New wine in new leather bags?

Hospital chaplaincy in Northern Europe – The Danish case



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ABSTRACT

Focal points of this article are preconditions and obstacles for the further establishing and increasing professionalisation of a specific field of pastoral care in the Lutheran Folk Church of Denmark (CoD). Since the mid-eighties general specialisation in society has implied a development of a multitude of chaplaincy in public domains in Denmark (Kühle & Christensen, 2019:182). This has generated an increase in numbers of chaplains in health care. In this paper we aim to show main trends in the development and current state of spiritual care[1] and hospital chaplaincy in Denmark and include first results from a proscriptive audit pilot developed for internal quality assessment and development.[2]

1. Introduction

What do we mean by "chaplaincy"?

A chaplain was, traditionally, a clergyman/-woman. In the broader international context, however, the chaplain might also be a rabbi or any other representative of a religious or philosophical tradition, a humanist or an atheist, as is the case in increasing numbers especially in the US, England and Holland (See Zock in this issue). In a Danish context in most cases it would imply ordained clergy within the Church of Denmark all though later years have seen the arrival of a Muslim hospital chaplain, as well as a few Muslim prison chaplains (Baig 2019).

Since Denmark has only recently and to a somewhat limited extent embarked on the journey towards a multi-ethnic, -cultural and -religious society, reminiscences of the old dominating Christian culture of premodernity is still somewhat prevalent and thus motivates the dominating presence of clergy affiliated with the CoD working as chaplains.

What are we talking about: How to define "Spiritual Care"?

Spiritual care as concept is found in the notion of Total Pain. Dame Cicely Saunders, founder of the modern hospice movement, was the first

to formulate the concept of Total Pain and described it as the overall situation of the seriously ill and dying. She defined the concept of total pain as holistic suffering encompassing a person's physical, psychological, social, spiritual, and practical suffering (Richmond 2005).

The understanding of total pain is reflected for instance by WHO as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (World Health Organisation, 2019). In continuation of the WHO's attention to existential and spiritual challenges, spiritual care is defined by the Danish Council on Ethics as "a care that includes both the specifically religious about grief and the consideration of the existential issues and concerns that may arise in any dying person, regardless of whether these questions and concerns of the individual are more or less or not at all characterised by religious aspects" (Tiedemann, 2002).

Distinguishing between "religious" and "spiritual" makes way for a broader understanding of chaplaincy traditionally understood as pastoral care, since spirituality is a broader term than religion. Although not everyone has a religion, everyone who searches for ultimate or transcendent meaning can be said to have a spirituality (Sulmasy, 2002: 25).

Accordingly, this article will understand both "spiritual and existential care" and "pastoral care" as just "spiritual care". A definitive definition on "spiritual care" intervention is contested and might be grouped into several general categories (Hummel, Galek, Murphy, Tannenbaum & Flannelly, 2008: 49), but we find it helpful to identify the spiritual component in spiritual care as a care regarding: 1. The possibility of another reality than already known (vertical transcendence); 2. Context, specific situations, activities or acts; 3. Individual longing and experiences of a special relatedness" (La Cour, Ausker & Hvidt, 2012: 80). Much along the same lines Stifoss-Hansen & Kallenberg writes their definition on spiritual care in health care: "... to be aware of the patient's existential issues and resources, to listen to the meaning they have in the patient's life history, and to assist the patient in his/her work on existential issues based on his/her own view of life" (Stifoss-Hanssen & Kallenberg, 1999: 23).

The strange Danish case Religion and research?

1. Religion and religious adherence

Sociologists have described Denmark as the "least religious society in the world". And surveys do show that Danes generally are among the least religious Europeans – who in general are less religious than people in other parts of the world. PEW research[3] in a 2018 survey thus ranks Denmark no. 32 of 34 out of the least religious countries in Europe (Pew research 2018). If value studies are consulted, however, a more differentiated picture appears indicating that a lack of traditional religiosity of Danes does not mean that Danes are not religious. The European Value Survey find that more people believe in a spiritual force (39 %) than in a personal God (16 %), which is an expression of a tendency towards non-traditional confessional spirituality to be expected as a result of an inclination towards individualisation. This is accentuated by a membership decrease of CoD from 86 % in 2008 to 77 % in 2017. Also, one finds that since 1981 there has been a steady decrease in the proportion of those who say they believe in God from 64 % in 2008 to 53 % in 2017, and in 2017 60 % say they are believers compared to 72 % in 2008 (Frederiksen, 2019: 236.).

2. Clinical studies of existential and spiritual needs

International studies show that patients in general, in different clinical contexts and across age groups, express existential and spiritual needs, and want to talk about issues related (Koenig, King & Carson, 2012). Danish studies suggest that Danes experience something similar in connection with life-threatening illness and crises. Research projects from Danish research institutions have provided insight into the spiritual needs of Danish patients and relatives (Opsahl, T. 2017). Ingeborg Ilkjær has shown that

existential reflections are intensified in patients with severe lung disease, and furthermore, that they often miss care directed at existential and spiritual conditions (Ilkjær, I. 2012). Lene Moestrup has uncovered that dying patients and their careers, even at hospice, often have uncovered ambivalent spiritual needs (Moestrup, L., 2015). Similar findings have been indicated from around the turn of the millennium when interest for the research area began. In 2006 a Danish Cancer Society survey study noted that 17 percent of the participating cancer patients responded that their illness had given rise to religious considerations (Grønvold, Pedersen, Jensen, Faber & Johnsen, 2006). A study from 2008 showed that patients intensify their thoughts about faith, doubt, meaning, life and death, and that religious considerations are part of this picture (Ausker, la Cour, Busch, Nabe-Nielsen & Pedersen, 2008).

