital] also in my research and luckily I could approach you for it.

P: I hope my answers are informative for you so I could help you a bit

I: I expect to finish the thesis in December.

P: I like to keep informed.

I: I will send you the thesis in the end. Would you like to have the transcribed interview, to read or check it?

P: No that is not necessary, I am just curious what you are going to do with this

I: Yes

P: Do you have a specific goal with the research, certain results or ideas?

I: I have some expectations, after reading theories and other researches in different countries. Hospitals are semi-governmental organizations, and I expect that hospitals maintain their neutral position concerning religion or philosophy. I think they want to stay neutral to guarantee equal rights. However, on the other side, there is a growth of the multicultural society with the result of patients with different backgrounds. It seems to be that hospitals take this also into account. I limit myself to the region of Groningen because I live here, and otherwise, it is too much

to include in my research.

P: Nowadays, many people receive a day treatment and do have a shorter hospitalization. We do not see those patients. In the area, many people are living with different backgrounds, but they are not all hospitalized for a more extended period or at the end of their life.

I: Yes, do you have any questions?

P: No, I wish you good luck

I: Thank you.

Transcription interview – nurses

Hospital 1

I: interviewer / P1: participant one department oncology / P2: participant two department intensive care

Before I started the interview, I introduced myself and explained in short the aim of my research and why I think it is informative to interview the participants. Before the interview, I send an interview set-up so that the participants knew about the topics we were going to discuss. Next, I explained that the information of the participants will be kept confidentially, and only my supervisor and second assessor can see this information. The name of the participants and the name of the hospital will not be mentioned in the final thesis report. Further, I told the participants about the possibility to ask questions during the interview or stop the interview whenever they want to.

I: What kind of patients do you care for in the hospital? And what kind of religious background do they have?

P1/P2: Especially Christian or Islamic patients, also sometimes Jehovah's Witnesses. On Sunday there is a church service. Most of the Islamic patients come from Syria, Yemen and Turkey. We do not often see patients with a Hindu or Buddhist background.

I: What kind of differences do you see with patients with different backgrounds?

P1/P2: Patients with an Islamic background do often have more requirements, and they are more direct in communication. They sometimes look slightly less friendly.

P1: That is not always the case. Turkish people are often more direct and demanding. They expect a lot. Also, many families come to visit. They do not always listen well with the result of the visit of large groups of families. We often say something about it to them. However, if the patient is really sick, it does not matter so much. But if it is irritating the health-care providers, it is clearly said to them. Especially in a quadruple room, it is not possible. Making a phone call needs to be done in the hallway. Once, there was a Syrian patient who came to Ter Apel in a truck. He came to the hospital, and first, there was no family, but when the patient's situation got worse, many family members came.

P1/P2: In Islam, it is customary to continue medical treatment as long as the body can do it. Sometimes, treatment is not possible anymore, and there are many complications. As a

health-care provider, you cannot do anything anymore. There are conversations about the quality of life, and if there are any nutritional wishes. Usually, comfort and medication are essential, so that there is a little pain as possible. Especially Islamic patients want to continue medical treatment as long as possible. For example, they want to continue the tube feeding; otherwise, they interpret it as stopping someone's life. Health-care providers listen to these requirements, but only if it is medically possible. In a particular situation, it is possible to shorten the pain, but Islamic patients and their family interpret this as ending a patient's life. For example, Islamic patients never use euthanasia.

I: Are there patients who want to perform specific religious rituals?

P1/P2: We did not experience certain religious rituals; patients can often not practice their rituals because of medical reasons. It happens that a woman does not want to be washed by a male nurse. We discuss the possibilities, and if there is a female nurse available, it is often possible. Concerning the request for a doctor with the same gender, it is more complicated. Sometimes they want to be buried within a certain amount of time. The organization CMO arrange all the care when a patient has died. Furthermore, sometimes a pastor comes to visit a patient to pray. I have never seen an Imam.

