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The authority of Norwegian hospital chaplains

Abstract: The questions handled in this chapter concern 1) how Norwegian hospital chaplains reflect on their authority while relating to staff and patients in a multi-faith setting, and 2) whether there are differences in how chaplains from the Church of Norway (CofN) compared to Muslim chaplains, relate to authority. These questions are discussed based on Max Weber' theory of authority and an empirical material comprising qualitative interviews with 22 hospital chaplains. Results show that hospital chaplains rely on legal and traditional as well as charismatic authority. This goes for Muslim as well as CofN chaplains. There are however differences. Muslim chaplains do not have the same chances to capitalize on legal authority, a fact making traditional authority more important to them.

Introduction

> I try, but this is a rather hazardous project ... I think, however, that it is important, although it is laborious, to make sure that in the wards where I am responsible [for chaplaincy] at this hospital, the staff are going to know who I am. They are not supposed to call for a chaplain, they are supposed to call for a chaplain named [mentioning his own first name]. That is me, who they have experienced and who they can recommend to the patient. They are supposed to be sure and feel secure: If we ask him to come, we'll get something that is watertight. The problem is that the staff in the wards are replaced all the time. (Hospital chaplain *C2*[1], *CofN)*

This quote from an interview with a hospital chaplain from the Church of Norway (CofN) illustrates how a Norwegian hospital chaplain works to establish his position as part of hospital services. Three or four decades ago, hospital chaplains like this one walked the wards and offered their services to patients who they met on their way. They were present and visible. Back then, being a hospital patient meant being exposed to religious staff on a par with medical staff. Religious leaders, more precisely chaplains ordained as priests in the Lutheran Church of Norway, the (former) state church, were self-evident parts of the institutions of the welfare state, such as hospitals. This has changed and

1 The interviewees are anonymized and given an alias based on a randomly chosen letter of the alphabet and a number.

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so has the position and work of chaplains. Norwegian hospital chaplains no longer walk the wards offering their services to patients they meet on their way. They need to be sent for by a patient and/or by doctors and nurses. Meaning that it is no longer self-evident meeting a chaplain as part of services offered at a hospital, and that the position of the chaplain in terms of visibility and authority has become more blurred.

These changes in the position of chaplains as part of Norwegian hospitals is due to changes in how religion and faith is present in society at large; how it is part of institutions, communities, relations and individual ponderings over existential questions. The UK sociologist Grace Davie ([2007] 2013) underlines how the postmodern turn in cultural life in the 1980s and 1990s challenged all kinds of certainties. The whole idea of grand narratives, scientific as well as political and religious, became suspect, turning religion away from something that is imposed or inherited into a matter of personal inclination (Davie [2007] 2013, 95–97). These changes as well as immigration to Norway from every part of the world, have caused increasing plurality in beliefs and belief practices among citizens. Religious pluralization challenges the hegemony of the Lutheran Church in the Northern part of Europe (Schmidt 2010). State-church systems are suspended in Norway as well as Sweden (although not in Denmark), and there are ongoing changes in the management of religion in public institutions (Kühle, Schmidt, Jacobsen and Petterson 2018). Concentrating on the Norwegian case, religion is still present in public institutions such as hospitals, but in an increasingly plural way: Chapels are accompanied by prayer rooms, multi-faith rooms and quiet rooms. Facilities and procedures have been put in place to facilitate Muslim rituals after a patient has died. Special diets offering halal as well as vegetarian meals have been developed. Staff uniforms include hijabs and sometimes long-sleeved coats. And interfaith chaplaincy is put on the agenda.[2] Chaplains from the CofN are, however, still dominant as hospital specialists in spiritual and existential care. They have a mandate to serve all patients, regardless of belief, unless the patient asks for someone else (NOU 2013:1). A development towards interfaith chaplaincy has been initiated at just a few hospitals – but has nevertheless begun (Bråten 2019). Equally important, the practices of hospital chaplains have gradually changed from a "religious service" model to an "existential care" model, emphasizing dialogue and professionalism. A practice affected by the increasingly multi-religious and secular profile of the population (Stifoss-Hanssen, Danbolt and Frøkedal 2019, 60).

2 Information from a survey conducted in hospitals in 2017 by the Ministry of Health on behalf of the Ministry of Culture (and Church). I had permission to access the data material.

Hospital chaplains as of today serve in a shifting context when it comes to religious leadership (Henriksen 2012), influencing how chaplains shape their authority as professionals in secular institutions. Max Weber elaborates on legal authority in a text which is among the sociological classics (Weber [1947] 1959). Here, authority is defined as "power with a reason" – something that makes power legitimate (ibid., 218). This is an approach to power well suited an ambition to explore and discuss the position of chaplains in Norwegian hospitals. Power, when related to hospital chaplains, is not in the form of domination, but more subtly in the form of influence, knowledge and organizing, enabling professionals who are listened to and who matter as part of hospital care. Richard Coble (2018) writes, from a US-perspective, on how a chaplain functions "[...] through innumerable connections and vast networks", how they are connected to a department, to patients, to hospital staff and to hospital administration (Coble 2018, 4). Why is the authority of chaplains at all important? The study of religion in public institutions is, Sophie Gilliat-Ray argues: "[...] an ideal context for mapping the evolution of new religious discourses because of the way in which it is possible to see far larger issues in microcosm [...]" (Gilliat-Ray 2018, 193). Hospital chaplains are placed at the very epicentre of changes in how faith is made or not made part of public institutions in societies marked by individualization, secularization and religious plurality. Therefore, it is an important question how they engage with authority as part of hospital staff, as hospital professionals.

The questions asked and explored in the following are: 1) How do Norwegian hospital chaplains reflect on their authority in relating to staff and patients in a multi-faith setting? 2) Are there differences in how CofN chaplains (who constitute a majority among hospital chaplains) compared to Muslim chaplains (who constitute a minority among hospital chaplains) relate to authority?

The data material I analyse are qualitative interviews made with 17 hospital chaplains from the CofN and five hospital chaplains/volunteers from Muslim communities (a total of 22 interviews). I start by introducing hospital chaplaincy in a Norwegian context before I present the interview material, analytical strategies and theoretical perspectives. I use theory, mainly on different kinds of authority and different kinds of spiritual counselling, to structure the analysis on how chaplains talk about authority when they reflect on their role and practices in the hospital. Results are presented based on the three types of authority coined by Weber ([1947]1995). Finally, I discuss results and compare chaplains from different denominations.