A study points out that "the belief in something bigger and patients' religiousness is not an irrelevant factor in connection with serious illness, even in a secular society such as the Danish", and that "the healthcare professionals and, for example hospital pastors/imams [...] could address the patient's spiritual and existential beliefs in order to identify and resolve possible negative ideas" (Pedersen, 2013).

The studies indicate that what has been called a "crisis religiousness" is activated in many patients, and that some patients experience that religious and existential thoughts are not given enough attention. A study points toward the fact that 45 % of doctors in general practice state that they take part in existential and spiritual care only once or less per year, which leads to the assumption that spiritual care issues might be unattended (van Randwijk, Opsahl, Hvidt, Kørup, Bjerrum, Thomsen & Hvidt N.C., 2017).

1. History: Church and chaplaincy in a transition period

The last 5 decades have seen the church of Denmark develop into a hot house of activities exploring new liturgies, expanding the traditional understanding of church and church gatherings and establishing new positions for clergy. Accordingly, the field of function and profile pastors, which is the term used in Denmark since the international term chaplain is not used, is growing. Thus, of the total number of clergy which makes approximately 2000, a little more than 1 in 6 is now working as a function or a profile pastor, often in combined positions also working as a parish pastor. This implies that every sixth pastor is working in an area of specialised responsibility (Center for Samtidsreligion, 2018).

Clinical Pastoral Education, a bypassed contribution.

An obvious contribution towards spiritual health care in a Danish context might had come from the clinical pastoral movement. Alas, the Clinical Pastoral Education (CPE) never made it to Denmark. The holistic orientation and integration of theory and practice of CPE has not been "*kosher*" in a Danish setting and for several reasons. Furthermore, the theology developed in relation to CPE was easily criticised (Howard, 2017). The CPE movement was brought to Europe via the Netherlands and Germany, where it gained influence, just as in Norway and Finland, becoming a formalised and recognised part of the church's work with spiritual care. This influence has bypassed Denmark partly because it seemed foreign to Danish theological education and attitude after World War II which was oriented towards dialectical theology and propounded especially by Tidehverv[4], and despite, one might add, the fact that influential theologians as Grundtvig, Kierkegaard and Løgstrup observe and work with matters well known to pastoral care. Partly, also, the bypassing was due to the fact, that in Denmark, academic theology has been promoted at the expense of the theological reflection that grows out of the encounter with practice. More to this point down standing.

Function pastors and profile pastors

There is no single term equivalent to the generic term "chaplain" (Kühle & Reintoft Christensen 2019: 187). But a report on chaplaincy has been compiled contributing towards a concept clarification as to how and when we talk of function pastor and of profile pastors: "The work of the function pastors usually takes place outside the

physical framework of the church, while the work of the profile pastors usually takes place within a church context. One might say that the work of the function pastors is 'outward', while the work of the profile pastors is 'inward'" (Kühle, Christensen, Asboe, Dollerup, Damgaard, Brodersen & Flyvholm, 2015: 14).

The underlying challenge of categorising clergy working as function or profile pastors is a matter not just about where and how they work but also how they are paid and thus has political implications. The numbers are compelling: If chaplains serving in the armed forces as well as other chaplaincy are included, the total number of chaplains is about 345 (Kühle et al 2015: 157). If one compares the number of chaplaincy working in health, prisons, universities and higher education as well as DanChurchSocial, the total figure has been growing from a mere 37 in 1971 to 78 in 1994 finally reaching 226 in 2015. Numbers of pastors working in health is even more significant as they have rocketed from 14 in 1971 to 102 in 2015 (Kühle et al 2015: 156). In this article the distinction between function pastors and profile pastors are maintained and the two together labelled "specialised" pastors.

Pros and cons towards specialised pastors.
The development towards function and profile pastor didn't take place without opposition. CoD is characterised by being a parish-oriented church with its emphasis on the local parishes.

This inherent understanding of CoD is reflected in the fact that almost all specialised positions are shared positions containing a specialised part and a traditional parish part. Compared to the other Nordic countries where much the same development took place, specialised pastors in Denmark, to a certain extent, was considered a danger to the church's anchoring in the local parish. The resistance towards specialisation of clergy was the case especially throughout the 1960s and 1970s being a result of the dialectical theology's strong position in Danish theology and church life. Reminiscences of this resistance were reflected throughout the 1990s and still prevails although the development must now be regarded as reversed. Nevertheless, there is little doubt that a certain scepticism towards particularistic congregations and pastors still exists (Iversen 2013: 64).

Several things worked in favour of the chaplaincy movement. First, the *Zeitgeist* worked in favour of a general specialisation of society: Cost benefit analyses meant bigger hospitals, which again implied a certain division of labour between clergy. Also, the role of religion in Western societies was redefined. Freud wrote "The future of an illusion" and meant "the end" of it (Freud, 2008). For most of the twentieth century sociologist worked from the expectation that modern age societies would become increasingly secularised and religion loose relevance. At the closing of the century, sociologists reached the opposite conclusion; religion was alive and kicking albeit in the post-modern clothes of spirituality, individualisation and a strong distaste for dogmas, clergy and institutions. The development is personified in sociologist and Protestant theologian Peter Bergers work and his late announcement, that he, in his secularisation-theories known from bestseller The Sacred Canopy and other works, had been all wrong stating that "the world today is as furiously religious as it ever was." (Berger 1967 & Berger 2005). Habermas emphasised that in post-secular societies, religion has an unforeseen role, because of the increasing differentiation most notable in the prevailing of individualisation (Habermas 2008). Contemporary sociology of religion is preoccupied with "lived religion", a phrase coined by Meredith McGuire and others, which has paved way for a new understanding of religion and its role in society (McGuire 2008). Researchers argue that especially the historic majority churches are viable and frame how religion is perceived and framed in the public sphere (Nielsen 2019).

