

Implementing spiritual care at the end of life: Finland

In this occasional series, members of the Task Force on Spiritual Care in Palliative Care of the European Association for Palliative Care report on recent developments and current debates in their respective countries. Here, **Raili Gothóni** takes a look at Finland

Considering healthcare as being only the treatment of illness carries severe limitations. One cannot isolate body, mind and spirit and separate them from one another. However, this is what happens when healthcare personnel become more and more specialised and economic factors and technical solutions play an increasing role in decision-making. Healthcare should be much more than the treatment of any disease, especially at the end of life, where spiritual care should be part of service provision.

In Finland, the four existing hospices are built according to the model established by Dame Cicely Saunders in the UK. People approaching death are usually looked after in hospitals run by the municipalities. The current strategy in healthcare is to increase efforts to develop non-institutional care and hospital at home.

The religious landscape in Finland

Finland has 5,451,270 inhabitants and, in 2013, about 78% of the population officially belonged to the Lutheran Church and 1% to the Orthodox Church – the two national churches. An increasing proportion of the population do not belong to any religious community. At the same time, several new

kinds of religious communities are emerging. There are 1,004 registered religious groups, most of them quite small. Sociocultural pluralism, individualism and spiritual idiosyncrasy are typical nowadays in Finnish society.¹ The situation is very different between north and south, and between countryside and big cities. Formal religious faith appears to be decreasing, with a growing number of people deriving meaning of life not from god or faith, but from their own personal actions, experiences and convictions.

Pastoral care at the end of life

In the provision of spiritual care, chaplains are usually the contact persons between patients and the different religious organisations. The Evangelical Lutheran Church of Finland runs a hospital chaplaincy service and, with the healthcare authorities, issues recommendations regarding pastoral care in healthcare settings.² Hospital chaplains are employed by parishes and provide services to palliative care patients, their friends and families, as well as staff. The Standards for Health Care Chaplaincy in Europe³ are often referred to as a guideline for all faiths to shape spiritual care provided in a healthcare setting.

Since the 1960s, hospital chaplains have to undergo aptitude tests and a three-year specialisation programme after a master's degree in theology. Continuing education and supervision help them to develop their ability to understand human illness and crises, and to enhance their self-knowledge and interpersonal skills. All the major hospitals provide organised spiritual care by a hospital chaplain. In 2013, there were 112 full-time and 25 part-time hospital chaplains in Finland.

Current challenges

In hospitals, spiritual care needs often go unnoticed. When spiritual care needs are

Key points

- There are two national churches in Finland, the Finnish Lutheran Church and the Orthodox Church. Most people are still Lutherans, but religious diversity and spiritual idiosyncrasy are increasing.
- The Evangelical Lutheran Church runs a chaplaincy service, and there are clear guidelines and special education for spiritual care.
- People's need for spiritual care is increasingly recognised; but who should be receiving, and who should be providing spiritual care?
- Major challenges are to provide spiritual care to those in outpatient settings and those who do not belong to a religious group; and to increase the religious literacy of healthcare and social services staff.

recognised, care is often provided by staff who feel unsure of themselves.⁴

Another challenge is the provision of care in outpatient settings. As the need for pastoral care in non-institutional care settings increases, co-operation between parish workers becomes increasingly important and new practices are needed. Local parishes and different faith-based organisations have a great responsibility here. There are also increased demands placed on volunteers. The Lutheran Church regards deaconesses, who are church workers but also nurses, as a significant resource. It organises further education courses in pastoral care for priests and diaconal workers in all of its nine dioceses.

The problem is recognising and meeting the spiritual care needs of those who have not been active in any religious group and of people without a family network. Their needs are easily ignored, and the economic pressures and requests for evidence-based effectiveness do not help. Spiritual care is about listening to people and helping them to untangle the spiritual issues that affect their well-being. It is also about performing religious acts and rituals such as praying and meditating.⁴ The question is to whom should it be provided and by whom?

The ethnic, cultural and religious background of both patients and staff is becoming more diverse. One of the challenges is to reach out to patients from different religious backgrounds and to those who are non-religious. The focus is more and more on spiritual care, rather than on a religious-based support. Self-determination to seek support according to one's own choices and world views is clearly stated in the constitution of Finland and in the law on the status and rights of patients. This is easy on paper, but more difficult in practice. According to their ethics, pastoral caregivers respect the human dignity, beliefs and integrity of patients, regardless of background or view of life. But can they provide spiritual care to people from a different faith? The question of the need for 'interpreters of religion' of different faith groups has been raised, and Islamic organisations have been active in this area. Another, perhaps more adequate solution is to educate healthcare and social services staff in religious literacy.

The interest in religion, spirituality, the spiritual aspects of counseling and the spiritual needs of dying people has increased.

The need of palliative care patients for religion- and culture-sensitive spiritual care is increasingly recognised. It requires that healthcare staff acknowledge an individual's religious traditions, cultural background and spiritual development, memories and experience. This leads to a clear need for education and supervision that give nurses and doctors the ability to work with patients of all backgrounds, religious or non-religious.

A person's life view and existential distress are no longer expressed exclusively in religious terms. More and more people argue that non-religious persons have the right to live without thinking of religious questions, especially at the end of life. Professionals need to explore and reactivate their own spirituality in order to be able to recognise and approach their patients' different kinds of spiritual needs. A hospital chaplain must have expertise in the ethics of various religious and non-religious world views. No one should feel pressure to receive care tied up with the Christian dogma.

Conclusion

Religion is often considered as being part of the larger (and more neutral) concept of spirituality; spirituality neither excludes nor is implied by religiousness; but then how does one conceptualise religious concerns? This question has become more acute with the rising number of immigrants from different cultural backgrounds, but it would be short-sighted if we did not see the need for religious literacy. Often, the economic and normative aspects are concealing the individuals and their needs and questions near the end of life. Healthcare staff thus need education to be able to address the psychosocial and spiritual needs of their patients.

Declaration of interest

The author declares that he has no competing interests.

This article is part of a series on spiritual care at the end of life. Previous articles have been published on the Netherlands (EJPC Vol 19 No 4), Italy (Vol 19 No 6), the UK (Vol 20 No 1) and Germany (Vol 21 No 2).

References

1. Tilastokeskus. Väestörakenne 2013 [official Finnish statistics for 2013]. www.tilastokeskus.fi (last accessed 12/08/2014)
2. Evangelical Lutheran Church of Finland. Recommendations for pastoral care in hospitals, health centers and social services. Church Council and National Board of Health, 1983.
3. European Network of Health Care Chaplaincy. Standards for Health Care Chaplaincy in Europe. 7th Consultation of the European Network of Health Care Chaplaincy. Turku, Finland, 2002. http://enhcc.eu/turku_standards.htm (last accessed 12/08/2014)
4. Gothóni R. *Auttava kohtaaminen II. Sielunhoidon menetelmät ja käytäntö.* [Helping interaction. Methods and practices in pastoral care] Helsinki: Kirjapaja, 2014.

Raili Gothóni, Senior lecturer, Diaconia University of Applied Sciences, Helsinki, Finland