The Norwegian context

Social change due to welfare, individualism and immigration reshape and reinvent religion and belief in different ways (Davie ([2007] 2013; Thorbjørnsrud/Døving [2012] 2017, 11–12). Swedish scholar Magdalena Nordin describes these changes as shaping a "blurred religious situation": There is increased religious plurality, a decline in religious belonging and in religious practices, but openness to spiritual beliefs and no decrease in belief in God (Nordin 2018, 162). The current situation when it comes to individual belief is, however, difficult to "measure". One way of doing so is to count members in faith communities: The share of the population that is part of the protestant, former state church, the Church of Norway (CofN), is declining steadily, but 64,9 per cent still count as members.[3] At the same time, the number of members of religious and faith communities outside the CofN has been on the increase and counts for 13 per cent of the population. The majority are Christians (most of them Catholics) and member of Islamic communities.[4] Counting members might, however, paint a somewhat inaccurate or incomplete picture. In the Norwegian survey on quality of life (2017), one question is whether the respondents consider themselves as part of a religion or belief: Only 47 per cent concur,[5] implying that individuals might be religiously affiliated without identifying closely with their community – a tendency which might be described as "belonging without believing" (Davie 2015). At the same time there might be individuals who do believe, but who lack a religious affiliation. They are "believing without belonging" (ibid. 2015). In a macro perspective, this is the plural group of people whom chaplains meet in a Norwegian hospital.

Chaplains provide religious and spiritual care within a secular institutional setting, such as a hospital, nursing home, prison, university, part of military forces or an airport (Gilliat-Ray et al. 2013, Sullivan 2014). The role has evolved from within Christian churches, but the term chaplain is, in an English-speaking context, used across different religious confessions, including humanist life stances. Interfaith hospital chaplaincy units are customary in countries such as the UK, Netherlands, the United States and Canada (Liefbroer 2020; Gillat-Ray et al. 2013; Cadge 2012; Isgandarova 2012) but are, so far, scarce in the Nordic region (Kühle et al. 2018).

3 Religion (ssb.no) (read 25.05.2022).

4 Religious communities and life stance communities (ssb.no) (read 25.05.2022).

5 Sekularisering i Norge (ssb.no) (read 25.05.2022).

In Norwegian and other Scandinavian languages, we also lack terms equivalent to chaplaincy and the related term, pastoral care. The term used in Norway to capture how priests and deacons ordained in the CofN talk about faith and existential questions with individuals who need it, is "sjelesorg", or spiritual and existential care. The term "sjelesorg" is borrowed from the German term "seelensorge", meaning "care for the soul" (Okkenhaug 2002, 7). Care for the soul is part of the practical theological work clergy and deacons in the CofN do, as well as part of public institutional caring practices: Norwegian hospital chaplains are employed and funded by the twenty public health trusts and by the relatively few private (often diaconal) hospitals. All public health trusts have what is known as a pastoral service, but a health trust usually consists of several hospitals, and not all hospitals have their own chaplain. When necessary, hospitals without a chaplain on staff use staff from the local community of the CofN and sometimes other denominations (Bråten 2019). Although they are employed at the hospital, hospital chaplains are supposed to have an authorization from their faith community – and the local CofN bishops are supposed to monitor the pastoral service at hospital units, although from a distance. The Lutheran dominance is inherited from the relationship between church and state. Kühle and Christensen (2019) refer to the political scientist Tim Knudsen and his argument that "the Nordic welfare states owes to the post-Reformation state appropriation of the church, which transformed local pastors into state officials" (Kühle/Christensen 2019, 187). Pastors were made into important local actors as part of "a religious infrastructure" in education and social services as well as health care (ibid. 187). While there is no longer a state church, CofN representatives are still very much present as part of Norwegian welfare services.

There are but four Norwegian hospital trusts with heterogeneous chaplaincy departments. The Pastoral and Counselling Department at St. Olav in Trondheim has, since 2010, engaged what is called a cultural consultant in a 30 % position working as a chaplain alongside colleges from the CofN. From the start different employees in the position as cultural consultant has been a Muslim, but since none of them have had the title imam they have been presented as *the hospital Muslim*. In the period 2015 – 2018 this department also had a hospital Humanist in a full-time position, replacing a CofN chaplain on a leave of absence. The second heterogeneous pastoral department is at the health trust in Bergen (Helse Bergen), where they have hired a hospital imam in a 20 % position. Additionally, Helse Bergen has a cultural adviser in a part-time position who is a Buddhist and does spiritual and existential care when needed (Bråten 2019). Recently the hospital trust in Tromsø has hired a hospital humanist. This is done in cooperation with the Humanist organization in Norway. Finally, there is at the Oslo University Hospital (OUS) established a temporary part time position (30 %) as a Muslim

conversation partner. This is a temporary arrangement financed through the Norwegian Ministry of Children and Family, which at the time, where responsible for religious matters. The initiative came from Oslo University Hospital in cooperation with the nursing homes in Oslo. OUS established, back in 2012, a team of voluntary conversation partners recruited from different local belief communities. The team got a specially designed training program at the Faculty of Theology at the University of Oslo. From 2019 the Pastoral Department at OUS has had the responsibility of administrating this team of volunteers. Patients who ask for a chaplain who is not from the CofN might be visited by one of the volunteers, who receive a fee for each visit. If the patient defines herself as a Muslim, one of the Muslim conversation partners is asked. If the patient defines himself as a Humanist, one of the Humanist conversation partners are asked. The volunteers at OUS and employed chaplains from other denominations in part-time positions, differ from those who have a full-time position. The former primarily visit patients who share their belief, while the fully employed chaplains have a mandate to visit all patients regardless of beliefs (Bråten 2019; Grung/Bråten 2019).

There is no standardized level or content of specialist skills required of those who are hospital chaplains (Stifoss-Hansen, Danbolt and Frøkedal 2019, 66). A kind of specialist competence known as Clinical Pastoral Education (CPE) is, however, recommended (Okkenhaug 2002, 20 – 21). CPE was started in Norway during the 1970s, inspired by similar training facilities in the United States, and focuses on psychological and communicative skills as well as theory (Stifoss-Hansen, Danbolt and Frøkedal 2019, 66). Until now CPE, has been reserved for those who are clergy or deacons in the CofN. It is considered as further training to clergy/deacons and access requires a master's degree. Qualification requirements are, however, slowly changing. An important change occurred in 2019 with a new master programme on Interreligious Chaplaincy and Leadership at the Faculty of Theology, University of Oslo (Grung/Bråten 2019).