2. Theology and spiritual care. In the shadow of dialectical theology.

The development of, and increase in, positions and subsequent professionalisation of chaplaincy as described above has, curiously, developed alongside the somewhat late development of the field of spiritual care. The field of spiritual care has during the 20th century undergone quite a different development than from that of other

Nordic countries due to dialectical theology, in Denmark in shape of the aforementioned Tidehverv, which, since the early nineteen-twenties until recently, has been a strong influence in the CoD especially among the clergy. In this very Danish trope of Neo-Lutheranism a heavy emphasis has been on the Word. Practical theology disciplines, and spiritual care as one of them, thus came to be understood as being of secondary importance. As consequence spiritual care was not considered a subject of its own for most of the 20th century and for a long time lived unnoticed as a discipline in its own right. In so far that spiritual care was dealt with, it was from the perspective of dialectical theology and Thurneysen's kerygmatic spiritual care (Harbsmeier & Iversen, 1995: 393).

This implied a contradiction between theory and practice, preventing the thinking together of theory and practice of spiritual care (Bach, 2007: 344). Moreover, a contradiction was presupposed between theology on the one hand and psychology on the other. The training of spiritual care givers was therefore essentially looked upon with a distinct distrust because of the supposed inherent threat of this leading to a psychologising of the theology, but also because education in this area was understood as a professionalisation that basically was at odds with the hart of pastoral care. Insofar as a Danish spiritual care tradition can be spoken of, through most of the last century, theology and spiritual care was not conceived of nor practiced in interaction with each other. Academic theology traditionally never made much of an effort on behalf of practical theology as a discipline, not to mention its subdomain of spiritual care.

The call for training.

In Denmark spiritual care is taught infrequent in different contexts for both professionals and lay; however the range of courses and competence-giving training offered in spiritual care is limited, and to a large extent offered ad hoc, with one exception. It wasn't until the early 1990s that a distinct and formulated interest towards education and professionalisation within spiritual care began to emerge due to a demand for supervision from the associations of hospital and prison pastors. A conference was set up in 1993, and in the aftermath, initiative was taken to establish a chair in spiritual care and pastoral psychology at The Pastoral College (Præstehøjskolen).[5] This was established in 1995.

Graduates in theology aspiring to an office in the CoD, do, in connection with a 5-month course at The Pastoral Seminars in Copenhagen or Aarhus, receive training in basic spiritual care. At university level offers remain scarce and infrequent. One existing offer is the Flexible Master at the University of Copenhagen, which offers the possibility to incorporate one and up to three "compact courses" in the area of spiritual care. A university level introduction to the "proprium" of spiritual care is not to be found. A master's degree focused at core areas of spiritual care was offered 2012–2013 at University of Copenhagen but was substituted by the above mentioned and somewhat fragmented – specialised? – model consisting of compact courses offering freedom in thematic choice and suspected lack of cohesion and an overall profile. Because of the "empirical turn" and the inherent growing interest for Practical Theology[6], spiritual care and related subareas has seen a growing interest resulting in an increasing number of Master projects as well as Ph.D. dissertations at the Theological Faculty in Copenhagen as well as at the Institute of Theology, Faculty of ARTS, University of Aarhus.

Compared with the Dutch situation the educational scene in Denmark is rather minimalistic. A multi-religious education program as initiated in Norway has been discussed numerous times but until now rejected (See Grung in the issue).

Training aside, in current years, CoD are looking to strengthen the spiritual care provided to members and non-members alike. An increasing number of parishes provide internet spiritual care, as do the websites Cyberkirke.dk and Folkekirken.dk. The CoD has been criticised by the Danish Deaconess Council for not focusing on young people's need for spiritual care (Dansk Diakoniråd, 2018). However, the church tries to meet the needs also of young people by reaching out. The website Sjælesorg.nu. (Spiritualcare.now) is a three-year project and the National

Church's latest effort in offering confidential conversations through chat with a pastor on the www.

Private agents as the Colony of Philadelphia and the St. Luke's Foundation in Copenhagen provide spiritual care training for caregivers at intervals. For many years, the St. Luke's Foundation and DanChurchSocial have provided counselling and telephone spiritual care, and IKON has provided spiritual care for people affected by the New Age or alternative religiosity.[7] For almost three decades Nordic Spiritual Care Symposium has arranged annual gatherings in the Nordic countries. Journals such as the "Critical Forum for Practical Theology" (Kritisk Forum for Praktisk Teologi) periodically publish thematic issues as "Disaster Theology" or "Spiritual Care". Furthermore, Norwegian based "Journal of Spiritual Care" (Tidsskrift for Sjelesorg) has a wide circle of Danish subscribers. The Norwegian milieu has been an inspiration and, for some time, the most obvious context for doing a CPE or other certified spiritual care courses, for instance at Modum Bad.

In the absence of lay courses in spiritual care, the right-wing context within the CoD seems to be the most persistent provider of such assisted by free church initiatives. One exception is biblical spiritual care courses now offered by the Danish Bible Society (Bibelselskabet, 2019).

