Healthcare Chaplaincy in Finland



SUVI-MARIA SAARELAINEN, UNIVERSITY LECTURER IN APPLIED STUDIES OF THEOLOGY
ISTO PELTOMÄKI, DOCTORAL STUDENT IN SYSTEMATIC THEOLOGY
AULI VÄHÄKANGAS, PROFESSOR IN PASTORAL THEOLOGY
suvi.saarelainen@uef.fi / isto.peltomaki@helsinki.fi / auli.vahakangas@helsinki.fi

ABSTRACT
The article provides an image of the beginning, growth, and current situation of healthcare chaplaincy in Finland. The history of the chaplaincy takes us back decades, yet the healthcare chaplaincy as we know it today was formed in the 1960s. The Evangelical-Lutheran Church of Finland has played a significant role in the development of the chaplaincy. Two contexts exist as chaplaincy locales: Healthcare and the Evangelical-Lutheran Church of Finland. It took decades for healthcare chaplaincy to find its place within and between these two contexts, yet the recent cutbacks in personnel do not promise easy years for the future. Research within this manifold subject is diverse, but new studies are still needed to tackle the challenges of the changing context, work climate, and divergent needs of the patients.

KEYWORDS
Healthcare chaplaincy, Development of chaplaincy, Finland

Introduction
This article focuses on Finnish healthcare chaplaincy – its formation, history, and current situation. We will begin with the history and theological roots of healthcare chaplaincy in Finland. Then we will introduce the two contexts of the chaplaincy: The Finnish religious climate and the healthcare environment. Analyses on chaplaincy training and recent research on the topic follow. At the end of the paper, we will map the current situation and identify some future challenges.

The article is based on the existing literature; in addition, to have a full picture of past events and to be able to grasp the current situation of healthcare chaplaincy, the first author conducted three specialist interviews. Of the interviewees, Rev. Kirsti Aalto (former Direction of Healthcare Chaplaincy, National Church Council) shared her knowledge on the historical events; D.Th. Matti-Pekka Virtaniemi (former Educator from the Church Educating Centre) focused on the impact of clinical pastoral education (CPE) and on supervision (in terms of work-based counseling); and Rev. Virpi Sipola, the current leading advisor of pastoral care and counseling at the

National Church Council, provided information on the present situation and on the future of hospital chaplaincy. As the hospital chaplaincy is fully based on the education and finances provided by the Evangelical-Lutheran Church of Finland (ELCF), it was natural that the interviewees were found in the same context. In the paper, we will discuss what it means for chaplaincy and its' future that the work is closely bound to ELCF.

History of Healthcare Chaplaincy and Theological Formation

The strong impact of the Evangelical-Lutheran Folk Church

The origins of healthcare chaplaincy in Finland can be traced back to the 1600s (Sippo, 2004: 1–16.) Pastoral care was understood to be a task that is carried out in general pastoral activity, which did not follow Martin Luther's tendency to personal comfort (e.g. Ebeling, 1997: 449–471). This liturgy-oriented old-Lutheran pastoral tradition formed the mainline scheme of pastoral care in Finland (Saarinen, 2003: 413).

In the late 18th century, pietistic pastoral care was constructed on the idea of spiritual rebirth: The aim of all pastoral action was to guide personal experience of faith (Saarinen, 2003: 412–413; Peltomäki, 2019: 24). In the first half of the 20th century, the task of pastoral care was carried out through moral upbringing, proclamation, and guidance to a closer parish connection (Kilpeläinen, 1966: 17–19), and thus the introduction of modern psychology did not have much influence on the pastoral care approach before the 1950s.

After the wars in Finland, the former military pastors experienced that preaching was not adequate to counter suffering and as a result the church began new forms of work such as family counseling and healthcare chaplaincy (Ylikarjula, 2005: 11–12, 14; Sippo, 2004: 66–67). These changes raised a need for therapeutic approaches to pastoral care. Yet these new forms of church work provoked suspicious discussions, as at the same time pietism was losing its grip while folk church ideology was being empowered (Ylikarjula, 2005: 13–14).