Hospital chaplains have a mandate to provide counselling, support patients and their next of kin during crises and grief, perform rituals and act as a resource for the rest of the hospital staff regarding ethical and spiritual issues (Kühle, Schmidt, Jacobsen and Petterson 2018, 109). They relate to patients and their next of kin – but also to health professionals and the hospital as an institution. A Danish study among hospital, prison and military chaplains revealed that the top three tasks among hospital chaplains were: 1) Pastoral care/conversation 2) Religious services and devotionals and 3) Religious ceremonies (baptisms, weddings) (Kühle/Christensen 2019, 190). There is no similar survey made in a Norwegian context, but my interviews show a similar pattern. Attention is directed towards an authoritative ambition in health care policy to provide holistic care. Palliative care is, for example, explicitly targeted at providing physical, psycho-

logical, as well as social and spiritual/existential care (Meld. St. 24 2019 – 2020). Nurses and physicians are expected to take care of spiritual and existential care as generalists, while chaplains are the specialists on these matters (e. g. Liefbroer et al. 2019). Chaplains are, however, a kind of deviant specialist among hospital staff. While the medical discourse is based on natural science, existential questions – the expertise of chaplains – follow a broader and more hermeneutic logic, actualizing core questions on coherence and meaning. Joy and hope and love are essential matters. Chaplains engage in how these notions are expressed in relations, towards our self, our nearest and dearest. Society, nature as well as spiritual figures and beliefs are at the core of chaplaincy services (Boelsbjerg 2013; Walderhaug 2018).

Authority

Norwegian professor in Interreligious Studies, Oddbjørn Leirvik, differs between two kinds of religious leadership: Spiritual leadership (conducted in formal or informal positions) and organizational leadership (Leirvik [2012] 2017). While Henriksen ([2012]2017) writing about power and powerlessness among leaders in the CofN differs between what he conceptualizes as the power to lead the CofN, versus religious authority as having an impact on how people ponder over faith. The latter is, he argues, a kind of power that is more ambiguous and less transparent (ibid. 201). Henriksen regards ordained priests in the CofN in the first row among leaders in the church (ibid. 202). Hospital chaplains are, I would argue, conducting a kind of spiritual leadership. This is due to their position as legalized and certified specialists on handling spiritual and existential questions in relation to patients – but also in relation to the rest of the group of health professionals. They do not have a local church or community to lead organizationally, but they are authorized by their faith community (CofN). When the group of professional hospital chaplains also include chaplains from outside the majority Church, these chaplains sometimes also have commitments outside the hospital setting linked to their faith community – making them into both spiritual and organizational leaders. Gilliat-Ray et.al (2013) conducting research among Muslim hospital and prison chaplains in a UK context, simply consider them a kind of Islamic religious leaders.

But how to approach authority when it comes to hospital chaplains? According to Max Weber, authority is – as underlined in the introduction – power with a reason. These are reasons making power legitimate and justified. Weber conceptualizes three pure types of *legitimate* authority: Authority based on 1) legal/normative grounds, 2) traditional grounds and 3) charismatic grounds (Weber [1947]

1995, 218). *Legal grounds* rest on patterns of normative rules and the right of those who have authority under such rules to issue command. *Traditional grounds* rest on an established belief (among people) in immemorial traditions and the status of those exercising authority under them, while *charismatic grounds* rest on devotion to the specific sanctity, heroism or exemplary character of an individual person and of the normative patterns or order revealed or ordered by him (ibid.).

The three kinds of authority differ in the way they capitalize on factors inside or outside the person in a leading position. Legal authority is a kind of impersonal order. It can be exercised by all who inherit the position with a legal mandate to lead. Traditional authority is gained by those – the individual persons – who inherit the sanctioned position as leaders, and rests on traditions at hand (for example disqualifying women from inheriting leadership in some religious communities). Charismatic authority is dependent on the person and might be conceptualized as "the gift of grace" (Weber [1947]1995). It is, as Weber describes it, accessible to those who are "obeyed by virtue of personal trust in him and his revelation" (ibid.) Charismatic authority is, however, not everlasting. It has to be proved and renewed: "the charismatic ruler has to show that he is a ruler by the 'grace of God'" (Weber [1922]1990, 100, my translation).

These grounds of authority are applicable to chaplaincy framed as a kind of spiritual leadership. The Norwegian theologian and teacher in "care for the soul", Berit Okkenhaug (2002), differs between three approaches to or kinds of care for the soul (see also Grevbo 2006). One type is based on "kerygma", which means message or news. Then, the task of the spiritual caring person is to take a lead in the conversation and pass on or explain the word of God, based on normative theology. An alternative type is based on the other in the conversation, in Norwegian referred to as "konfidenten". The spiritual caring person is brought into the conversation by the other. The task is to create an atmosphere that is safe and non-judgemental in a way that allows the other to dare to talk about difficult feelings and themes. While the *kerygma* approach is based on a theological platform, the *konfident* approach relies on a therapeutic psychological platform, paving the way for a third alternative – a kind of golden mean: A *Church-based belief and life help*, an approach that takes into consideration that listening to and understanding the other is not enough, the spiritual caring person also needs to point in the direction of God (Okkenhaug 2002, 15–17).

In my interpretation, Okkenhaug's first two alternative approaches resemble the distinction between a directive and a non-directive approach in pastoral counselling (see for example Rassool 2016, 16–17). A directive approach means that the counsellor takes the lead and acts as an adviser or teacher, while a non-directive approach is client or person-centred: The counsellor is sup-

posed to be non-judgemental, genuine, and more concerned about the client's perception of the problem than of the problem per se. These concepts explicitly attach theology to both alternatives. A chaplain might use his or her knowledge about religion and belief in a directive or not-so-directive way. While the chaplain in the directive kind of relation has a message based on an evangelist intention, the chaplain in a non-directive relation pays full attention to the needs of the other as they evolve in the conversation. However, the last one might also turn to religion and belief – turning toward Okkenhaug's (2002) third alternative, belief- and life help.

If we, again, turn to Max Weber's different forms of legal authority, a directive approach in chaplaincy practice might be said to rest on tradition: The CofN-chaplain has a historical position interpreting the gospel. But the authority of chaplains might rest on law as well, at least in a hospital setting making formal competence claims to chaplains employed as part of hospital staff. Finally, authority might rest on charisma inherited by individual chaplains – on the trust he or she manage to create in relationships with patients and the rest of the staff. Given what we know about the resonance for people of belief and their eagerness to make choices for themselves, traditional authority might be the least familiar and the least useful in relating to patients in hospitals of today. Before we turn to how hospital chaplains as of today talk about authority and whether these approaches can be categorized as legal or traditional or charismatic – or perhaps all three, I will present the data material.

Interview data and analysis

The empirical analysis is based on qualitative interviews made with hospital chaplains from the CofN (17) and Muslim chaplains (5). All the CofN chaplains are employed at Norwegian hospital trusts, while the Muslim chaplains are partly employees, partly volunteers. The 22 chaplains "belong" to seven different hospitals located all over the country, six public and one private. Among the interviewed CofN chaplains there are nine women and eight men, while among the Muslim chaplains there are four men and one woman. While some of the CofN chaplains have worked in hospitals for several decades (some since the early 1980s), others have just a few years of chaplaincy experience. Compared to the CofN chaplains, the Muslim chaplains have less experience in their role.