P1: Once, I had to take care of a Christian woman who had the choice for three kinds of treatments: no treatment, radiation or surgery. Medically, surgery was the best option, because the tumor was in the pelvis. However, the patient thought she had to wait for the decision of God. Sometimes there are patients with specific spiritual thoughts. I experienced twice that a patient chose for ethical oils or alternative medicines. Some patients do not want treatment. Once, a woman went to rehabilitation to think about it. Most of the time, patients live a couple of months without treatment and some years with treatment.

I: And what about the refusal of blood transfusions from Jehovah's Witnesses?

P1/P2: Blood transfusions are not allowed in their religion, but in certain situations, the patient will die without blood transfusion. It happens that the bag will be sealed because the patient wants a blood transfusion, but the patient does not want the family to know this. In practice, it turns out many Jehovah's Witnesses want a blood transfusion. If they really do not want a blood transfusion, it will be accepted. Medically, blood transfusion is necessary, but in the end, the patient decides. As much information as possible is given. In an emergency situation, first, the action is needed, and later they can discuss the medical treatment.

I: To what extent there is knowledge of religion in the hospital among health-care providers?

P1/P2: We had ethics on school, but not specifically about the role of religion. In the hospital, we know there are spiritual caregivers. Often, the patient does not know there are spiritual caregivers. During the intake conversation, the patient will be asked about this.

I: What are the possibilities of nutritional practices and wishes?

P1/P2: The department assistant controls this. No pork and Halal is possible.

I: Does the hospital organize any holidays, and what about nutritional practices during holidays?

P1/P2: Around Christmas, as many patients as possible go to their home. People can go to church services if they want to. Sometimes this is not possible. In the cardiology department, patients are connected to equipment, and therefore it is not possible to go downstairs to the church service. Concerning Christian patients, we do not always notice they have a religion because they do not show it. Often we hear they get a lot of strength and power from their religion and know they will go to the right place at the end: heaven. What we mainly do is listen. Some of our colleagues are Christian, and they can have more in-depth conversations with the patients.

P1: Once there was a boy from 21 years old who was going to die, and he was very religious. I asked my colleague if she could pray together with him. Sometimes we search for an Arabic or Turkish colleague who can communicate with patients. Otherwise, we make an appointment with the interpreter service. With important family conversation, an interpreter will come to the location. Most of the Islamic patients are family-orientated, and the family takes care and take their responsibility for the patient. Home care is often not necessary.

I: Is there a specific policy, or are there protocols concerning religion in the hospital?

P1/P2: No, there is no policy and no protocols. The most important is patient-centered care. Professionality is paramount.

I: Did you ever experience a dilemma of a family request not to tell the patient he or she is terminally ill?

P1/P2: The family do not want to tell the patient that he or she is terminally ill because the patient will lose hope. So, this is not exactly told the patient in this way. You cannot say: “You are going to die”. The situation will always be explained; it is necessary. For example: “We cannot do anything for you, you will probably die soon”. Doctors need to be fair about the situation because it is established by law. Another option is to say that the disease has been

increased with many complications with the result nothing more can be done. They cannot say: “You will die”, because it will take away the hope of the patient.

I: Thank you for the information

P1/P2: You are welcome

I: I can send you both the transcribed interview and I will send the thesis in the end

P1/P2: That is not necessary. We look forward to seeing the thesis.

Appendix 3

Codebook

Family	Code	Type (inductive/deductive)	Description	Example from the collected data
Spiritual care	Religious background spiritual caregivers	Deductive	The presence of spiritual caregivers with a specific religious background	"I studied at the Protestant University, and I am a pastor too."
	Accessibility of spiritual caregivers	Deductive	The extent to which patients know about spiritual care in the hospital and how they can contact spiritual caregivers.	"The third route is the most common one in which health-care providers, most of them are nurses, notice there is something wrong."
	Awareness of spiritual care	Inductive	The awareness among patients about the possibility of receiving spiritual care.	"This morning, I heard that Islamic patients do not know at all about the possibilities of spiritual care; this concept is unknown in their community."
Religious facilities	Nutritional practices	Deductive	The possibilities for patients to eat specific food based on their religion, also during religious holidays.	"I can imagine if you know, there is a patient who needs to be hospitalized for a longer period; the kitchen can do something for this patient. But it is not the standard."
	Prayer room	Deductive	The presence of a prayer room and the facilities in it	"Within the room, there is an Islamic prayer room, in the middle but still separated."
	Washing room	Deductive	The presence or possibilities for washing before praying	"Yes, in our new prayer we have taken into account there is a special washing room for people."
	Religious services	Deductive	The presence of religious-based services	"We have every Sunday a meeting, also called a church service or inspiration service."
	Religious holidays	Deductive	The celebration or activities concerning religious holidays.	"Christmas is celebrated, but I have never heard they do something with the festival of breaking the fast."