The therapeutic turn grows from and within the changes in the field

Healthcare chaplaincy was established during the 1960s and became recognised by the bishops' conference (Ylikarjula, 2005: 19, 33). The therapeutic turn was explicated by the female healthcare chaplain Irja Kilpeläinen (Kilpeläinen, 1969) at the time when the role of church discipline began to loosen (Peltomäki, 2019: 20–22, 24–25). The educational model and the pastoral care movements in the UK and the United States provided inspiration for the education of the Finnish chaplains (Sippo, 2004: 66–67). Kilpeläinen's patient-centred method emphasises the idea that the confident discovers personal ways to encounter suffering with the support of the chaplain (See Peltomäki, 2019: 20–22).

The Christian three-fold perception of mankind – created, fallen and redeemed – is the theological basis of Finnish hospital chaplaincy (Kettunen, 2013: 55–58; Kettunen, 1990: 60–64). In the early years, biblical words "I was sick, and you visited me" provided grounds for the chaplaincy work (Aalto, 2019; Virtaniemi, 2019). Nowadays, the idea of the God who suffers with the suffering is seen as crucial (Sipola, 2019). Ultimately, the therapeutic approach began to shape the actions and theology of healthcare chaplaincy; theology became distinctively contextual as it developed and continues to develop strongly in the context of taking care of the ill in Finnish society.

From decades of debates to stability

The 1970s was a mixed bag for healthcare chaplaincy. Chaplains were criticised for a "psychiatric attitude" as modern psychology was exploited in chaplaincy. Chaplains were also accused of "hospital terror" when organizing devotions and discussing death with the patient. Others considered that chaplains had drifted too far from the church. (Ylikarjula, 2005: 41–43; Kettunen, 1990: 64). Nevertheless, appreciation of the chaplains among the doctors and laymen was strengthened (Ylikarjula, 2005: 50).

From the perspective of resources, the 1980s were fruitful. Healthcare chaplains were strongly involved in societal discussions and work rela-

ted to AIDS and abortion. In addition, the hospice movement was introduced, and it became understood that family members are involved in the dying process. (Ylikarjula, 2005: 53–56). Also, the education of hospice volunteers began at 1986 (Aalto, 2019). Another significant change occurred when nearly half of the female chaplains were ordained after the decision of the ELCF to ordain women in 1988 (Ylikarjula, 2005: 69; Sippo, 2004: 57). Yet some jarring notes were heard, and it was even proposed that the vacancies of chaplains should to be based on local congregations instead of hospitals. (Ylikarjula, 2005: 62–66).

Conflicts and lack of congregational cooperation finally seemed to ease up in the 1990s; still, the economic recession hit hard and more than 10 % of the chaplains were fired. To secure the pastoral care of the ill, the collaboration between chaplaincy and local congregations was found to be crucial (Ylikarjula, 2005: 79–80, 87). Furthermore, congregational clergy became more and more interested in the education of the healthcare chaplains as local congregations found that people's need for pastoral care and counseling was increasing (Ylikarjula, 2005: 75–76). Nevertheless, the rise of pastoral psychology once again evoked some discussions on the relationship between church and psychology (Ylikarjula, 2005: 91–92). The appreciation of chaplaincy became evident in the 90s. Among laymen, 84 % of Finns found the work of healthcare chaplains important or extremely important in 1999 (Ylikarjula, 2005: 87, 92).

Currently, chaplaincy has established its significance in hospitals (Avohoito, 2019), and after the millennium most of the congregational personnel found healthcare chaplaincy to be important or extremely important (Ylikarjula, 2005: 109–110). Still, it seems that the future holds insecurity and the threat of cutbacks when the finances of congregations are declining; filling the posts of hospital chaplains needs to be negotiated often (Sipola, 2019).