The interviews were conducted as part of my post-doc project on palliative care in a multicultural society (2017–2020) located at the Health Services Research Unit at Akershus University Hospital and financed by the Research Coun-

cil of Norway.[6] The research project's main ambition was to reveal potential challenges in palliative care relating to a social and cultural plural group of patients and their next of kin. I soon realized that spiritual and existential care as part of palliative care was one such potential challenge. Palliative care is supposed to meet physical, psychological, social, as well as spiritual and existential needs. And with a religious plural group of patients it seemed like a paradox that hospital chaplains turned out to be mainly from the CofN. Simultaneously, I noticed that there were discussions and changes going on. The Norwegian hospital context provided access to interfaith chaplaincy in the making.

The research project was presented to the Norwegian Regional Committee for Medical Research Ethics. The Research Ethics Committee deemed the study to fall outside their remit as specified by the Norwegian Health Research Act.[7] The study was approved by the Privacy Ombudsman at Akershus University Hospital.[8] All the interviewees signed a consent form.

The interviews with hospital chaplains follow a prepared protocol of questions, but I have tried to be open to unexpected turns – to depart from the plan for a while and "go with the flow" (Johnson 2001). The interview guide starts out by asking the chaplain at hand who they are, about education and job experience, as well as why they wanted to become chaplains. Then we talked about what they do and how they do it when they are asked to visit a patient and/or their next of kin: How they are asked to come? Who asks for them? How do they prepare? How do they relate to the patient when they enter the room and in the conversation? What are they asked to do? What are the conversations about? How is religion and belief part or not part of it? We also talked about what they do when the patient in the encounter does not share their belief, about their experiences with a religiously plural patient group. My main interest has been to get access to their practices, or more precisely – since I have not observed what they do – the way they talk about and interpret their practices.

All the interviews were taped, except for two where detailed notes were made. Afterwards I transcribed the taped interviews. Then I read through the transcripts and, partly inspired by what the chaplains said, partly by theory and former research, I have defined themes and identified patterns in the interview material. The analysis is inspired by the thematic analytical method of Braun and Clark (2013). Thematic analysis can, as they describe it, be descriptive. Descriptive analysis tries to capture what is said and how the interviewees

6 ref: 256431.
7 ref: 2017/553 – 1.
8 ref: 17_101.

understand practices, situations and themes. Thematic analysis can also be theoretical, using theory to interpret and discuss what is said (ibid. 2013). The analysis presented in the following started out identifying how chaplains talked about their role and position in the hospital. Since authority was mostly talked about implicitly as part of their role, I asked reading the interview transcripts how chaplains define their role as chaplain – towards the hospital, the belief community they are part of (including how they relate to belief/God) and in relation to the patient. The next step was to use theory, mainly on different kinds of authority and different kinds of spiritual counselling, to structure what is said about roles and positions, and to interpret and discuss what is said. Results are presented based on the three types of authority coined by Weber ([1947]1995).

Legal authority: Insiders as well as outsiders in the hospital institution

Some of the Muslim hospital chaplains and all from the CofN are, as described earlier, employed at the regional hospital trusts, while the rest of the Muslim chaplains are volunteers. They are, however, a special kind of volunteer since they have agreed to be trained and join a particular group of lay chaplains. The job or appointment at the hospital and the knowledge requirements they are supposed to fulfil, give employed chaplains legal authority as professionals in their field. Employed chaplains also have a legal position as part of the hospital staff. This is providing authority they can rest on in relations to the rest of the hospital professionals and to patients. Their institutional belonging is, however, seldom made into a theme in the interviews.

Some CofN chaplains mention, though, the fact that chaplains who are not ordained as clergy or deacons in the CofN do not have the same educational background they as CofN chaplains have. As mentioned earlier, Clinical Pastoral Education (CPE) has not been accessible to those who are not part of the CofN. The alternative training chaplains from other denominations have had is insufficient, some CofN chaplains argue. In that way they establish a distinction between themselves and chaplains from other denominations, a distinction that indirectly downplays the professional authority of these “other” chaplains.

Additionally, the group of lay chaplains is not part of the hospital as an institution in the same way as employees are. They are asked for when needed in patient relations only. They are not asked to educate and supervise hospital staff or take part in ethical guidance at the hospital – something those who are employed do. In that way their legal authority is limited toward staff and the hos-

pital as an institution. The position the group of lay chaplains inherit, may all the same give them authority in relations with patients, who are not that familiar with the distinction between employees and volunteers. One Muslim chaplain explains, for example, how people he meets and who are immigrants, tend to think of him as a kind of governmental representative since he has a position at the hospital. That gives authority, but also obligations since some perceive him as someone who can sort out almost everything relating to public authorities in general and particularly in relation to health authorities.

Hospital affiliation gives legal authority through professional positions and by regulatory means. But as an institution, a hospital is also comprised of normative and cultural elements (Scott 2008, 48). In a hospital there are specific ways of relating to problems and humans who carry these problems along, this is a medical discourse focused on fixing problems (Bondevik, Madsen and Solbrække 2017). The discourse on curing and healing – and in that way solving the problems of the patient, is strong. This establishes a certain frame for how professionals relate to patients and how patients are supposed to respond, an approach easily making the way professionals relate towards patients, pretty directive. Increasing individualization and reflexivity, as described by Davie ([2007] 2013) referred to in the introduction, have shifted the medical discourse somewhat in favour of the patient as a competent agent and towards shared decision-making. There is however still a tendency to see patient choices not consistent with medical advice as illogical or deviant (cf. Blaxter [2004] 2010, 83 – 84). Contrary to this pretty directive approach, there is a tendency among the chaplains to explicitly define their role – in relation to the patients and their next of kin – in a non-directive way: Chaplains tend to define themselves as helpers, but helpers that are present not to heal or cure. The helper they speak of themselves as has an ambition to make it easier for patients/families to deal with difficult life experiences, but not to fix any problem. One CofN chaplain defines himself as a "pilot boat": There are difficult weather conditions for a while, and a need for some assistance, but these are temporary conditions patient manage to handle themselves – with a little help. Others talk of being someone who walks with the patient for a while.

