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Liidia Meel  
*University of Tartu, Estonia*

Tõnu Lehtsaar  
*University of Tartu, Estonia*

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INTERDISCIPLINARY TEAM-BASED PASTORAL CARE:
A POTENTIALLY ADAPTABLE MODEL FOR ESTONIAN
HEALTHCARE INSTITUTIONS

By Liidia Meel and Tõnu Lehtsaar

Liidia Meel, University of Tartu, Estonia. She is a PhD student in the University of Tartu Faculty of Theology (Tartu 50090, Estonia). She has a master’s degree in social work, additional applied higher education in pastoral care and working experience as a clinical social worker and pastoral counselor in North-Estonia Medical Centre and Tartu University Hospital. Previous publications: “Implementing spiritual care at the end of life: Estonia,” EJPC, 22(1, 2015): 36-37.”Socio-Cultural Aspects of the Development of Contemporary Clinical Pastoral Care in Estonia: A Systematic Review,” Health and Social Care Chaplaincy, 4(1, 2016): 57-70.

Tõnu Lehtsaar, University of Tartu, Estonia. He is currently working as the staff counselor-chaplain at the University of Tartu, Estonia. He has a diploma in social psychology, PhD in education and a doctorate in psychology of religion. He has written several university textbooks concerning pastoral counseling and interpersonal communication in the Estonian language.

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ABSTRACT

This article aims to build a potentially adaptable model of clinical pastoral care for Estonia’s healthcare institutions. To help the development of spiritual support provision in Estonian healthcare institutions, we are currently working on creating a model of clinical
pastoral care that would be in accordance with the local circumstances. Preparatory research in the matter has addressed the socio-cultural and institutional context that shows the great need for interdisciplinary teamwork. The current article offers concrete proposals in the following main points: a) presentation of the pastoral caregiver; b) main actors; c) forms of cooperation; and c) education and internal trainings. The model construction draws information from international research and considers it in Estonia’s local context.

Spiritual support provision in Estonia’s healthcare has not yet been taken for granted and the concept is not fully understood. Secularity and religious diversity also set complex frames. Therefore, the model is suggested in guiding proposals, not in a rigorous structure. As such, the model could also be useful for healthcare spiritual support developments in other countries with similar characteristics. The article also poses possible questions of the implementation potential of the model.

**Keywords**: pastoral care, healthcare chaplaincy, spiritual support, interdisciplinary team, holistic care, patient centered care.

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**Introduction**

Lately, international discussion in holistic healthcare has addressed spiritual support measurable outcomes as well as its ethical rationale. Different models have been created for integrating spirituality into patient care, also emphasizing the importance of model adaptability in particular settings and cultural environments.¹ Next to clinical pastoral care, there is the idea of wider spiritual support in healthcare institutions. That includes different

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team members recognizing and responding to patients’ spiritual needs—referring to possibilities of receiving particular spiritual (including religious) care or offering a supportive presence.  

To help the development of spiritual support provision in Estonian healthcare institutions, we are currently working on creating a potentially adaptable model of clinical pastoral care that would be in accordance with local background. Preparatory research in the matter has addressed the socio-cultural and institutional context where clinical pastoral care in Estonia has to function. The conclusions of these two studies show the great need and also the will for interdisciplinary teamwork.

Interdisciplinary teams in healthcare settings have been highlighted as more flexible than multidisciplinary ones, also engaging different specialists more through informal cooperation and lessening the status differences. The purpose of the current article is to present a potentially adaptable model of interdisciplinary team-based pastoral care for healthcare institutions in our specific context. For creating the solid model, we offer concrete proposals in the following main points: a) presentation of the pastoral caregiver; b) main actors; c) forms of cooperation; and c) education and internal trainings.

We also point out that this potentially adaptable model is not perfect or the best possible solution that would not need further development. It is the one that would be the most

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acceptable for our patients, medical staff and organizations at the given moment, considering our current circumstances. The context analysis indicated a transition period in our healthcare, with spiritual support only rooting and palliative care developing. Since during the Soviet period, religion was banned from hospitals, spiritual support provision in healthcare has not been taken for granted nor is the concept itself fully understood. Pastoral care is often associated either with end of life care or with a strictly Christian worldview. Therefore the model cannot be suggested in any rigorous structure but rather in guiding proposals. As such, the model could also be useful for healthcare spiritual support developments in other (especially post-Soviet) countries with similar characteristics as Estonia. Should the proposals be accepted in our healthcare system, we can in time move towards a more structured model.