3. What are you really doing, chaplain? Self-understanding, organisation and practice.

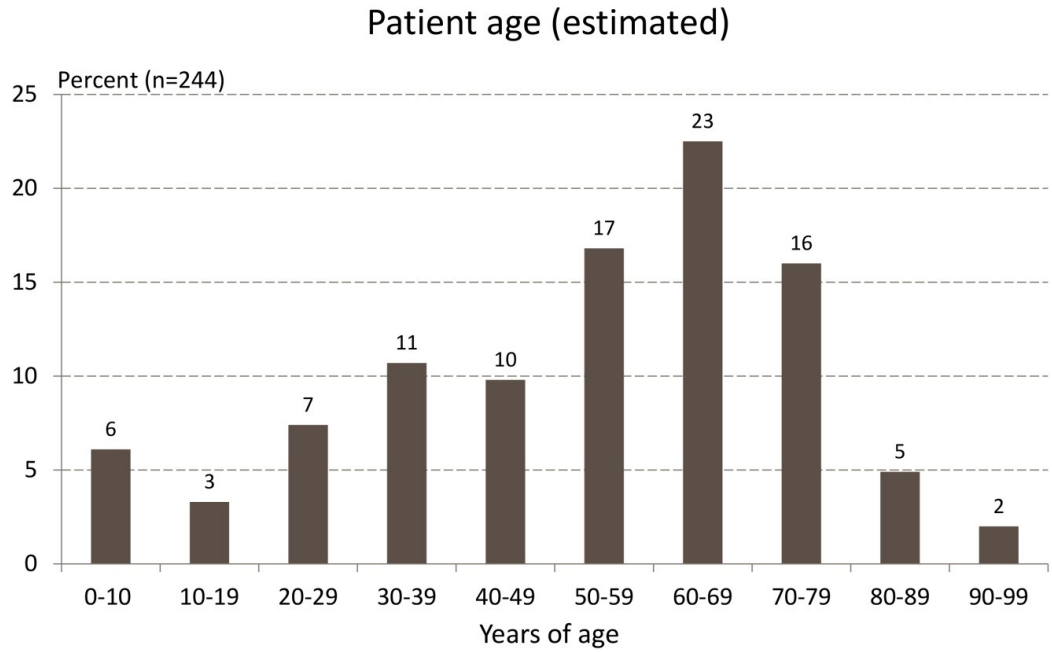
Several chaplains have met a welcoming attitude from staff when visiting wards, but also the somewhat curious question above.

This has to do with mainly two aspects. First, the organisation of chaplains as kind of a "go-between" in the overlapping areas between hospital and church. Second, it also points to the self-understanding of chaplaincy as being on the fringes of public healthcare.

Self-understanding and organisation

Self-understanding has to do with the greater organisation and result in a certain practice. So, first a few remarks on the organisation. Historically, public hospitals with patients coming from a large area had their own churches and clergy to serve the patients. In cases with smaller hospitals it was the parish vicar who visited "parish-

Figure 1.



ioners" and performed emergency baptisms and lead the worship services.

Following the structural reform in 2007 hospital chaplaincy is now organised regionally, with biannual or yearly regional meetings in a more or less formal cooperation with the bishops. At national level, structural reform is reflected in the fact that there now are regional representatives forming the board of directors of PRIS (Præster i sundhedssektoren), an abbreviation for Clergy in the Health Sector (Præsteforeningen, 2019).

Chaplaincy in the healthcare sector are employees of the CoD, and as such they are under supervision of local deans and bishops. However, in recent years, establishing of hospital chaplaincy deans has gradually been seen in several dioceses and/or regions.

Thus, in organisationally terms, the hospital and hospice chaplains are closely related not only to the diocese but even to the parish. They are, however, not formally part of the organisation of the institution in question. The hospital chaplain attends local conventions and collaborate with the parish clergy in local activities. At the same time, they participate in the parish, in council meetings, parish activities, and committee assignments to an extent equivalent to the percentage of their total employment in the parish.

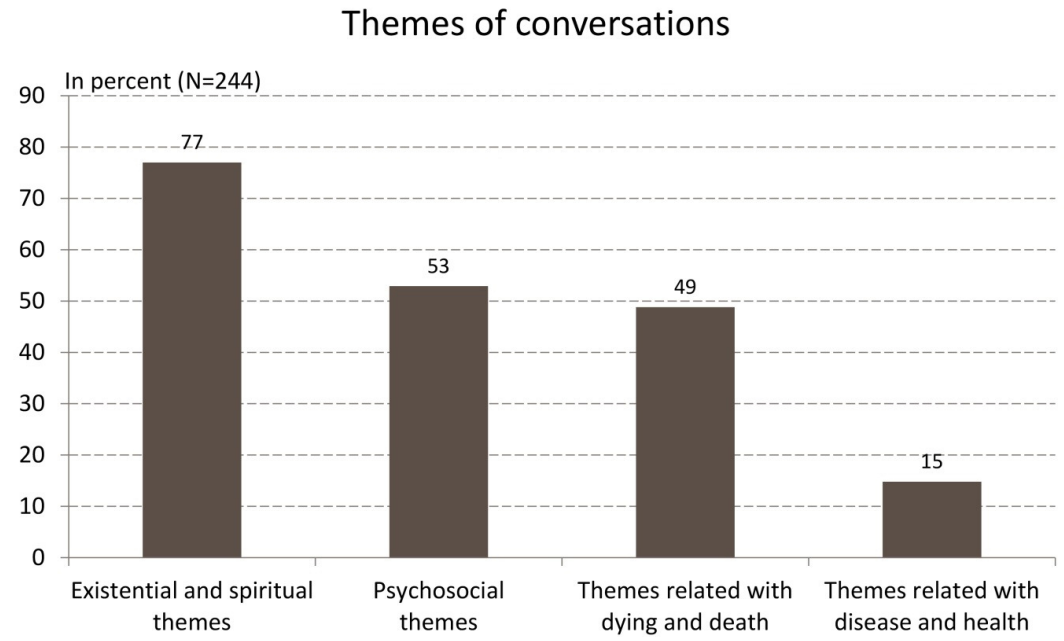
The dean oversees and allocates financial resources to hospital chaplaincy and negotiates the part of the chaplain's employment for hospital duties. When a position is vacant, the institution participates in the hiring process by reading the applications, participating in interviews, and, if desired, submitting a statement to the bishop. When a chaplain is hired, an agreement is made between the diocese and the hospital management outlining the broad lines of the future common cooperation. The hospital chaplain is thus one coming from outside the clinical world and at the same time belonging to the institution as well.