As an underlying consequence, patients are constructed not as helpless and in need of rescue and fixing, but as capable of figuring things out themselves – with some assistance from a fellow who is trained in facing existential difficulties, a professional who does not evade hard questions and themes. Some of the chaplains explicitly talk of this as a contradictory way of relating to patients, when compared to a traditional medical approach towards patients. They talk about themselves and their practices as contrary to what they interpret as a dominant medical discourse. This is underlined when some chaplains refer to the

hospital as an institution relating to humans as if they were constructed in fragments, and to treat them as cars, where different parts are possible to fix or replace. In that way they point towards a tendency in medicine to deny a genuinely holistic approach towards humans, to overemphasize medical possibilities and make it difficult to accept death as part of life. These are approaches chaplains tend to emphasize that they do not share, underlined by one CofN chaplain who says ironically: "Hospitals do not prevent death, they postpone it."

Chaplains stress that to grieve, for example, is part of life, and is not a diagnosis. To grieve, to encounter death and experience crisis are part of normality; something that is difficult, but possible to deal with. And it is their mission, as chaplains, to assist others in facing reality. Some explicitly emphasise that they take this approach, representing a kind of complementary or even counter cultural competence inside hospitals. This counterculture is, for example, brought to the fore when patients are facing death. Here are two chaplains:

> [...] We all have an inherent capability to be born. We know how to do it. We do. In the same way all humans have an inherent capability to die. So, it is all about having people trust their capabilities: I have all that I need to manage to face this. Bottom line, I have (*Hospital chaplain B1, CofN)*.

> You need to accept that you are going to die. However, ... the doctor says that I am going to die, but no one really knows ... God decides. That gives him (the patient) a glimpse of hope, at the same time we have to prepare him. He has to accept that he is going to die. That is the way life is. And if he has something to sort out in his life, I can help him; if he has children and is concerned about the inheritance, if he has a family. Some want to be sent off to their country of origin when they die. Others don't, they let me know (*Hospital chaplain K1, Muslim)*.

These two quotes by a CofN and a Muslim chaplain, respectively, treat death and dying as realities to be faced and handled. The two chaplains have their attention fixed on the capabilities of the dying, on their resources and ability to accept and handle. Their role, as chaplains, is to be by their side as "pilot boats" and guides, not as healers.

Another difference the chaplains are proud to represent inside the hospital, is their special code of confidentiality. Chaplains do not need to tell the rest of the staff what has been going on in the conversation with a patient; the content of the conversation does not become part of the medical records. They are supposed to follow their own duty of confidentiality, not sharing knowledge about the patient unless it is necessary due to life and death. In this way, some chaplains argue, they have an ability to perceive the other as a human, not as a patient – and to create a "space" inside the hospital where the patient can be who they are beyond the patient role.

Hospital chaplains are part of the hospital institution and they extract legal authority from their professional position. At the same time, chaplains position themselves as a contrary culture to a medicalized hospital discourse focused on fixing humans who have a defect. They tend to define a counterculture based on a genuinely holistic stance towards people. In that way they construct an alternative to the medical hospital discourse, and a fundament for their own professional authority.

Traditional authority: Belief managers

Traditional authority rests, according to Weber, on an established belief in immemorial traditions and the status of those exercising authority under them. Traditional authority is, historically, a way to inherit authority easily applicable to understand the role and position of clergy and others who inherit spiritual leading positions as part of faith communities.

Inside the hospital, chaplains across denominations, share having a belief, or as some of the interviewed chaplains from the CofN state: "We are the ones who carry hope with us". Hope is, used like this, a rather ambiguous concept, but it is as I interpret it, linked to God or faith or – something that might work as resources to patients finding themselves in distressful situations. Implicitly, they carry God/the gospel with them – something that might be comforting and/or useful tools in relations to patients in need of support in dealing with severe problems.

This is, however, contradictory – especially in the way CofN chaplains tend to talk about it. Most of them stress that they first and foremost are professionals who carry their unique competence inherited through Clinical Pastoral Education (CPE) and through experience. They are qualified, as they talk of it, to meet all kinds of people, something that is described like this by one chaplain:

> Competence is an absolute demand. We are hired on competence, not on our belief. We have an education on world views and health, and we are supposed to take care of this for all patients. Our education is supposed to make us capable to see, understand and meet (clients) [...] (*Hospital chaplain F, CofN).*

Chaplains are, as spelled out here by a CofN chaplain, hired on competence, on their dialogical capability to address difficult existential matters meeting patients, regardless of who the patient is and what she believes in. CofN chaplain F tends to position belief contradictory to competence, an approach underlined by the words: "hired on competence, not on our belief". Others are more ambiv-

alent or nuanced, as one CofN chaplain puts it: "I believe. I am a clergy after all". Approached like this, belief is underlined as an important asset in the professional job they do as hospital chaplains. It is linked to their position as believers and to their position as ordained by or representatives of their religious community. This is, however, an asset talked about as important to handle wisely as part of their professional work. Something that is expressed in different ways in the interviews, sometimes while underlining that they do not preach; they are not directive in that way. Here are two chaplains:

> [...] I can't have salvation from evil for people facing death as my main motivation. That would have made me crazy (laughs) if I considered that as my responsibility. There are, however, Christian gospels/beliefs resonating like that, holding it as the most important. And it might be important to me, as well, beneath a lot of layers, but not in the professional job I do. [...] (*Hospital chaplain W2, CofN)*

> [...] you know, I believe in a great God who is tolerant. We are allowed respecting the beliefs of each other. But if you had asked me, as a Christian, I would have wished that the whole world was becoming Christians. Because I have a comforting belief and feel that Jesus is my best friend. But as a hospital chaplain, I think that what is most important is to take care of and meet the needs they (patients and their next of kin) have. And I am willing to go an extra mile when it comes to that, because that is – if you ask me – what is most important. [...] (*Hospital chaplain D2, CofN)*

These two chaplains reflect on how a task of proselytizing in one way is built into who they are as Christians and as clergy. They experience their own belief as a benefit, as something they find support and comfort in – and something they love to share with others. But, as both these CofN chaplains underline in their interpretations of their mandates, this is not the main part of the professional job they are supposed to do as hospital chaplains. This is explicitly underlined in the last quote, where the chaplain pinpoints that their mandate is to meet the patient and to figure out what the patient needs; a practice focusing the other, in a non-directive way. Meetings with patients and their next of kin are underlined by all the interviewees as vitally important, some even described them as almost sacred meetings.