ELCF and Healthcare Environment Provide Context and Organisation

We have shown how context and history have impacted the formation and work of chaplaincy. In this section we present the current context and organisation of healthcare chaplaincy in Finland. The section describes how the context of healthcare chaplaincy is constructed on religious and spiritual grounds as well as on the status of Finnish healthcare.

Finnish constitutional law declares that everyone has freedom of religion and freedom of conscience. Furthermore, the legislation regulates church law and church order of the Evangelical-Lutheran Church (ELCF) and the Orthodox Church. Both churches are entitled to collect taxes from their members. Other registered religious communities are financially supported by the government. The Finnish religious constituency has been highly homogeneous throughout the years. Today, the reduced percentage of members is 69.7 % in the ELCF. For the Orthodox Church, the membership had decreased to 59,560 (Finnish population is 5.5 million) by the end of 2017 (Seppälä, 2019). Around 1.6 % of the population are members of other registered communities. Jehovah's Witnesses, the Evangelical Free Church of Finland and the Catholic Church in Finland form the largest body of registered communities. Furthermore, there are tens of thousands of Muslims living in Finland, but only a minority of them are registered members of any Finnish religious community. (Ministry of Education and Culture, 2019; Info Finland, 2019).

Even today, Lutheran impact can be seen in Finnish values. For Finns, values such as aspiration to the common good, responsibility to one another, understanding work as a calling and service to others as well as bringing up children with strong values carry high cultural importance (Ketola, 2016: 85–87). Even though the number of Lutheran rites has decreased, the number of Lutheran burial rituals has remained relatively stable and nearly 90 % of the people are still buried with a Lutheran service (Sohlberg & Ketola, 2016; Toimintatilastot, 2019). In addition, a strong foothold of congregational youth work exists, as most 15-year-olds attend confirmation rites (e.g., in 2016, the number of confirmands was 85.5 % of the age group; Rippikoulu ja Rippikoulun käyneet, 2018). It can be concluded that the use of traditional Christian rituals has

decreased in Finland, while the use of religious practices has diversified (Palmu et al., 2012: 37–39).

The Finnish healthcare system is very much based on public healthcare that provides low-cost care for clients. Care for children and minors is free of cost. For adults, the maximum fee for the calendar year is set at 603 euros; when an individual reaches this limit, all subsequent care and medication is free of charge. Healthcare is carefully regulated with legislation and generally the Finnish healthcare system is considered one of the leaders in international comparison (e.g. Quality of care, 2015). Nonetheless, in a study that compared the of quality of death by ranking palliative care across the world, Finland was placed at 20th based on the regional differences, low number of volunteers, and lack of community (Economist, 2015). Furthermore, the limits of costs for homecare are not set and municipalities have varieties of ways of addressing the costs. The political will related to such care shows a strong urge to shift the care of the elderly and dying back to individual homes. In 2015 legislative changes were made to affirm home-based elderly care. In Spring 2019, the parliament resigned after not being able to find consensus for a new model for healthcare that had been in preparation for years (e.g. Yle, 2019). In sum, the context of healthcare is going through a period of transformation, and as of now no clear directions or indications about healthcare reform can be made.

Healthcare chaplaincy is fully based on the personnel of the Lutheran Church of Finland. Chaplains work within these two constantly shifting contexts: The changing spiritual climate and healthcare reform. The current organisation of the chaplaincy is based on a tripartite agreement made in 1965. It was agreed between the government of the church, the government of medication and the association of hospitals that healthcare chaplaincy was recommended as part of the work in hospitals (Ylikarjula, 2005: 21–22; Sippo, 2004: 70–72).

The two bases of the hospital chaplaincy are also made vivid in the document "The principals of hospital chaplaincy 2011," which defines the goals of the chaplaincy as follows:

> The aim of health care is in the promotion of health, prevention and treatment of disease and alleviation of suffering. The objective of pastoral care is to address the religious, spiritual and life-view questions of the sick and suffering. A pastoral caregiver respects the human dignity, beliefs and the integrity of the patient regardless of his/her background or view of life. Self-determination is clearly stated in the Constitution of Finland and in the Act on the Status and Rights of Patients. In helping the sick and suffering, the values of health care and pastoral care meet; both health care and pastoral care view people holistically, considering their physical, mental, social and spiritual needs.