**Method and Design of the Article**

The article uses research synthesis for selecting and combining relevant studies in the subject field. The chosen approach allows us to inform the different aspects of the model by looking at the international research and current Estonian situation. The latter is presented through the preparatory context analysis and related research in Estonian pastoral care, healthcare and socio-cultural background. Searches for international literature was conducted from February 2016 to December 2016 in MEDLINE, EBSCO, Scopus, Social Science Research Network and Google Scholar databases, using a combination of keywords including “healthcare”, “spiritual support”, “pastoral care”, “interdisciplinary”, “chaplaincy”, “holistic care”, “teamwork”, “outcome/s oriented” and “patient centered”. Complementary theoretical background is used to explain the mutually interwoven nature of holistic care dimensions, such as the physical, psycho-social, spiritual, and also organizational components.

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6 Meel, “Socio-Cultural Aspects.”
According to the design of the article, it introduces in the first section the pre-existing foundations in Estonia; in the second section, it deals with building the model; and in the third section, it discusses the possible questions about its implementation potential. The conclusion summarizes the model by extracting the concrete proposals for each section.

The Existing Foundations

The analysis of Estonian socio-cultural context shows the following cornerstones: 1) cultural and religious diversity; 2) a mainly secular society, while at the same time, expecting the Church to participate in caring for the people in need; 3) an indicated need for interdisciplinary cooperation; 4) the Estonian healthcare chaplaincy’s openness to international discussion, sharing the best practices and orientation to become more research-based; and 5) the clinical pastoral care in Estonia which is not financed from the state budget health insurance funds. Estonian institutions are also moving towards a more human-centered management, which values cooperation and networking.

The research on the institutional setting of Estonian healthcare institutions adds to the previous specific findings: 1) the perceived need and good will for interdisciplinary cooperation with a pastoral caregiver; 2) the expressed need for internal trainings in the subject of pastoral care among other healthcare professionals; 3) the preference of a pastoral caregiver to be a professional member of the staff; 4) the disposition of medical staff—half of the respondents believe or tend to believe in the existence of the benevolent higher power; 5) the need to explain the pastoral care working outcomes; and 6) the need to clarify the presentation of the pastoral caregiver in healthcare institutions.

7 Ibid.
8 Eneken Titov, “Management Paradigm Values in Real and Propagated Level as Prerequisites of Organisational Success” (PhD diss., Tallinn University of Technology, 2015).
9 Meel, “Defining the Context”.
According to the analysis of the current situation in Estonian pastoral care, the following characteristics are presented: 1) practical theology and pastoral counseling that are getting closer to the social scientific approach; 2) the start and development of a chaplain’s institution at healthcare, police, and military settings; 3) different churches that have started their own pastoral care services; 4) working out a professional standard for chaplains and pastoral counselors; and 5) a widely reported need for conceptualization of the role and meaning of counselor at concrete institutions.  

Based on these findings of the context analysis and the analysis of the current situation in Estonian pastoral care, it can be suggested that pastoral caregivers in Estonian healthcare institutions should be:

- mainly outcome-oriented, supporting their work with adequate research, and able to express their working outcomes in a language understandable to co-workers and management;
- prepared to “join forces” with members of the institution’s psycho-social support (clinical psychologists and social workers) for upholding the idea of holistic care and making their voice heard in management;
- focusing on existential questions and spiritual/religious reflections while also being able to address social and psychological issues as well as potential cultural conflicts;
- a supportive member of the institution’s working community: adjusted to interdisciplinary teamwork, well-prepared for giving internal trainings and supporting the staff, while also being aware of the possible lack of cooperation due to different worldviews and the fact that spiritual support provision is not yet fully rooted in our healthcare;

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• open-minded towards cultural (incl. spiritual/religious) diversity, but also able to
detect harmful practices that could affect the patient’s treatment; and
• rooted in their own faith but not exclusively propagating their worldview.  

These above-mentioned observations are to be taken as a basis for the model creation and
to be addressed on theoretical background and earlier studies.

Building the Model Body

Based on the context analysis, the following parts of the model body are outlined: (i) presentation of the pastoral caregiver; (ii) main actors; (iii) forms of cooperation; and (iv) education and internal trainings. Each are to be built by looking at the international research and theoretical background according to Estonia’s specific characteristics as noted above as well as considering the need for interdisciplinary treatment, education, assessment, and management.

Presentation of the Pastoral Caregiver

The current aim is to address the matter of introducing the profession of pastoral care in
everyday contact with patients and co-workers, during the internal trainings and in preparatory education, in contact with management, and also to the wider public.

With three different organizational forms of spiritual support provision, Estonian clinical pastoral care faces the question of self-presentation. Professional standards have been set and Estonian healthcare chaplaincy has shared ENHCC’s (European Network of Health

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12 Community clergy visits; hospitals permanent chaplains or pastoral counsellors; chaplain or a pastoral counsellor as a member of a hospital's palliative care team (Meel, “Socio-Cultural Aspects”).
Care Chaplaincy) common statement, which has been issued to clarify the basis of professional presentation in the context analysis. The question still remains: in order to highlight the value of spiritual support in healthcare, is our work better explained through the process of a supportive presence or measurable outcomes?