Practice: Introducing APO

Conversations between chaplaincy and patients make up the bulk of most hospital chaplains' everyday activities, with an average of 46 conversations per month, hospice chaplains a little less, namely 39 (Kühle et al 2015: 90).

Other tasks might be conversations and tea-

Figure 2.



ching (and, for some chaplains, supervision) with staff, staff meetings, interdisciplinary meetings, administrative work, attending ecclesiastical duties, to name a few.

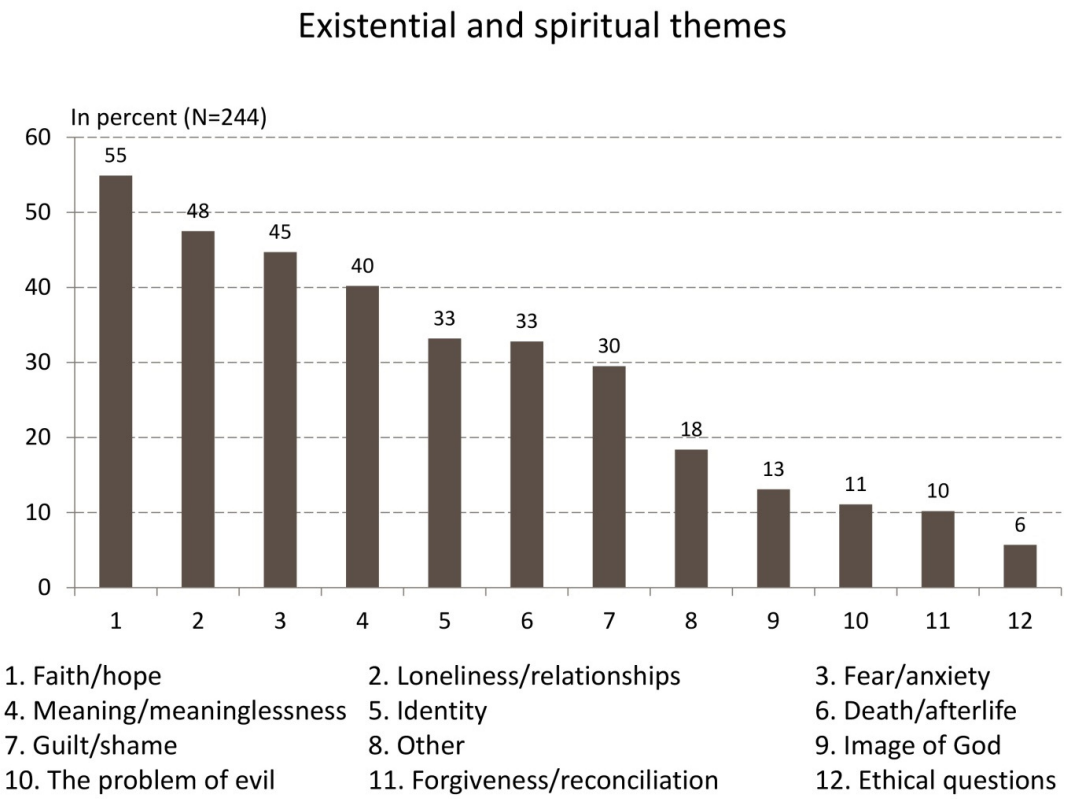
But what might then be the typical conversation? Results from a pilot audit gives a first hint. Audits record characteristics of each patient encounter for the professional to obtain better knowledge about his/her way of work and to compare it to other participants in the audit (Munck, A 1998).

Now, the preliminary results of the first APO-audit among Danish hospital chaplains have become available offering a first glimpse.[8] Due to the limitations of this article results will be more elaborate described elsewhere.[9]

The audit shows that the bulk of conversations last between 30 minutes and 69 minutes, ranging from 10 to 100 minutes. We have defined a conversation as any contact lasting more than 10 minutes. Very few conversations lasted less than 30 minutes, perhaps indicating that most of them were pre-arranged, thus making it possible to leave other health issues aside. There is a slight gender difference demonstrating that women talk with chaplaincy more frequently than men, indicated by a difference of 50.8 % to 46.3. Furthermore, the audit show chaplains are used by a variety of patients from early childhood to retirees, the ones using the chaplain the most aging 50–79 years (figure 1). This is hardly surprising as most hospitalised patients are in the range from mature adults to elderly people. Also, there is a coincidence in age groups between patients and chaplains, especially when it comes to the age span from 50 to 69 years, as we know many of the chaplains are in this age group (Kühle et al 2015: 85). One might expect an easy and trustful interaction between people of the same age indicating that chaplaincy ought to be represented by a variety in age.