The quotation highlights that two bases of healthcare chaplaincy – healthcare and pastoral care – are merged as one. Human dignity grows from respect for an individual; the legislation provides a starting point for holistic encounters. From the point of view of the legislation, the role of healthcare chaplains began to change in 1993. In the 1990s patient law was interpreted so that chaplains were not seen as integrated staff members (Ylikarjula, 2005: 85–86). Similar discussions appeared in 2011 when the Act on the Status and Rights of Patients was updated. Nowadays chaplains are authorised to see the medical record of the patient only with the permission of the patient (Principles for Hospital Chaplaincy, 2011).

In this section we have discussed how strong the Lutheran impact on healthcare chaplaincy in Finland is even though it is obvious that religious freedom and various religious denominations exist in Finland. Next, we will explain how religious diversity is dealt with in the training and daily practices of the chaplains.

CPE-based Training as Grounds for Respectful Practices

The education of healthcare chaplains established in the 1960s greatly improved the psychological understanding of the patients in the practices of chaplaincy Finland. Psychodynamic studies have since been integrated into the healthcare chaplain training, and chaplains are guided to get a full psychotherapeutic education (Aalto, 2019; Ylikarjula, 2005: 75). The training of hospital chaplains was based on ideas of clinical pastoral education (CPE) although this has

not been explicated in written sources. Still, in the early years of such education, several practitioners got their training at CPE centres in the US. (Virtaniemi, 2019; Sipola, 2019).

The original CPE education highlighted the importance of understanding people from different religious backgrounds. The idea of accepting and cherishing religious diversity was fostered among the chaplains in the late 1960s: it became crucial to understand the emotions behind the words of the client. The introduction of CPE also affected the formation of supervision of chaplains in Finland, as there had been two competing traditions. One tradition highlighted the importance of dealing with the patient's situation in supervision; the other focused on the experience of the counsellor him- or herself. The contribution of CPE made it clear that supervision had to include both aspects to meet the needs of chaplains (Virtaniemi, 2019).

Today the training of hospital chaplains is based on CPE ideas, although some modifications are made, and the training is provided only by the ELCF. The three-year training consists of 60 credits (1 cr. = approximately 27 hours of work) and includes five thematic modules (Orientating module 5 cr.; Progression as healthcare chaplain 10 cr.; Pastoral care and counseling 20 cr.; Specific questions of healthcare chaplaincy such as pastoral care, psychology of health and mental health, couple and family relationships, developmental psychology, crises and traumas, therapeutic methods 20 cr.; and the final project 5 cr.) (Training, 2019). Those ordained ministers who have a permanent post or long-term contract as a healthcare chaplain are obligated to take the training. In addition, deacons whose main work is based on hospital or in social care context, can apply to the education. Still, candidates must fill out a motivational application and pass psychological tests before the training begins (Sipola, 2019).

For healthcare chaplains, a new training group begins approximately once every three years. Therefore, the training model of each group can be slightly modified depending on the needs of the group and the societal situation. Furthermore, education is constantly provided on topical issues: for instance, the questions of how to meet the pastoral needs of transgender individuals were recently discussed in the educational course. Therefore, people who come to work as chaplains know how to discuss and deal with a variety of minority groups. It is also a task of the hospital chaplains to form networks with other religious groups in the area so they can be contacted if there is a patient in need of chaplaincy from some individual religious group. Within hospital chaplaincy, it is taken for granted that trust, respect, and equality are the pillars of the chaplaincy. Patient-centred care is the premise of the hospital chaplaincy. Therefore, chaplains also provide existential and spiritual care for non-religious people. (Sipola, 2019).