The idea of “hopeful presence” is seen as a value in itself with no prescribed but still observable outcomes. As such, it almost reached its unique position in the end of life care also seen in Estonian healthcare institutions. We say “almost,” because for example, in 2013, pastoral care was integrated and pastoral caregivers were valued as team members, also supporting the staff in Estonian hospice care. Now, we can see standstill and some relapse here. Health insurance fund still does not see spiritual support as an integral part of healthcare, and since October 1, 2015, East Tallinn Central Hospital officially abandoned offering pastoral care service.

The problem of funding as well as the expectations of individuals pressure Estonian clinical pastoral caregivers to explain the outcomes of their practice. In connection with Christianity or other spiritual practices, people in Estonia seek mainly practical aid and solutions to solve their problems. When talking about aligning with the international professional community, there also has been a general call to action stressing

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14 Meel, “Socio-Cultural Aspects.”
15 Steve Nolan, „Re-evaluating Chaplaincy: To Be, or Not…“ Health and Social Care Chaplaincy, 1(1, 2013): 69-60, doi: 10.1558/hscc.v1i1.49
16 In Estonian healthcare hospice care is offered in hospital departments.
18 East Tallinn Central Hospital, e-mail message to author, November 30, 2016.
the healthcare chaplaincy’s need to become more outcome-oriented and evidence-based.\textsuperscript{20} And, of course, there already has been some discussion about the difficulties, possibilities, pros and cons of outcome-oriented approach. Outcome-orientation has been addressed as beneficial by many authors—conducting the research and defining the outcomes would help us to identify and meet the needs of the care-seekers, and enhance the mutual understanding in interdisciplinary cooperation through clarifying what pastoral caregivers actually do.\textsuperscript{21} Potential problems and limitations are pointed out as the lack of research-based definitions.\textsuperscript{22} Problematic is the fact that pastoral caregivers would sense the conflict between the “transcendent” aspect of their work and normal criteria of outcome measures.\textsuperscript{23} There is also the need to develop the suitable tools for studying spiritual matters.\textsuperscript{24}

The outcome-oriented approach allows us to present spiritual support measurable benefits to the institution’s management. But what about the rationale of spiritual support provision if assessment is complicated or spiritual support seems to have only a marginal effect? This is not a problem in its essentials for caregivers, as the presence and outcome-oriented approach can be and certainly are used as parallels. Nolan issued an invitation to re-evaluate chaplaincy so that it would benefit from an outcome-oriented and evidence-based


approach, but in ways that value and promote spiritual care through a person-focused presence. In their call to action, Handzo et al. stress:

[---] this should not be interpreted to mean that the patient's values and expectations and the chaplain's professional expertise, ways of relating, and professional wisdom rooted in rigorous formation and nurtured by ongoing reflective practice are no longer of value. [---] Research-developed evidence needs to be included as a driver of better care but only as a driver along with others, not as the driver (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). [---] The evidence for chaplaincy outcomes can be developed without compromising the sacredness of the chaplain-patient relationship.

It may become a problem if among the institution’s management and in healthcare policy, the outcomes are seen as the sole reasoning for spiritual support financing. The potential problem is ethical from the point of view of the decency of healthcare institutions in general. Sedmak has addressed the subject of decent institutions in the ethical perspective of business success through sustainability, and presented it also in the context of healthcare chaplaincy. Inspired by Avishai Margalit’s The Decent Society, he claims: “decent institutions are those that do not humiliate people; these are minimum standards for humane hospitals and should not be hellish. Among other things that make an institution hellish are: no opportunity for discussing the question Why, and no room for individual thinking and expression.”

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25 Nolan, “Re-evaluating Chaplaincy..”
26 Handzo et al., “Outcomes”.
30 Sedmak, “Challenges”.

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Another relevant conclusion from *The Decent Society* is that a person should not feel deprived from any essential part of their lives. The latter is something that inpatients may easily feel, being unable to follow their usual religious/spiritual life outside, if not granted any spiritual support inside the hospital. From this perspective, spiritual support as an important part of holistic approach can be taken for granted. Next to the outcome-oriented reasoning, spiritual support also has been recognized as “affirming the worth of an individual” in holistic care for long-term conditions, fostering the humanity of the patients in emergency medicine, and considering in counseling the results of research in the field of psychology of religion and psychotherapy.