The initiative towards a conversation is taken by a patient in 41.8 % of the cases. The department accounts for 32,4 %, next of kin 15.6 %

Figure 3.



and the chaplain for 9.8 %. The rather small number representing the chaplains' initiative is significant and might be interpreted in several ways. First, it might be due to the culture of chaplaincy in Denmark. Chaplaincy has traditionally not been characterised by culture of "outreach" into wards. Rather, the connection between chaplain and staff implies that chaplaincy to a large extent rely on the initiative from staff when it comes to the actual patient contact. Secondly, it might also signify that chaplains do have the necessary and adequate contacts through calls from patients, relatives and ward.

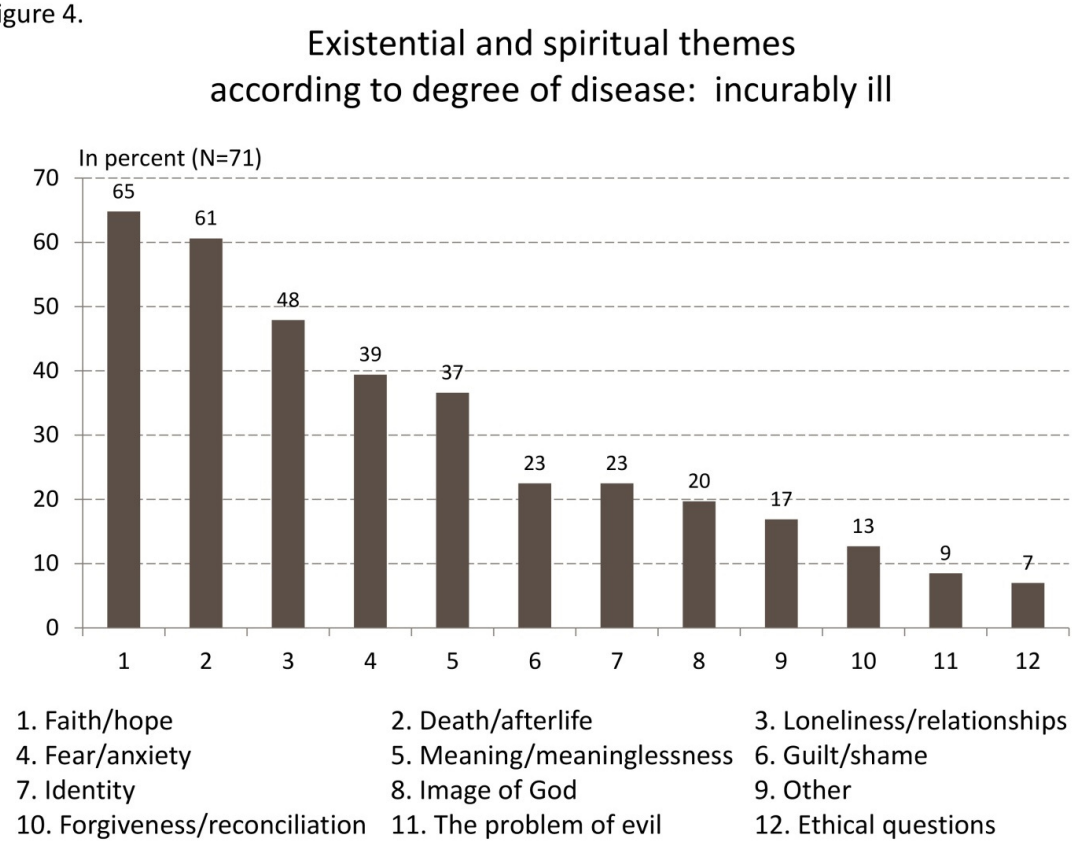
Finally, it should be added that the statistics are based on information given by the chaplains and remain questionable since it is unclear whence the chaplain has her or his information.

In 80.3 % of the cases the conversation partner was a patient, in 29 % a relative. Staff was represented by 3.3 %, perhaps indicating that chaplains as a possible conversation partners are unknown to staff members. It might also be a question of embarrassment or lack of relevance on behalf of staff. The perhaps surprising high score on behalf of the relatives might be explained by the boost of the inclusion of two palliative wards which traditionally are characterised by a greater degree of relative involvement than most somatic wards.

In the audit we chose to make an overall distinction between 4 main categories also used widely in the literature (fig. 2).

Since we suspected that the existential and spiritual category would be the most used, we chose to focus on this category, breaking it into 12 points showing the most common conversation themes. The 12 themes were, like the APO study as such, discussed and selected through a process spanning over three meetings with a group of chaplains. One could argue that pairing the themes, as for instance, "faith/hope", would make the answers less significant but to the chaplains it made sense to see them as pairs pertaining a connected context.

Figure 4.



A comparison of the group of incurably ill patients with less seriously ill patients (figure 4 and 5), visualises the range of needs and anxieties of patients indicating the most common themes from the left and the less common themes at the right in percentage.

A closer look at figures 4 and 5 illustrates that patients in general wants to talk with chaplains on themes such as 1: Loneliness/relationships and 2: Meaning/meaninglessness and 3: Fear/anxiety, all of which are among the top-5 regardless of their diagnosis being "incurably ill" or "less seriously ill".

The questions making the bottom 5 – apart from "ethical questions" – are just as significant, as they are notoriously theologically loaded and don't seem to be of any remarkable significance indicating a less dogma-orientated and a more explorative conversation.

This might be confirmed as we turn to the means invested in the conversation in terms of prayer, reading, etc. (Figure 6).

