European Network of Healthcare Chaplaincy
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"Growing together in our pain:
Differences and tensions in healthcare chaplaincy in Europe"

"Differences and tensions in healthcare chaplaincy in Europe:
State level."

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Professional integration and Pastoral integrity

My presentation will focus on differences and tensions among us on how we connect to the state level in European health care.

We have as headline for this consultation the words "differences, tensions and pain". It is obvious that there are differences among us on how we as churches relate to state authorities. The political and national historical development has been very different in European states, and we represent also different theological and ecclesiological traditions on the relation between church and state, between church authorities and secular authorities. These differences are obvious, but how do they create tensions among us in the network? And if there are tensions – how do the tension become painful?

For me, the most painful focus within the network is the fact that healthcare itself is not delivered with the same amount of resources to the population in Europe. But that is a pain we can share in solidarity. The next painful focus is that healthcare chaplaincy is not delivered with the same level of accessibility, acceptance and support. We meet each other in this network bringing in very different conditions for our chaplaincy projects. This is also a pain we can share in solidarity.

The most central pain within the network must be the fact that we have different principles on how we should connect to the secular, state level. This was exemplified in Turku 2002 when we agreed upon Standards. We worked on formulating 2.2:

> "Chaplaincy services are delivered by clergy and lay persons who have been professionally trained in the area of pastoral care. They are authorised by their faith community *and recognised by the health care system."*

We had discussions on the word "recognised". It was proposed words more like "authorised", but then we felt the tension within the network on how far we should be integrated within the secular health care system. It should not be the secular authorities that gave chaplaincy authorisation. Only a faith community can authorise a chaplain. For some, the integration went too far if the health care authorities were given the pastoral authorisation. That was never the intention. The intention was to put down as a fact that our work is actually happening within a public setting, and that hospitals and health care settings have the right to give or not to give their acceptance, support and recognition to those working within their structure. This is necessary for the sake and protection of the patient and it is therefore needed for us to have this acceptance and recognition for our work as chaplains. Otherwise we very fast might end up as visitors from outside.

So, how do we relate to the state level and how do we find connection? And what are the tensions within the network on this concept of relating and connecting to the secular health authorities?

1. Act according to the fact

It is a fact that health care is no longer delivered as caritas by the church. Health care has been secularised and is one of the main products given to the general population from the state authorities. It is a political and economical product using high-tech tools from the laboratories and factories of the impressive modern medical research.

The State level is the one that has secularised an area that used to be sacred – health care. It is the political and administrative level that gives legislations and budgets so that health care can be delivered. That is the fact – so we have to react according to this fact.

I will use as a concept for understanding our relation to this state level, a picture given to us by prof.dr Leif Gunnar Engedal in Oslo, from his lecture at the Nordic Conference on Healthcare chaplaincy last week. He was lecturing on "Where are the rooms of faith in the cathedral of health?"

Health has gone from caritas to marketplace. In EU they are talking about "Health and Wealth".

The health concept has been secularised and there is a fundamental need to protect the dignity and integrity of the patient.

Healthcare has been secularised and churches might have felt they are outsiders – not relevant for the modern healthcare machinery.

After this secularisation, we might say that both health as concept and healthcare as system in a psychological and sociological way have been re-sacralised.

The cathedral is the place we turn to in our deepest distress, where we seek advice, healing, meaning and happiness. Has the concept and system of health become this new cathedral?

2. The cathedral of health

1. Health has in our culture become wealth, happiness, control, miraculous victory over diseases and control and administration of life and death – even the control of whether life should start or be ended before birth and if life should be ended or prolonged at the end. The cathedral of health.
2. The cathedral of wealth and economy. In Europe we use a tremendous amount of economical, human and research resources to get control over diseases and illnesses and deliver healthcare.
3. The cathedral of science. Health is the place of great scientific endeavours. It is the cathedral of positivistic optimism and truth-finding.
4. The cathedral of popular political decision-making. No European politician would dare to meet the election without having healthcare at the top of the list of priority. It is one of the primary needs in the public, with great political impact.
5. The cathedral of modern managing and a paradise for modern reorganising consultants.
6. The cathedral of marked and competition between healthcare deliverers. The state level gives the budgets and the only task is to deliver high quality heath care at the lowest price possible.

3. How to connect to the state level and create rooms for faith in this cathedral

It used to be the scientific medical doctors that run the healthcare institutions. They represented the local "State level" as medical professionals. Chaplains had to struggle in discussions about the scientific value, credibility and relevance of theology and pastoral care against medical scientific research. The medical doctors became priests in this new cathedral, and took moral decisions and made miracles. Now we see that economists, administrators and legal advisors have taken over the cathedral of health.

Is there any room for faith in this cathedral?

We know, and it is our mission to know about the tremendous need for faith. Just ask the patients – and ask even the system itself.

How do we connect and should we connect?

1. Intra-church level might have been struggling on a structural level on how to understand healthcare chaplaincy as pastoral within an ecclesiological framework. This is more evident when healthcare has become a secularised economical and political marketplace. This is often solved theologically by using the concept of "categorical ministry" . A sort of church department inside the healthcare institution. A clerical visitor. It might be better for us to use the term **"contextual ministry".** We then connect to the extreme context of life/death/suffering/healing/ethical decision-making that State level administer within public health care. This is a context that actualise existential and spiritual and religious dimensions far beyond the political and economical dimensions of this new cathedral of health.
2. Modern **healthcare legislation** has changed from being legislations protecting the professions to become legislations protecting the patients. Patients have the legal right to get treatment, high quality in a secure and accountable way. They have the right to be treated according to, and in respect to their faith and cultural integrity.
3. Chaplaincy is in the modern language, a supplier of care on the spiritual, religious and existential level that links to the deep integrity and dignity of the patient. If this "product" should bee delivered from the healthcare system, we must be **accountable and responsible as profession.** The state level should have every reason to be interested in that our "product" is developed and delivered according to the healthcare responsibility to patient rights, and accountable to professional standards. State level should therefore feel responsible for secure connection between chaplaincy and healthcare administrators.
4. As the cathedral of health has become a cathedral of wealth, the new administrators are no longer only the medical doctors that ask for evidence based proofs of our relevance , but are now the doctors of economy and modern management. Their question to us will be the economy question on **"cost-benefit".** There are interesting research on this, trying to see the connection between good health and access to pastoral care. This is of great interest for the new economical leaders, but might not bee the main foundation of health care chaplaincy. We might be

relevant even if it is not obvious the we increase the production rates.

4. Integration and integrity

Healthcare is given within a secular system. Our task is to integrate pastoral care as an accountable profession within this structure. If integration is felt as a threat to our pastoral integrity, this might be felt as pain in the network. This tension should therefore be used to clarify our responsibilities, and possibilities in this context, that are in great need of rooms for faith.