Being a part of holistic care (WHO definition of palliative care), spiritual support would be at least accessible for every patient at their own will and the staff would have basic knowledge for recognizing spiritual needs and referring to a pastoral caregiver. Therefore we propose that professional presentation of the pastoral caregiver should stress both the importance of supportive presence for granting the ethical minimum and measurable outcomes for addressing the patients’ particular problems and for further organizational planning.

When dealing with the patients’ particular problems through interdisciplinary teamwork, we have to discuss potential role confusion and conflict. Role blurring, role conflict and role

31 Margalit, *The Decent*.
competition have been seen as undermining teamwork.\textsuperscript{36} Lack of clear role definition also has been found to be stressful for pastoral caregivers.\textsuperscript{37} Better team functioning can be reached by both clear defining roles and interdisciplinary training, as well as policies, resources and structures that would support the interdisciplinary team model.\textsuperscript{38} Continuous education of the team members and including caregivers in the reflective process of patient care can also be seen as promoting active learning and collaboration within the teams.\textsuperscript{39}

In multi-professional education, Atkins has stressed the importance of respecting the traditions and maintaining the self-confidence of different professional groups. He points out the potential resistance (also retreat and rejection to a change) with the elements similar to bereavement when group boundaries and traditions are threatened by integration.\textsuperscript{40} The same can be experienced by the pastoral caregivers in the process of integrating spiritual support in healthcare, which demands specific consideration of other disciplines according to the particular area of practice (e.g. oncology, rheumatology, mental health, end of life care etc.). Such behavior can be related to the patterns of thinking learned during previous experiences.\textsuperscript{41} Whether these experiences have been positive or negative, creating either confusion or clarity, influences further teamwork and therefore also need to be addressed through highlighting the possibilities and boundaries of each profession. For example, the study in Estonian hospitals show that the majority of medical staff working directly with

\begin{footnotesize}
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\item Moira O’Connor and Colleen Fisher, „Exploring the Dynamics of Interdisciplinary Palliative Care Teams in Providing Psychosocial Care: 'Everybody Thinks that Everybody Can Do It and They Can't',“ \textit{Journal of Palliative Medicine}, 14(2, 2011): 191-6. doi: 10.1089/jpm.2010.0229
\item Wittenberg-Lyles et al. “Interdisciplinary Collaboration”.
\item Tõnu Lehtsaar, \textit{Hingehoiu psühholoogia [Psychology of pastoral counselling]} (Tallinn: Logos, 2015), 60-114.
\end{enumerate}
\end{footnotesize}
patients or managing patient care were familiar with the concept of pastoral care, but most of them would like to get additional knowledge.\textsuperscript{42}

Considering this, we propose that the professional presentation of clinical pastoral caregivers in Estonian healthcare should further highlight the proficiency in spiritual/religious issues and existential questions, and stress the complementary nature of acquired knowledge in other disciplines for better teamwork.

**Main Actors**

Different needs of an individual are interconnected and should be addressed as such in healthcare. For example Koenig (2014) presents a structured model of a spiritual care team for different inpatient and outpatient settings.\textsuperscript{43} But better communication with the patient’s treatment team would enable the pastoral caregiver to meet the patient’s spiritual needs in a biopsychosocial context and provide more holistic support even without a structured spiritual care team. We propose integrating spiritual support in Estonian healthcare through an interdisciplinary model, also engaging informal meetings and lessening the status differences through mutual respect.

By Real and Poole, an interdisciplinary team in healthcare is considered to be more flexible and adaptive than a multidisciplinary team. A multidisciplinary team brings together different expertise as well as benefits in learning from each other, and usually has formal meetings and some informal ways for awareness-building. But it also has more communication barriers rising from the discipline-based frames of reference. An interdisciplinary team communicates through informal meetings as well and has fewer status differences. A further step in flexibility would be transdisciplinary teams that have more

\textsuperscript{42} Meel, “Defining the Context.”

\textsuperscript{43} Koenig, “The Spiritual Care Team.”
cross-disciplinary skills, but these are in danger of dilution and erosion of disciplinary skills.44

Next, we will discuss the main actors of an interdisciplinary team according to the principals of the patient-centered approach that is also gaining attention in Estonian healthcare.45 Here, we do not present the main actors solely in the perspective of pastoral care, but as equal members of a treatment team.

IAPO (International Alliance of Patients’ Organizations) Declaration on Patient-Centred Healthcare states the following:

Health systems in all world regions are under pressure and cannot cope if they continue to focus on diseases rather than patients; they require the involvement of individual patients who adhere to their treatments, make behavioural changes and self-manage.