The numbers indicate, perhaps somewhat surprising, that in most conversations, chaplains did not make use of any traditional Christian means of consoling her or his conversation partner in terms of prayer etc., indicating that Danish chaplaincy is as religious as her or his conversation partner calls for. Traditional chaplaincy understood as primary religious – and as such less asked for by patients – are increasingly understood as existential orientated and patient centred spiritual care.

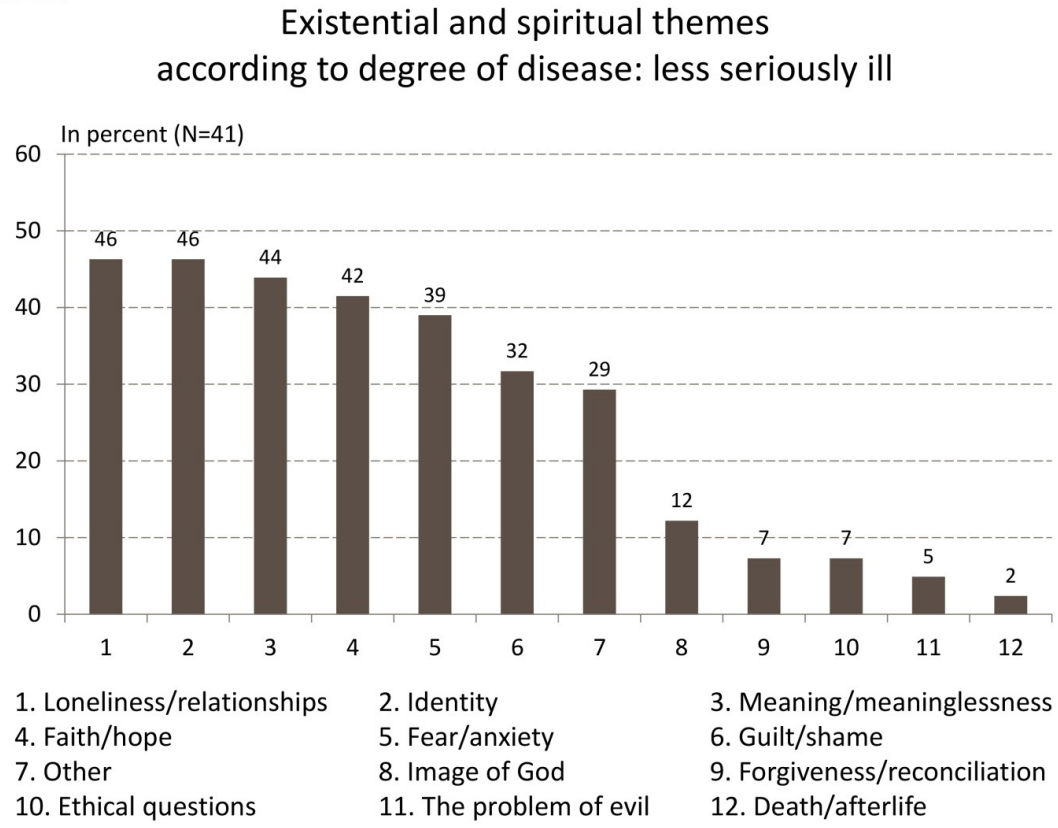
This "turn" is a common marker in all countries represented in this issue; see for instance Zock and Stifoss-Hanssen, Frøkedal & Danbolt.

4. The future. Concluding remarks

The scope of this article has been to describe broad outlines of establishing and increasing professionalisation of spiritual care personified by chaplains within the CoD.

The health care context is a dynamic setting, not the least in these years. In Denmark we see

Figure 5.



the construction of new and bigger entities called "super-hospitals", and the structures of health care itself are remodelled with a shift from intra mural to extra mural care and a further expected rise in outpatients.

Work is done to accommodate the structures of chaplaincy to the needs of healthcare facilities and imply education, research and quality development. As we have seen there has been an extensive numeral expansion of chaplains. The efforts by FUV in the field of continuing education has paid off, implying a notion of strong professionalism and a robust identity as Christian chaplains. A newly defended PhD thesis find, that "the therapeutic ethos has not eradicated evangelical Lutheran Christianity or transformed the hospital pastors into semi-therapists" (Aalborg diocese, 2019).