The current number of healthcare chaplains working at the field is 117. Altogether the number of chaplains is 132 when taken the number of team leaders into account. (in March 2019, Henkilöstötilasto, 2019; Sipola, 2019). During the previous decade, the number has decreased around 9 %. The main work of chaplains is based on individual conversations with the patients (more than 33,794 consultations per year); in addition, conversations are held with family members (11,808 conversations) and the hospital staff (9423 conversations). In 2018, worship services and Lutheran rites were held 2933 times in the hospitals; these services reached more than 39,000 individuals. In addition, chaplains organised 3708 devotions and other events during 2018. (Statistics, 2018).

Research on Hospital Chaplaincy

In this part of the article we introduce that practice-oriented literature and PhD-level research which has analysed chaplaincy or more widely the practice of pastoral care in Finland during the past thirty years.

As previously explained in this article, Irja Kilpeläinen was very influential in developing hospital chaplaincy in Finland. Her books on a patient-centred counseling model (Kilpeläinen, 1969) and on death and dying (Kilpeläinen, 1978) are widely read classics even though they are based on practical experience and not on empirical research. *The Finnish Journal of Pastoral Care* (*Sielunhoidon Aikakauskirja*), launched in 1988(–2009) and edited by Kirsti Aalto, was a

central vehicle for discussing topical issues. The journal demonstrates that topical questions primarily concentrated on practical work and pastoral psychology as the key theoretical framework (See Ylikarjula, 2005: 71). Chaplaincy was discussed in various issues, for example, from the point of view of the theology of care (Erikson, 1992) and the nature and goals of pastoral practice in hospitals (Sainio, 1993). This journal was widely read among chaplains and other Lutheran ministers and thus influenced the discussion on chaplaincy. The journal was recently relaunched as an internet-based journal that seems to be practice oriented in the sense that chaplains are writing their experiences and ideas based on their work (Sielunhoidon Aikakauskirja, 2018).

Among the first ThDs was a quantitative study on pastoral counseling in Finnish hospitals, the results of which revealed that patients experience a chaplain simultaneously as a preacher, a servant, and a participant (Kruus, 1983). These results indicate that even though a patient-centred model was actively followed, patients in the 1980s still saw that preaching of the gospel was an important role of a hospital chaplain. Other studies in the 1980s and 1990s dealt with religiosity of the patients and patients' understanding of dying. A study on the worldview and religiosity of elderly chronic patients focused on the importance of a shared life story between an elderly patient and the chaplain and discussed issues connected with values, religiosity, and attitudes toward approaching death (Gothóni, 1987). A health care chaplain, Kalervo Nissilä, conducted two further studies, the first focused on immortality of the dying (Nissilä, 1992) and the second on a suicidal person's understanding of his/her own dying (Nissilä, 1995), both of which were based on interview data of hospitalised patients.

Some studies focused on the congregational context but also contributed to the hospital setting. Among these was a study on grief group counseling in congregations (Harmanen, 1997), which has been widely read among theologians and thereby influential on healthcare chaplaincy in Finland. Most of the authors during this early phase were chaplains themselves, and they collected the empirical data from the hospitals in which they worked. The exception was Paavo Kettunen whose dissertation was based on the written training material of healthcare chaplains in the ELCF between 1960 and 1975 (Kettunen, 1990). Even though Kettunen's dissertation was defended in 1990, it contributes to this early period because the focus is on the patient-centred model in which the concept of man was defined inductively from the life situation of a person and additionally the study is based on data from these years.