The patients have a right and responsibility to participate in healthcare decision-making; the choices in treatment and management options should fit in with the patient’s particular needs, and their preferences, values, autonomy and independence are to be respected.46 Carman et al. point out that at the level of direct care, the patient and family would both be engaged in developing and initiating the treatment most suitable in the specific case. In organizational design and governance, they would help in planning, delivery, care evaluation, staff hiring and training, quality improvement and development. Patients and their families would also be engaged in

44 Real and Poole, “A Systems Framework.”
policy-making focusing on development, implementation, and evaluation of healthcare policy and programs.\textsuperscript{47}

When involving the patients in treatment decisions, thorough information should be provided about their disease and treatment options.\textsuperscript{48} Since in a patient centered approach, the patients are considered partners, they are also the providers of information for treatment process and decision-making.\textsuperscript{49} The patients’ family and friends are seen supporting the patients and also informing the patient care.\textsuperscript{50} As much as there is mutual consultation about the medical condition and corresponding psycho-social support, patients/close ones and staff may need consultation about particular spiritual or religious issues that influence decision-making and the patient’s adherence to their treatment, considering religion can be one of the healing factors in a treatment process.\textsuperscript{51} Therefore the pastoral caregiver can be seen as one of the important actors at all levels of healthcare, alongside patients and their close ones, doctors, nurses, clinical psychologists, and social workers.

Preparatory education, internal trainings, treatment, and management decisions in interdisciplinary teamwork benefit from conducting the research and defining the outcomes in all holistic care dimensions. In a patient-centered approach, it is suggested that clinicians and investigators should focus on patient importance rather than on clinically relevant

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\item \textsuperscript{50} Carman, et al., “Patient and Family.”; Pomey, et al., “Patients as Partners.”
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outcomes. That places the patients’ preferences and values also in the center of studies. The research process should involve the patients as equal partners rather than research objects, as the patients can help us develop tools and terminology.

When it comes to actual cooperation, we have to pay attention to the differences between active treatment and hospice care. Balanced team functioning in active treatment is more complicated than in hierarchy-reducing hospice care; in active treatment, the complications in teamwork may rise from unequal status and uneven distribution of power. As previously noted by Real and Poole, an interdisciplinary team has less communication barriers and therefore the voices of the team members can be equally heard. In actual cooperation, we have to think also how to empower the patients’ voices through their representation in the team (e.g. pastoral caregiver mediating the spiritual needs of the patient or social worker explaining the coping difficulties, and how these two may be interconnected).

Based on the patient-centered approach, we suggest the main actors at different levels as follows: Patients and their close ones, pastoral caregiver, doctors, nurses and institutions psycho-social support as equal partners in reciprocal continuous education and in research informing the decision-making process in treatment, management, and healthcare policy. Pastoral caregiver, nurses, and the institution’s psycho-social support as mediators balancing the traditional authority of doctors’ expertise and patients’ values and preferences. Pastoral caregiver as a specialist and staff’s educator, particularly in the matters of spiritual support and Estonia’s religious/spiritual diversity.

Decision-making, behavioral changes, and adherence to the treatment may require additional support for the patients and their families. Therefore the team should also consider

52 Guyatt, et al., “Patients at the Centre.”
54 Olshever, “Integration of Groupwork.”
55 Real and Poole, “A Systems Framework.”
engaging the representatives of the patient’s support group (e.g. illness-focused, religious/spiritual or self-help) according to the particular case and the patient’s wish.

**Forms of Cooperation**

Consultation, collaboration, coordination and referral have been introduced as beneficial forms of cooperation for pastoral care practice in interdisciplinary settings. All of them require recognizing the need of another specialist. The current idea addresses the specific forms of cooperation in the context of clinical pastoral care and wider spiritual support in Estonian healthcare.

Consultation is a method for deepening one’s knowledge and improving one’s skills with assistance from another specialist and with the aim to work more effectively with care-seekers.56 Based on Macht (1978),57 Cunningham presents client-centered and consultee-centered case consultations as the most helpful in pastoral care.58

Thompson offers four basic types of consultation for clinical pastoral care: a) ongoing consultation (either in a peer group or an individual model; case-centered, process-centered or combined); b) ongoing consultation limited to a particular client (including different consultants in compliance with the patient’s specific background); c) one-time or limited consultation (gaining additional information in a concrete incident or particular issue); and d)


educational consultation (expanding knowledge; e.g. training programs, introducing new developments, clinical case conferences).  

The study in Estonian healthcare institutions showed the medical staff’s wish to consult with the pastoral caregiver about the patient’s feelings, spiritual/existential questions and reactions; most of the respondents would also consult with the pastoral caregiver about the ethical issues. Therefore we can see the best grounds for client- and consultee-centered case consultations and educational consultations. These can also function as potential platforms for expanding the consultation range to program/service development and management.