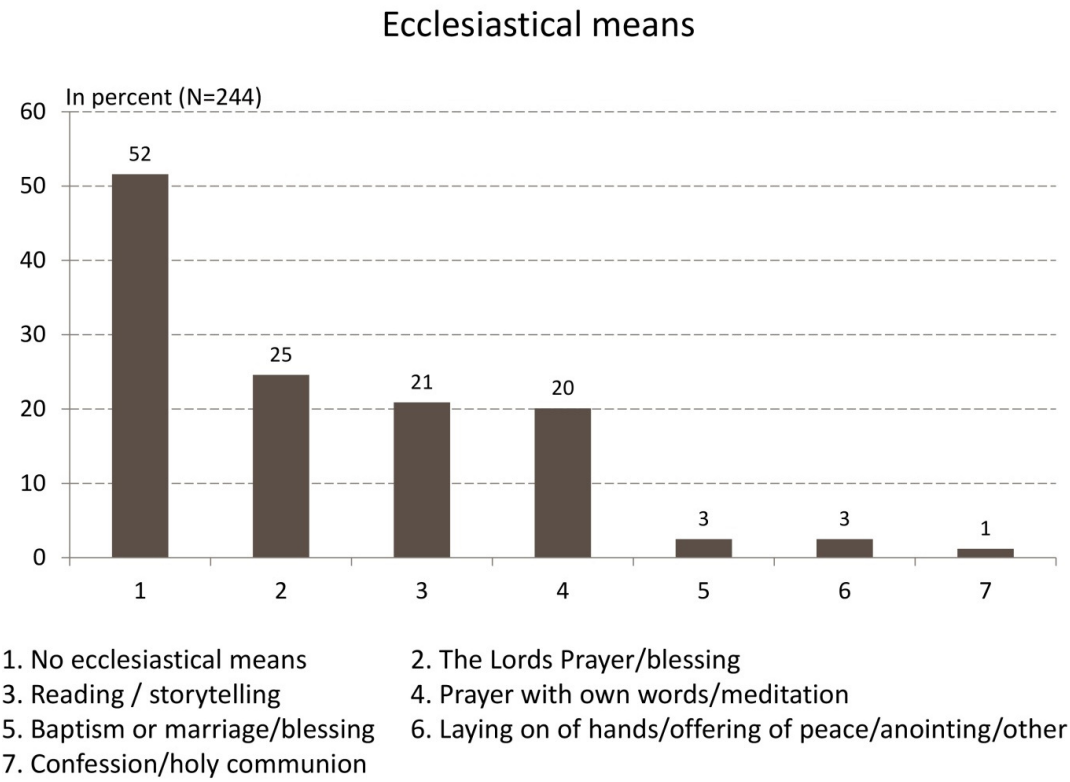
Chaplaincy operates in secular society as representatives of CoD which, as we have seen, has a solid stance among Danes with a (whopping) 76 % membership. As such, hospital chaplains represent a well-known religious and somewhat generally accepted component in a secular setting addressing the needs of believers and non-believers alike caring for both majority and minority religions (Kühle & Reintoft-Christensen, 2019: 194).

One aspect recognised by health staff and management is the "presence approach" of chaplaincy. Another aspect of chaplaincy appreciated by institutional staff and management is the counterculture brought to the fore, consisting of other value variables than the dominating rationale of the bio-mechanical perception of medicine, health and man.

An example expressing this kind of influence might be the Existence Laboratory (Eksistenslaboratoriet) developed to encourage and strengthen the existential discourse at hospitals, a project met with interest and support among different strands of clinical staff (Sygeplejersken 2018).

Scientific research in the field of chaplaincy is

Figure 6.



scarce but growing. Awareness of the need to show what chaplaincy is about are found. A PhD-project on Danish chaplaincy investigating the conversation between chaplain and patients is coming up. Completed projects have been mentioned and new Ph.D. projects and general research projects are in the pipeline. This is in line with international trends in chaplaincy referring to the importance of evidence-based studies reflecting the activities of chaplaincy, showing the public what chaplaincy is about and, at the same time, reflect on "best practice" on behalf of chaplaincy[10].

The arrival of the Nones (people with no religious affiliation) or SBNRs (people identifying themselves as "spiritual but not religious") and the call for research present new questions.

As does multi-faith teams. Also, secular, generic or humanist chaplaincy are gaining increasing public understanding in western societies. These factors might present a challenge to the until now well-established acceptance of Danish chaplaincy understood as Christian chaplaincy.

Spiritual care is contextual theology shaped in specific situations, and as such met by the dual challenge towards its relevance on the one hand and its uniqueness as a profession on the other. The situation is not new. At stake here is: How can spiritual care work on the premises of the present and at the same time preserve the opportunity to work for change, courage, reconciliation and faith?

Summing up, much is happening in the field of chaplaincy in Denmark. The adaptability of chaplaincy has been its trademark through history, and, indeed especially for the last century. Coming back to the headline of our article, we might say, that chaplaincy is a case of old wine in old baskets, but baskets accommodated for and further developed towards new contexts.

We live in exiting times. New demands and new questions point to new possibilities and opens inroads to yet unknown answers. This, indeed, is all in the trade of chaplaincy.

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Notes

1 This article follows the definition used by The Danish Council on Ethics and clinical guidelines and use the term "spiritual care" as inclusive of "spiritual and existential care". In our understanding "spiritual care" includes "pastoral care".

2 2. APO: Audit project Odense. Located at Southern Danish University, Odense. APO is a resource center for quality development and continuing education developing and executing quality development projects based on activity registration.

3 3. Pew Research Center is a nonpartisan fact tank that informs the public about the issues, attitudes and trends shaping the world, conducting public opinion polling, demographic research, content analysis and other data-driven social science research. https://www.pewresearch.org/about/.

4 4. Tidehverv: Danish journal and theological working community influenced by the thoughts of Søren Kierkegaard and Karl Barth. Champion of Neo-Lutheran thought. Forum for ardent critic of modernity. https://en.wikipedia.org/wiki/Tidehverv.

5 Now FUV: Centre for Pastoral Education and Research (Folkekirkens Uddannelses- og Videnscenter).

6 Dan Browning has had a crucial impact with his under-

standing of theology as basically practically theology.

7 September 2019 rebranded as "Tro i Dialog" (Faith in Dialogue).

8 The pilot study involved 242 conversations between patient, relatives, staff and 9 chaplains from hospitals in cities across the country in a 10-day working period gathered in Aalborg; Aarhus, Odense and Copenhagen. For further information about this project, see https://faith-health.org/?cat=3. Of 9 chaplains two were working in psychiatric care and two others in palliative care. Results accumulated from September 16th to September 30th 2019, making an average of 26.8 conversations / 2.68 conversations per day.

9 https://faith-health.org/.

10 Highlighted by Christian Scharen in his publication "Field Work in Theology". Mary Clark Moschella has written on the importance of ethnographic studies.

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