Hospital chaplains and patients ideally relate to each other in an open and mutual way. If such a meeting is not possible to create, it might be that no relationship is established. This might be due to lack of personal chemistry (I will get back to that). But first and foremost, it depends, chaplains argue, on the chaplain's ability as a professional, on their ability to be open, respectful, humble and inquisitive in order to reveal the needs of the other person. Sometimes patients are not fully aware of their needs and the meeting is a golden opportunity to search for it. Sometimes the conversations do not encompass God, belief or

religion in any way; sometimes it is "only" a patient who wants to tell the story of his life, to reflect on difficult close relationships, or to talk about existential questions not involving religion. But sometimes the conversation comprises God, belief, or religion. This might be because the patient explicitly highlights these subjects. Some chaplains emphasise that they do not bring belief into the conversation unless the patient does. But it might also be the chaplain who brings religion into the conversation without a "signal" from the patient. Here is one chaplain reflecting:

> [...] To intercede for someone (gå i forbønn), it is quite surprisingly many who either signal or who agree when I find it natural to bring it up. They want me to do so, even if they do not define themselves as Christians or religious. They are more kind of Christians because of the crisis. Or they agree to light a candle. But I am a bit careful to suggest it. I need to be confident that the patient finds it all right. (*Hospital chaplain Y2, CofN)*

The quote illustrates situations where chaplains are the ones who put God on the agenda. This is, however, addressed as something that needs to be done very carefully, without being insistent or intrusive. Some CofN-chaplains describe how they might say something like: "You know I am a clergy, is there anything you want me to do?" The reasons for bringing this into the conversation are several. One is a perceived lack of spiritual language among people, a kind of embarrassment concerning God and religion. The patient may not know whether they need or want to talk about belief or do symbolic things like lighting a candle. Or it might be that God is needed because a crisis has occurred. But a tendency to hint at belief and/or symbolic practices also concerns who the chaplains perceive themselves to be in the relationship and the tools they keep in reserve: They are the ones who carry hope, who carry God and belief with them. Although it is underlined in the interviews that it is often difficult to tell how they, as hospital chaplains, are interpreted by others, they tend to think that patients are well aware of their role as members of the clergy. One CofN-chaplain talks about how some patients, for example, mention angels in the conversation in a way they perhaps would not have brought up while relating to any other kind of professional:

> [...] I think that, even if I do not believe in angels – at least not very much – I think that this is part of the symbolic universe of a Christian culture and a Muslim culture as well, this is part of their tradition. A lot of people believe in angels and relate to angels. Angels might mean a lot of things. Many carry this picture of an angel watching you, like the picture you used to have beside your bed as a child. Angels are related to safety, and I think it is part of the symbolic universe I as a clergyman carry with me, even if I do not mention it at all. But because I am a clergyman, it is with me [...]. *(Hospital chaplain H1, CofN)*

Even if this hospital chaplain does not mention God and religion and angels, this is something he expects people to think is possible to bring into a conversation with him. The chaplain expects people to expect that these themes are part of his mandate, something he can handle based on the toolbox in a chaplain's disposition. Chaplains tend to think that these are expectations making it natural to bring religious matters into the conversation for patients, and from such a viewpoint it is also plausible for chaplains to bring religion into the agenda.

CofN-chaplains report a tendency among patients who have asked for or agreed to meet the chaplain to underline that they are not very religious. Patients tend to refer to their belief from childhood (in Norwegian: *barnetro*), they talk about how they are baptized and have married in church, how they used to pray in the evenings, but still – that they perceive themselves as not that religious, or only a little religious. Chaplains interpret this way of talking as a kind of religious embarrassment and as a need for religious privacy considered common among Norwegian Lutherans. I will argue that an additional interpretation is possible: That this is a way to ask the chaplain whether they qualify as Christians, whether their belief is sustainable and good enough. CofN chaplains are, in my interpretation, read as religious authorities by the patient, as someone who is in a position not just to carry God with them, but to know how God resonates. The tendency among the interviewed chaplains is not to step back and refuse to be an authority on such matters. They tend to meet these questions with reassurances that all kinds of belief are good enough. Indirectly, they accept their position as religious authorities, although these incidents are not talked about as situations where they exercise or display authority. When they explicitly talk about being religious authorities, it is usually as part of narratives involving sacraments.

Sometimes chaplains are asked for advice. This might – as we have seen earlier – be practical advice, but it might also be ethical questions: What is right and wrong? How ought a person to live the rest of their life? Chaplains talk about how they respond by giving practical advice, but also by attempting to activate belief as a mastering tool. The patient's image of/relation to God is brought to the fore. Sometimes this is a relation that is experienced as good by the patient, sometimes it is experienced as bad. If it is bad, then it is necessary to change or reform or adjust it. Some chaplains tell how they reflect together with the patient on how it is possible to use belief as an asset, how it is possible to activate resources the patient inherits. This might include praying for, or together with, the patient, blessings, confessions and on some occasions (for chaplains from the CofN) Communion. These are talked about as powerful "tools" brought into the meeting by the patient or by the chaplain. However, they usually ask patients or their next of kin for permission:

> [...] Sometimes, a few times, I am allowed to be clergy and confessor. It is seldom, but it happens. [...] (*Hospital chaplain D2, CofN)*

Are there differences when it comes to being religious authorities, comparing CofN and Muslim chaplains? Are Muslims chaplains more directive based on religious tradition, more eager to give concrete advice? When it comes to focusing on law and legal interpretation of the Qur'an I find a tendency in my interviews with Muslim chaplains to emphasize this. For example, one voluntary Muslim conversation partner underlines how on several occasions he has been asked (by hospital staff) to come to wards to clarify in disagreements between patient and health professionals:

> [...] A classic is Ramadan and medicalization. The patient needs to get his medicine at the exact time, and then the patient wishes to fast at the same time. And then a dilemma occurs ... and then I have been asked to come to talk to the patient and the next of kin and tell them that it is ok, you can do it (to fast) when you are getting better, now it is your health and getting well that have to be first priority. (*Hospital chaplain, E2, Muslim)*

The Muslim chaplain is asked to come to talk to the patient. The mission, the reason why health professionals ask him to come, is the need to sort out a difficult situation at the hospital ward. Hospital staff find that they lack authority on a religious matter. Consequently, they need to get someone the patient and the patient's family will listen to. This concrete hospital had no Muslim chaplain among their employees and the voluntary Muslim chaplain was asked to come. Entering the disagreement, it turns out that this chaplain inherits the kind of authority required. How this is achieved in relation to the patient, on what grounds, is not elaborated on when he talks about such occurrences. However, the chaplain reports that when he arrives as a Muslim chaplain, patients often tend to think that he is an imam. At least he thinks that they think he is an imam. And although he is not, he usually does not tell them. Anyway, he has the authority – and I interpret it as traditional, in addition to the legal authority he inherits from being paged by hospital staff as a Muslim chaplain. The paging is important, because an important reason for Muslim chaplains to be preoccupied with giving legal advice based on their religious expertise is that this is asked for by hospital staff. They are explicitly asked to be traditional religious experts because that is what the hospital needs in some patient encounters. Sometimes, when there are critical situations and no Muslim chaplain is available, hospital staff ask a CofN chaplain to come and solve the problem via law and a legal interpretation of the Qur'an. That might work as well, but then the CofN chaplain acts based on knowledge about Muslim belief (a kind of professional and legal authority) not on their own belief or authority inherited

through tradition. These situations differ from those where they face patients who want a Christian chaplain's opinion on their status as believers.