In client consultation, the patient-centered approach has addressed the benefits of engaging the patient in a decision-making board. Compared to the standard consultation, greater involvement has been proven to increase the patient satisfaction with decision-making and also provide more knowledge about the disease and treatment options. Since spiritual/religious issues may influence the decision-making process, an opportunity of also engaging a spiritual support specialist (pastoral counselor or chaplain) in such boards at the will of the patient would be potentially beneficial.

Collaboration is a form of cooperation where different specialists address different aspects of care, offering complementary services and mutual support. Preparation, time and supportive structures that are founded on pre-existing clinical relationships are seen as factors necessary for successful collaboration. Collaboration in clinical pastoral care (for example

59 Thompson, “Referral,” 355, 357-359.
60 Meel, “Defining the Context.”
63 Craven and Bland, “Better Practices.”
through regular meetings) enables the interdisciplinary team to actually work together for problem solving in direct care or service development, also sharing the responsibility for the process and outcomes.\textsuperscript{64} For helping successful collaboration in direct patient care for example, a collaborative deliberation model has been created proposing the following points: a) constructive interpersonal engagement, b) recognition of alternative actions, c) comparative learning, d) preference construction and elicitation, and e) preference integration.\textsuperscript{65} In addition to regular team meetings, collaboration can take place during the morning rounds, informal meetings or through written communication.

Actual teamwork that would include spiritual support has not yet been rooted in Estonian hospitals. As a formal palliative care team, it functions only in North-Estonia Medical Centre,\textsuperscript{66} and we do not have any overview of informal teamwork in other settings. Therefore the awareness-raising about the possibilities of engaging the pastoral caregiver in team meetings and morning rounds could also be done through client and consultee-centered case consultations and educational consultations. That would help pastoral caregivers find allies among healthcare specialists for upholding the idea of holistic care and a patient-centered approach.

On the other hand, in the healthcare teams that also offer psycho-social and spiritual support, pastoral caregivers would have potential duplication, overlap, and contradictions with clinical psychologists and social workers. Here is helpful coordination, where different specialists inform each other aiming to synchronize their work and prevent overlap, duplication or counterproductive actions.\textsuperscript{67} Coordination in medical teams can be organized

\textsuperscript{66} Põhja-Eesti Regionaalhaigla [North Estonia Medical Centre], Palliatiivravi talitus [Palliative Care Service] (2016),URL: http://www.regionaalhaigla.ee/sites/default/files/documents/Palltiisooniteenistus_-_luhiinfo_patsiendile_emosel_kontakti.pdf
\textsuperscript{67} Macht, “Community,” 237.; Cunningham, “Consultation,” 165.
in different ways, considering the particular tasks, size, and structure of the team as well as
the time pressure (explicit vs implicit coordination).\textsuperscript{68} In a pastoral care ongoing process, the
care-seekers would be asked for information and permission to contact the other professional
working with the case.\textsuperscript{69} Koenig proposes a nurse or a clinic manager as the spiritual care
coordinator, providing the resources like information on pastoral care services and local faith
communities, or spiritual reading materials.\textsuperscript{70} Considering Estonian institutional context and
socio-cultural background, we cannot suggest the nurse in Estonian healthcare institutions
cover any wider range of spiritual care coordination than providing information on pastoral
care services. The lack of time, exhaustion, and overwhelming amount of one’s own specific
work has been thought to prevent conversations on spiritual/existential topics between the
medical staff and patients in Estonian hospitals.\textsuperscript{71} The spiritual screening and coordination of
spiritual care, as suggested by Koenig,\textsuperscript{72} would require additional time and training to the
overall awareness-raising for spiritual support. We also have to consider the great diversity of
the Estonian religious/spiritual landscape that would require even more work in the
coordinators’ training.\textsuperscript{73} Therefore we do not propose the nurses or clinic managers as
spiritual care coordinators at this particular stage of our healthcare. This does not mean that
such spiritual care teams by the example of Koenig would not be welcome in piloting the
further development.

\textsuperscript{68} Torsten Reimer, Tillman Russell, and Christopher Roland, “Decision-making in Medical Teams,” in
\textsuperscript{69} Cunningham, “Consultation,” 165.
\textsuperscript{70} Koenig, “The Spiritual Care Team.”
\textsuperscript{71} Meel, “Defining the Context.”
\textsuperscript{72} Koenig, “The Spiritual Care Team.”
\textsuperscript{73} Meel, „Socio-Cultural Aspects.”
Cunningham and Thompson both introduce referral as a beneficial form of cooperation in clinical pastoral care. Referral is used in the cases where a specialist can see the need for particular assistance, but is not able or in the position to offer such. Making adequate referrals requires clear definition of the problem and identification of the potential source of suitable assistance, be that treatment, advice, support services or something else. The person may follow the referral at their own wish; referrals do not necessarily end the existing relationship but may bring in additional or parallel assistance.74

Handzo and Puchalski address the matter in palliative care where referrals to the pastoral caregiver should be triggered automatically if the patient’s spiritual distress is evident, or be automatic if the patient is referred to palliative care. They suggest previous spiritual screening and spiritual history for triggering referrals in larger and more complicated settings, but additionally to automatic referrals. In any case, pastoral care should be presented as a regular service being an integral part of palliative care.75

At the same time, the importance of spiritual support should also be recognized outside the palliative care service, e.g. emergency medicine and neonatal intensive care.76 There, the referrals to the pastoral caregiver could be seen as a required minimum of interdisciplinary cooperation.