Most of the dissertations around the turn of the century also focused on patients' experiences. Among them was a study on the integrity of life of aged pacemaker patients (Ylikarjula, 1998) and the pastoral expectations of cancer patients (Lankinen, 2001). There was an interesting follow-up study on the Specialised Training Program in pastoral care and counseling (Hakala, 2000). This training was offered to hospital chaplains but also to chaplains working in other specialised ministries. The aim of the study was to examine the changes that occurred during the training in the ways in which trainees practiced pastoral care and how they understood their caregiver identities. The data were collected by interviewing 17 students both before and after the training. The results show that training strengthened pastoral caregiver identity and increased the spiritual aspects of pastoral care. Additionally, the study included recommendations on how to improve the specialised training. These suggested improvements included integration of self-directed study, seminars, and supervision (Hakala, 2000: 357–365). The study findings were later used when planning new chaplaincy training. The same year, Sippo's (2000) study focused similarly on the chaplain's professional identity. This study reveals that chaplains focus on their patients but that their professional identity is built on both the healthcare and the congregational contexts. This underlines the argument we have shown elsewhere in this paper that these two contexts form the work spaces and identity of a chaplain in Finland. Here we must note that there are two different models of how the leadership of chaplains is organised: The superior is either a vicar or a

leading chaplain. The first model focuses more on the parish context while the second model is in the healthcare world.

During the past ten years, pastoral theological research has focused on spirituality and health. Among these is a study on the significance of the loss of a child for the formation and development of parents' spirituality (Koskela, 2011). Even though this study does not focus on the clinical setting or on the role of chaplains in the parents' narratives, it does contribute to the wider discussion on spirituality and health. A quite similar study on parents' narratives of grieving and recovery processes after the death of a child reveals that chaplains were more prepared to face the grieving parents than the parish pastors were (Itkonen, 2018). This is an important finding because currently there seems to be pressure not to continue with chaplains but that parish pastors should take care of the hospitals in the area instead.

The two most recent studies have focused on patients' experiences with spirituality and health. The first one dealt with young cancer patients and analysed their coping narratives (Saarelainen, 2017). This study found that most of the emerging adults interviewed would have benefited from additional psychological and spiritual support. Most of the interviewees had not met healthcare chaplains during their cancer process even though they experienced strong existential questions and spiritual seeking. A second recent study focused on the purpose of life of ALS patients (Virtaniemi, 2018), which revealed that the existential process of an ALS patient consists of two separate but connected processes. The first one deals with the ultimate concerns in life while the other addresses the issues of meaningfulness and meaninglessness in life. Both studies deal with an important issue of chaplaincy, the discussion on the meaning and purpose of life when facing death.

All these recent dissertations have contributed to the understanding of Finnish spirituality during loss and illness in which Lutheran traditions combine with everyday spirituality and the search for meaning in life. The researchers during this phase have a variety of backgrounds from emeritus pastoral care trainer Matti-Pekka Virtaniemi to the first non-Lutheran researcher Harri Koskela. It is interesting that none of them worked as a chaplain during the research and they thus did not collect the data while working in a hospital themselves. From ongoing studies, Virpi Sipola's dissertation focuses on chaplaincy encounters from the perspectives of both chaplains and patients.

Various course books focusing more widely on pastoral care and counseling have been used during the theological training and have thus influenced future chaplains as well. The Handbook of Pastoral Care and Counseling gave a good overview of the background and practice of pastoral care and counseling in Finland (Aalto, Esko & Virtaniemi, 1998). Another handbook on hospice care gave a multidisciplinary overview of the new approaches to palliative care (Aalto, 1986/2000). Two course books dealt with the theology of care (Latvus & Elenius, 2007) and on pastoral care and counseling (Kiiski, 2009), both of them giving an analysis of various approaches to pastoral care and counseling in Finland based on the analysis and structure by Norwegian Tor Johan Grevbo (2006). Grevbo has been widely read and discussed in the early part of this century by Finnish chaplains and has influenced both the practice of and research on chaplaincy in Finland. A bit later, a two-book series on the caring encounter was written in which the first volume focused on the history and theology of pastoral care and counseling (Kettunen, 2013) and the second volume on methods and practice (Gothóni, 2014).

Challenges of the Future in Chaplaincy

In this article we have presented an overview of hospital chaplaincy in Finland. We have shown how the Finnish context played a significant role in the formation of the chaplaincy and its theology over the years. Still today, the context for hospital chaplaincy exists within the contexts of healthcare and the ELCF. Even though the impact of the ELCF is and has been strong, the CPE tradition has provided for chaplains to be trained to answer the needs of all the people. With 2020 right around the corner, we see two great challenges for hospital chaplaincy in Finland: the lack of research and the risk of cut-

backs in the number of chaplains. In this last part of the chapter, we will discuss these challenges in more detail.