	Prayer rugs	Deductive	The presence of religious prayer rugs	“U heeft hier bijvoorbeeld de gelegenheid een kaars te branden, te lezen en gebruik te maken van gebedskleden”.
	Religious books	Inductive	The presence of religious books	“En als mensen bijvoorbeeld een Bijbel of Koran nodig hebben, kunnen ze die zelf meenemen of hier lenen”
Knowledge of health-care providers	Education	Deductive	To what extent health care providers are educated about religion or the extent to which spiritual caregivers educate others about spiritual care, religion or the meaning of life.	“We work towards this and put much effort into education, to explain what spiritual care is, what we contribute and how this connects to other disciplines.”
	Knowledge religious practices	Deductive	The extent to which health-care providers are aware of the most common religious practices.	“What happens sometimes is the questions of health-care providers concerning cultural differences.”
Religious needs and wishes of patients	Reaction to religious wishes and practices	Deductive	How health-care providers react to specific religious needs and wishes of patients.	“One time, there was a male patient who did not want to get care from a female nurse. It can also be related to sickness. I think they always try to take this into account.”
	Reaction medical treatment	Deductive	The way health-care providers react to the confrontation of the wish for specific religiously based medical treatments.	“Yes sure, a well-known example is the refusal of blood transfusions of Jehovah’s Witnesses. It is written down in their dossier. Of course, it will not be implemented.”
	Requests of patients	Inductive	The extent in which patients ask for specific religiously-based services, facilities or wishes.	“Occasionally, it happens that a patient specifically asks for someone with a specific religious background, such as Catholic.”
	Rituals	Inductive	The extent to which religious rituals can be performed.	“We do not do only conversations but also rituals. Explicitly, a sickness blessing or rituals for saying goodbye”.
Demographics	Religiously diverse patients	Inductive	The number of patients with a religious background and the extent to which the patients differ in religious background.	“I think the group of patients with a strict view of religious identities becomes smaller.”

Hospital's understanding of religion	Understanding of health-care	Deductive	The way of thinking among health-care providers and others working in the hospitals and what includes health-care in a hospital.	"Values can conflict with each other; from a medical perspective there are questions if it is still useful to continue the treatment or is the treatment harmful to the patient due to too much suffering from pain."
	Symbols	Deductive	Physically visible symbols which are related to religion.	"Then, they decided to design the room with the use of universal images. You could say a religiously neutral room. You will not find there arrows towards Mecca, but also no crosses. It was a choice, and if we want to get rid of the chapel kind of room, we need to look at universal things. Much light, for example."
	Policy	Deductive	Policy or protocols of the hospital about how to respond to situations in which religion is involved, such as religious needs or wishes.	"Yes one and a half year ago, because the hospital has some difficulties with the finances there is no new spiritual caregiver."
	Vision spiritual caregivers	Inductive	The vision of spiritual caregivers in the hospital about spiritual care in relation to health.	"From our vision, we believe that mental and spiritual care is part of the total range of care in a hospital."
	Patient-centered care	Inductive	The patient is central and is involved by their health-care process and decisions to be made. The patient, their opinion is important.	"We are in the [name hospital] focused on patient care."
	History	Inductive	The history of the hospital, related to religion.	"Traditionally, the [name hospital] was called the [old name hospital] and had a Roman-Catholic section."