In the study of Estonian institutional setting, 89 percent of the responding medical staff would refer the patient to the pastoral caregiver; the pastoral caregiver is also preferred to be

an official member of the staff. The latter would also enhance the reliable working relationship and learning about each other’s profession as a basis for adequate referrals.

Considering this, we propose that the pastoral caregiver should be an official member of the staff for enabling better cooperation; if the pastoral caregiver is invited from outside, it should not be a random but a long-time working relationship that would allow them to engage them in the team. Client and consultee-centered case consultations and educational consultations could be used as initial platforms for awareness-raising and expanding the consultation range to program/service development and management. These forms of cooperation could also be used as platforms for awareness-raising about the possibilities of engaging the pastoral caregiver in team meetings and morning rounds. Consultations and internal trainings could be used as platforms for clarifying the indicators that trigger mutual referrals between different specialists. We suggest coordination between the pastoral caregiver, clinical psychologist, and social worker for avoiding overlapping, duplication, and contradictions. We also propose engaging the pastoral caregiver directly in the decision-making process at the will of the patient; all patients should be informed about this possibility.

**Education and Internal Trainings**

For palliative care education, spiritual support has been proposed as a crucial component to be included either as a part of a wider program or as a separate course. Here, the care providers are expected to be able to both recognize spiritual issues and also to deliver spiritual care.

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77 Meel, “Defining the Context.”

78 Paal, et al., „Spiritual Care Education.”
At the same time, the idea of whole person care is expanding the subject of spiritual support integration across the entire healthcare system. As a fundamental part of compassionate and high-quality healthcare, spiritual support should not be limited by the borders of palliative care.\textsuperscript{79} In primary health and social care, the joint locality-based trainings of chaplains, health and social care practitioners from across sectors are recommended for introducing the meaning of spiritual care as a part of person-centered holistic care.\textsuperscript{80} Clinical pastoral education program (weekly meetings for five months, 400 hours of supervised training) has been created, tested, and proven valuable for clinicians in intensive care.\textsuperscript{81} The importance of spiritual support also has been pointed out for critical care nursing in intensive and progressive care units, suggesting in-service training or continuous education.\textsuperscript{82}

The study of Estonian institutional setting of clinical pastoral care showed the medical staff’s willingness to listen to the pastoral caregiver during the internal trainings on the topics of grief and illness-related crises, and the wish to learn more about the concept of pastoral care.\textsuperscript{83} This also indicates the good possibilities for the pastoral caregiver to engage medical staff in creating the spiritual support training programs. Based on the abovementioned study, the topics for spiritual support education would be hope, death (also fear and expectation of death), grief, suicide, the afterlife, the question about maintaining consciousness after death,
the importance of passed life, the need to change and learn, the joy of life, the issues connected to starting or ending the active treatment, ethical questions, the staff’s coping with patient death, and the indicators for triggering mutual referrals.84

The processes of spiritual screening, spiritual needs assessment and marking down the patient’s spiritual history have been proposed as helpful in spiritual support integration.85 Therefore, introducing the responding tools has to also be part of education and internal trainings.

For integrating spiritual support in Estonian healthcare, we propose engaging the medical staff in creating joint and mutually beneficial internal trainings. The initial subjects for spiritual support training could be: spiritual/religious issues connected to death, grief and illness-related crises; valuing life (passed life, joy of life) and the need to change and learn; the issues connected to starting or ending the active treatment; the indicators for triggering mutual referrals; spiritual screening and assessment tools for helping the referrals; ethical and organizational questions in interdisciplinary cooperation; and Estonian religious/spiritual diversity for helping staff value the importance of patients’ different backgrounds.

In Estonia, we already have a functioning pastoral care additional education program for professionals from various fields, and to some extent, adapted specifically for clinical pastoral care.86 We propose creating the clinical pastoral care additional education program for medical staff. That should be done by consulting the healthcare specialists and institutions’ management about the topics, scope, organization and funding.