Charismatic authority: Partly personality, partly expertise

Finally, we turn to charismatic authority. This is the most mysterious kind of authority the way Weber describes it. It rests on the individual person and the person's sanctity, heroism (something done/achieved) and character. Weber refers to it as a gift of grace. As a gift of grace, it can be considered as granted to some, but not to others. At the same time, Weber underlines, that this is dependent on trust – a kind of personal trust individuals must struggle to inherit. In that way it is not given, it needs to be activated or constructed. When I ask about their chaplaincy practices, there is a tendency among the interviewees to state that they "use" themselves. To use oneself differs from using legal position, pastoral care techniques or traditional religious authority. What is it that they use when they use themselves? In the following quote from an interview, the interviewer (me) and a CofN chaplain elaborate on this:

> CofN chaplain, I1: [...] You need to be present as a person, in the situation. [...] I often think, what is my competence? Well, I am a theologian and therefor I have conducted an extensive program of professional study. I have studied other subjects as well and I have worked as a clergywoman in a congregation and now ... here. But then I think ... that it (the things she does) is not in a way possible to ... it can't be formalized, it's just there. I tend to think that I do not know very much, but then I get these responses; it was good, it was really important that you asked those questions, it was just so good that you were present with those people, or they managed to calm down when you had visited and talked with them. So, I think ... I do not know what it is that I am good at, but I am.
>
> Interviewer: A bit like riding a bicycle?
>
> CofN chaplain, I1: Yes, a bit like that ... and when you ask, what do you say to them? Well, what *am I* saying? When I have greeted people and looked them straight into their eyes, then it just goes on ... in a way. It starts where it starts. I do not know what I am saying ... actually.
>
> Interviewer: And at the same time, you know, because as you have told me: You need to be really present, something can't just slip out.
>
> CofN chaplain, I1: No, it can't for sure. And I am pretty conscious asking open questions, giving people a possibility to "go and get" some of the things they are struggling with and thinking about, if they want to share it. [...]

In the conversation we – the chaplain and the interviewer – try to capture what it is that makes this chaplain good, what it is that makes patients and hospital staff telling her that her presence is important. This is talked about like trying to capture and name something that can't be captured. It can't be "formalized", she says – "it's just there". Chaplain I1 talks about a capacity that is present and real, in a rather general and abstract way. But many interviewees, Muslim and CofN chaplains alike, use examples when they talk about their practices, sometimes to illustrate typical or difficult situations and questions, but also to present a kind of best practice. I do not interpret this as bragging or something they do to "sell in" chaplaincy in hospitals, I rather interpret it as a technique to explain to me something that is difficult to put into concrete words. An example is a Muslim chaplain who tells about a patient who reassured him, when he entered the patient room, that she "knew everything about Islam" and "that she had told the nurses that she did not need anyone to talk to". But, the patient added, "since this was what the Muslim chaplain did for a living, he was welcome to sit down and talk to her". A rather unwelcoming start, but after five minutes, the chaplain explains: "She told me the story of her life". When I ask him to elaborate, he explains:

> [...] She did not know who I was. It's not enough to tell them that you are a conversation partner and that's it. It is no use thinking; that is what it takes to create safety necessary to talk to me about almost everything. That is not the way it works, unfortunately. We humans, we are all different and we need time. But the minute she understood that this is someone who is completely independent, he does not care about who I am and what I do and ... he is present only in order to listen to me. He is here to me ... then she started to tell. (*Hospital chaplain B2, Muslim)*

Based on the story of the patient who did not need to talk to anyone, but who ended up telling the Muslim chaplain the story of her life, the more abstract considerations of chaplain I1 and the quote in the introduction, it is possible to trace a couple of marks distinctive to these chaplains and their practices. The CofN chaplain quoted in the introduction talks about being not any chaplain, but the chaplain *he is* – the watertight one. All three touch trust and safety as notions in need of construction, not present when they enter the room, but possible to construct in the relation. They "use" themselves and who they are, their personality as well as a trained intuition. This is perhaps why Weber writes about charisma as a gift of grace in need of activating. But there is more to it, they activate distinctive techniques using time and patience to signal an ambition to be present and to listen, having no other agenda. To be able to communicate this, can be interpreted as a kind of expertise, possible to learn and cultivate. It is about a genuine interest in the other person, about asking open questions

(and not fearing any reply or follow-up questions), about strength and inner security – an ability to be beside other people when life is at its most difficult. Interpreted like that, the x-factor of charismatic authority is also a technique. Something it is possible to learn and train to be proficient in.

Concluding discussion

The questions posed in the introduction concerned how Norwegian hospital chaplains reflect on their authority in relating to staff and patients in a multifaith setting. Secondly, whether there are differences in how CofN chaplains (in majority) compared to Muslim chaplains (in minority) relate to authority.

Norwegian hospital chaplains shape their work relating to staff and patients in a religiously plural setting. They need to be recommended (by staff) and asked for (by patients). This is an institutional fact placing them in a position where they need to build authority in one way or another. An important question is how they legitimize a role as an expert in a context and a time when people's belief is chosen, not inherited. Hospital chaplains not necessarily inherit authority as automatically attached to their position.

In the introductory quote, a CofN chaplain is concerned about the personal factor: He wants staff to know him and to perceive him as good with the patients. The reference to the personal factor points to charisma as an important asset, a kind of grace or intuition or x-factor, but at the same time – as we have seen – techniques and part of training, an expertise. To be watertight is also to be a convincing professional, someone who identifies what is needed and who is capable of handling it. Chaplaincy work is, however, professional work without an accurate manual. The personal factor is assets chaplains carry with them in their professional work, their way of relating to people of faith and those who do not know what to believe in.