The early focus of chaplaincy research in Finland was on the chaplains themselves, which led to a focus on the experiences of patients. Still there seems to be a significant gap in knowledge on the needs of existential support of religious and non-religious minorities in Finland. Further, only some studies scrutinise the attitudes of care personnel toward sexual minorities (Hentilä et al., 2012; Mäntylä & Tuokkola, 2013). These studies did not deal with healthcare chaplains; however, they reveal that sexual minorities had negative experiences from healthcare because of the care personnel's old-fashioned attitudes. The most recent theological study shows that more than half of the ELCF ministers would perform a Lutheran wedding service for same-sex couples if this were allowed by the bishops (Kallatsa & Kiiski, 2019). This study shows a positive attitude towards minorities but does not scrutinise how the LGBT people experience chaplains nor how the chaplains are prepared to serve their LGBT patients. In sum, studies indicating relations between health, wellbeing, and religion as well as correlations between the experience of meaning and wellbeing have mainly been conducted with a quantitative approach (la Cour & Hvidt, 2010) and have often focused on the majority populations in their respective countries. There are few exceptions dealing with minorities or on interfaith approaches. None of these have studied the Finnish context.

It took decades for the Finnish healthcare chaplaincy to grow and develop as a tangible and respected part of the healthcare system. Harsh tones and lack of congregational understanding have been evident during the past decades. When looking to the future, relief cannot be guaranteed: the number of hospital chaplains is decreasing, and more cutbacks are expected. The church policy seems short-sighted when the chaplaincy personnel are let go even though the need and value of the chaplaincy is well known at the hospitals (See Karhu, 2019; Sipola, 2019). Chaplaincy follows Lutheran traditions, and this has not been openly challenged as is the situation for example in the Netherlands (See Ganzevoort et al. 2014, and Zock's article in this volume). This need to widen the religious scope of chaplaincy has not been much noted in public discussion or scholarly works.

There is an urgent need to stronger societal discussion on the role and expectations on the chaplaincy. World health organisation (WHO) has identified that holistic and compassionate healthcare should be secured for each patient. Further in the statement on the palliative and end of life care the Finnish Ministry of Social Affairs defines that each person working with the dying patients should be at least able to identify existential and spiritual needs of the patients and their careers. In the same document, hospital chaplains are positioned as a stakeholder to provide existential care for inpatients and homecare patients (Saarto et al., 2017). The question of multi- or inter-faith pastoral care remains untouched in political discussions. Hospital chaplaincy continues to be bound to the financial politics of the ELCF; yet, in the same time state seem to expect the chaplains to have more resources and developed skills to meet the needs of the diversifying patient groups. Even with the current number of healthcare chaplains, it is impossible to meet all the needs of the chaplain services (See Karhu, 2019; Sipola, 2019). Healthcare chaplains are deeply committed and motivated in their work. Yet it seems that when 2020 is reached, hospital chaplaincy in Finland will have to testify to its importance once again.

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Suvi-Maria Saarelainen, university lecturer in applied studies of theology
University of Eastern Finland, Philosophical Faculty, School of Theology, P.O. Box 111, FI-80101 JOENSUU, FINLAND
suvi.saarelainen@uef.fi

Isto Peltomäki, doctoral student in systematic theology
University of Helsinki, P.O. Box 4 (Vuorikatu 3), FI-00014 HELSINGIN YLIOPISTO, FINLAND
isto.peltomaki@helsinki.fi

Auli Vähäkangas, professor in pastoral theology
University of Helsinki, P.O. Box 4 (Vuorikatu 3), FI-00014 HELSINGIN YLIOPISTO, FINLAND
auli.vahakangas@helsinki.fi