84 Ibid.
85 Koenig, “The Spiritual Care Team”; Smith, “Using the Synergy.”
Possible Questions of the Implementation Potential of the Model

The model constructed in the current article is theoretical and its adaptability must be addressed in fieldwork before it can be actually suggested to Estonian healthcare institutions. Different specialists who would be engaged in such teamwork might have their proposals for each point in the model. Therefore an additional qualitative research is needed. For example, engaging the suggested main actors in providing spiritual support may appear to be too complicated due to the lack of time and the work overload. At the same time, there may either be possible ways to achieve it or better alternatives.

When considering the professional presentation, we have to take into account that due to the uneven knowledge and different ways of spiritual support provision in Estonia’s healthcare institutions, the understanding of the role of the pastoral caregiver may vary. This also means that the expectations in teamwork may be different. As it comes to stressing either the outcome-orientation or the idea of supportive presence, the preferences may vary also due to the different nature of each profession.

Forms of cooperation can be expected to be already rooted according to the organizational culture. Giving guidelines rather than rigorous structure, the presented model points out the possibilities of these forms. Whether these would be accepted and implemented depends greatly on the patterns that already work effectively in the particular institution. The question is also whether the acquired knowledge of different forms of cooperation would inspire the teams to try a new approach in their work.

The planning of education/internal trainings for interdisciplinary teamwork has to consider the basics of each included discipline. What exactly do the other specialists in the field consider to be the necessary elementary knowledge of their profession and what would they like the pastoral caregiver to know? What exactly would the other specialists need to
know about spiritual support in their specific local context to make healthcare more holistic and learn to understand the individual patient?

Finally, considering the possible differences and/or consensus in each point, can we make adjustments to the model in a way that we could claim it to be adaptable in different healthcare institutions? Can we to some extent set it to a universally agreeable structure that would help to even the provision of spiritual support in Estonian healthcare? And can we do it in a way that maintains the flexibility that respects the organizational culture of each institution?

**Conclusions**

The current article aimed to construct a potentially adaptable model of clinical pastoral care for Estonian healthcare institutions. It has been done by drawing together the information from international research and theoretical background, considering Estonia’s specific context. Summarizing this, we present the model in the following points:

**Professional presentation**

- Stressing the importance of supportive presence for granting the ethical minimum of spiritual support provision.
- Stressing the measurable outcomes for addressing the patients’ particular problems and for further organizational planning.
- Highlighting the proficiency in spiritual/religious issues and existential questions.
- Stressing the complementary nature of acquired knowledge in other disciplines for better teamwork.
- Outlining the needs and possibilities for internal trainings and personal continuing education.
Main Actors

- Patient/close ones, pastoral caregiver, doctors/nurses, the institution’s psycho-social support (clinical psychologists and social workers as equal partners in reciprocal continuous education and in research informing the decision-making process in treatment, management and healthcare policy.
- Nurses with the respective will and training to recognize patient’s spiritual distress as complementary links between patients and the pastoral caregiver.
- Pastoral caregiver, nurses, the institution’s psycho-social support as mediators balancing the traditional authority of doctors’ expertise and patients’ values and preferences.
- Pastoral caregiver as a specialist and staff’s educator particularly in matters of spiritual support and Estonia’s religious/spiritual diversity.
- Patients’ support groups as additional support according to the particular case and the patient’s wish.

Forms of Cooperation

- Pastoral caregiver as an official member of the staff for enabling better cooperation; if the pastoral caregiver is invited from outside, it should be a potentially long-time working relationship;
- client and consultee-centered case consultations and educational consultations as initial platforms for awareness-raising and expanding the consultation range to program/service development and management;
- engaging the pastoral caregiver directly in the decision-making process at the will of the patient; all patients should be informed about this possibility;
• client and consultee-centered case consultations and educational consultations as platforms for awareness-raising about the possibilities of engaging the pastoral caregiver in team meetings and morning rounds;
• coordination between the pastoral caregiver, clinical psychologist and social worker for avoiding overlapping, duplication, and contradictions; and
• consultations and internal trainings as platforms for clarifying the indicators that should trigger mutual referrals between different specialists.

Education / Internal Trainings

• Engaging the medical staff in creating joint and mutually beneficial internal trainings;
• The initial subjects for spiritual support training would be:
  - spiritual/religious issues connected to death, grief and illness related crises;
  - valuing life (passed life, joy of life) and the need to change and learn;
  - the issues connected to starting or ending the active treatment;
  - the indicators for triggering mutual referrals;
  - spiritual screening and assessment tools for helping the referrals;
  - ethical and organizational questions in interdisciplinary cooperation;
  - Estonian religious/spiritual diversity for helping the staff to value the importance of the patients’ different backgrounds.

The next step is to address the implementation potential of such a model in Estonian healthcare institutions and make the necessary adjustments in each point, considering the comments of different specialists in the field.

Conflicts of Interest

Authors have no conflicts of interest to declare.
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