Traditional authority is easily applicable when the leaders at hand are spiritual, being part of a tradition of spiritual leadership. This might be the way the spiritual part of religious leadership and authority is historically portrayed. Those who are clergy in the CofN also have legal authority as employees in the hospital institution; they are part of Norwegian hospital history, of a tradition where first Roman Catholic and then Protestant clergymen were important cornerstones in the first caring hospitals, forerunners to the curing hospitals. When the very first curing hospital with a national mandate (Rikshospitalet) where established in the Norwegian capital almost two hundred years ago, the group of employees included two professors in medicine, two physicians, four candidates (physicians to be) and an hospital chaplain (additionally, administra-

tive personal and those who should look after the patients during the day) (Evensen 2017). When curing hospitals were established, medical and theological professions where both present. Hospital chaplains from the CofN have been present since. But the hospital environment and the role of religion as part of it, has changed tremendously – making traditional authority less important. Hospital CofN chaplains as of today are required to have theological academic education (as they always have had) but they are also required to have additional training and professional expertise in spiritual and existential care, *and* they are ordained as clergy by the Church. As a vicar/pastor in a protestant Church, they are preachers, managers of sacraments and rituals and spiritual advisers.[9] They are religious leaders by law. The interviewed CofN chaplains tend to downplay their traditional authority compared to their legal – and especially the professional part of their legal authority. This may be interpreted as caused by the environment they work in, health workers are professional workers, building their authority on their professional expertise. CofN-chaplains underline that so are they. Additionally, focusing professional capacity is focusing on the entrance requirement (cf. Leseth & Solbrække 2011) to the chaplain profession. That said, CofN-chaplains are also aware that they are framed and approached as clergy by patients, positioning them as someone possible to talk to on spiritual and existential questions. They tend to underline how they differ from other health professionals, having a guiding and supporting role as complementary or counter to the curing role.

Traditional authority, as Weber ([1947]1995) coined the term, is plausible to interpret as working through a directive approach to patients. However, as we have seen, it does not need to be so in a plural and individualized setting. When chaplains from the CofN meet with patients who underline that they are not very religious, and in that way indirectly ask the chaplain to evaluate their belief, chaplains take on the role as evaluators. But they do this in a rather non-directive way, by reassuring people that there are no definite standards attached to belief. They act, in such relations, as religious authorities, an authority not easy to frame as based on their clinical pastoral care education. Their practice as trusted evaluators are more likely to rely on their traditional authority as clergy.

Muslim chaplains who are imams or have other positions/roles in Muslim communities and mosques, lack a formal legal confirmation as religious leaders in a Norwegian context. Although some of them have had some official training in spiritual and existential care, they have not had permission to Clinical Pastor-

9 https://snl.no/prest (read 15.11.20).

al Education (CPE). Compared to their Lutheran colleagues, Muslim chaplains in a Norwegian context are more dependent on traditions when it comes to authority construction. Most of them lack a formal position as hospital staff and the professional requirements attached to it, both important assets to legal authority. They are however, by patients who are not that into formal legal requirements, often interpreted as part of the hospital institution – since they are send for by hospital staff and have a kind of position in the institution. Still, when Muslim chaplains are trusted on their legal advice, it seem to be part of the traditional authority patients, their families and staff ascribe to them as religious leaders. This is an authority not caused by formalized education or their capacity as hospital employee – they might lack both – but in their position as part of a Muslim tradition, as an imam (some are), as part of a specific mosque or religious community.

Gilliat-Ray et al. (2013) have done empirical research on Muslim chaplaincy in institutions in the UK and state that "there is no formal institutional tradition of pastoral care in Islam" (ibid, 2), a point of departure making it important how the interviewed Muslim chaplains understand what they do in their capacity as chaplains. Gilliat-Ray et al. (2013) find that Christian and Muslims chaplaincy practices are very much alike – in a UK context. They are both influenced by an assumption that public spaces and institutions "will not be used to evangelize or coerce captive or needy people into particular belief systems" (ibid. 169). The focus of their work "lies with supporting people as they cope with the realities of institutional life, and the challenges of illness, death, imprisonment or other transitions" (ibid. 173). This is pretty much in line with what I find in the Norwegian hospital context – comparing Christian protestant and Muslim chaplains. However, Gilliat-Ray et al. (2013) argue that there are also differences when Muslim and Christian practices and understandings are compared: one being that Muslim chaplains more often need to facilitate a range of Islamic practices, another that Muslim chaplains more often have to explain their role to others, and a third that Muslim chaplains often have a distinctive focus on law and legal interpretation of the Qur'an, while Christian chaplains are not so concerned about "correct" belief or practice (ibid. 169).

I find that the Muslim chaplains interviewed in a Norwegian context often are asked (by hospital staff) to interpret what is said by laws and written texts, while CofN chaplains more seldom are asked to do the same. It can be considered as two rather different things to reassure a patient that there are no particular faith standards versus interpreting religious "laws" on for example how to fast. But CofN and Muslim interviewees share a rather pragmatic stance. They are eager to interpret the needs of the patient and the needs produced in each situation, such as disagreements on medical treatment. They also share

how religious questions and ponderings seem to be close at hand when patients address them – compared to when patients address others among hospital staff. This might be because of the professional capabilities of chaplains – they know the Bible and the Quran, they know rituals and symbols, they know prayers, and patients know that they know. They are religious professionals. But there is more to it. The example of CofN chaplains being asked about texts in the Qu'ran, or about Muslim rituals, illustrates this. When CofN chaplains are asked about Muslim matters, they are asked in their capacity as religious professionals (in a legal capacity), not as an authority managing religious traditions and history. When a Muslim chaplain is asked, he is addressed – or so it seems – as both a professional and a traditional authority on religious matters. More the latter than the former, since legalized professional training as a Muslim chaplain – in line with the training CofN chaplains get – is not possible to achieve in a Norwegian context.

This is an important point to make, because as Gilliat Ray et.al. (2013) underlines, the context, the institutional frames chaplains work "inside" influences their practices and how they understand their role. Muslim chaplains in a Norwegian context are bound to be more dependent on their traditional authority. This is due to their weak legal position in hospital institutions compared to their colleagues from the CofN. Muslim chaplains are in minority and they also lack the legal position CofN chaplains have, since they are engaged in part time positions or as lay chaplains (conversation partners).

Chaplains work in a context and with people who tend to live religion not by the book, but by the needs and existential ponderings in difficult situations. To be trusted as an authority in these relations seem to activate all the three kinds of authority. Chaplains (in my interviews) are hospital employees or part of a formalized group of volunteers at the hospital, and they all have *some* education and formalized training making them professionals. Their legal authority rests on these credentials. Chaplains are also spiritual leaders activating a heritage from their predecessors and carrying along hope but also sacred insights. Their traditional authority is made up of this. Finally, chaplains are persons with their own individual way of relating to people but also with a particular need to train and activate their individual way of relating to others, to hone their ability to be a fellow human being. Their charismatic authority rests on this activation.

To be a hospital chaplain does not rely on only one of these parts of authority, it relies on all three. This goes for Muslim as well as CofN chaplains. But, due to their different possibilities to obtain formal education and qualify as employees, they are given different chances to capitalize on legal authority, a fact mak-

ing traditional authority more important to Muslim chaplains as part of hospital institutions.

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