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Liidia Meel

University of Tartu Faculty of Theology, Estonia

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INTERDISCIPLINARY TEAM-BASED PASTORAL CARE MODEL FOR ESTONIAN HEALTHCARE INSTITUTIONS: THE PROFESSIONALS' INSIGHT AND THE MODEL ADJUSTMENTS

By Liidia Meel

Liidia Meel is a PhD student in the University of Tartu Faculty of Theology (Tartu 50090, Estonia) and pastoral counsellor in the North-Estonia Medical Centre palliative care unit. 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 counsellor in the North-Estonia Medical Centre and Tartu University Hospital.

Her previous publications include the following: "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. "Defining the Context for Best Practices: Institutional Setting for Clinical Pastoral Care in Estonia," *Journal of Religion and Health* 57(1, 2017): 328-332. With Tõnu Lehtsaar "Interdisciplinary Team Based Pastoral Care: A Potentially Adaptable Model for Estonian Healthcare Institutions," *OPREE* 37(3, 2017): 1-33. Her email address is liidia.meel@gmail.com

ABSTRACT

The current article addresses the application potential of an interdisciplinary team-based pastoral care model in Estonian healthcare institutions. To support the inclusion of pastoral care in Estonian healthcare institutions, the initial model of interdisciplinary team-based pastoral care was created as a theoretical construction. The current article deals with the model applicability and aims to adjust the model to be adaptable to different healthcare institutions in Estonia. To inform the model adjustments, a qualitative research was conducted in three Estonian hospitals that have included pastoral care provision in different organizational forms. The expert sample consists of pastoral caregivers of these three institutions, and the staff members who have continuously or have had an actual working contact with the pastoral caregiver of their institution.

The discussion and proposals address each of the initial theoretical model's sections and the model adjustments are based on the insight given by the respondents. The conclusions present the adjusted model in the summarizing table.

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

INTRODUCTION AND BACKGROUND

The current article discusses the application potential of an interdisciplinary team-based pastoral care model in Estonian healthcare institutions. The importance of increasing the patient-centered approach has been recognized in Estonian healthcare, also raising the awareness about holistic care and interdisciplinarity.^{1 2} The idea of holistic approach and interdisciplinary teamwork in patient care has been noted among the Estonian medical personnel to be the further road to follow, but also the one where they would need more education and solving the organizational problems (e.g., work overload, forms of cooperation and possibilities for internal trainings).³ Also, the human-centered values (including interpersonal relationships, communication and teamwork) have been highlighted as beneficial in both Estonian hospitals⁴ and in the management of Estonian institutions in general.⁵ The latter draws attention to the working relationships even more widely than only in the context of direct patient care, since the overall supportive institutional culture can be contributing to the direct patient care and patient satisfaction.⁶ In Estonian hospitals that have included pastoral care provision, the pastoral caregiver is seen as a professional supporting not only the patients and their close ones but also the staff. At the same time the Soviet-era ban for religion in public institutions still has its effect on Estonian healthcare—the pastoral

¹ Väino Sinisalu, “Patsiendikeskne käsitus – samm edasi tõendus põhise meditsiini kontseptsiooni arengus” [“Patient-centred Approach – A Step Forward in the Development of Evidence-based Medicine”], *Eesti Arst* [Estonian Physician], 94(2, 2015): 70-1. <http://ojs.utlib.ee/index.php/EA/article/viewFile/12057/7167>

² Ilme Aro and Tatjana Oolo, ed., *Patsiendikesksus Eesti tervishoius – patsientide ja nende lähedaste vaatekohad* [Patient-centeredness in Estonian Healthcare – Perceptions of Patients and Their Relatives] (Tartu: Tartu University, 2015),

http://dspace.ut.ee/bitstream/handle/10062/45219/Artiklikogumik_Patsiendikesksus_30012015.pdf

³ Liidia Meel, “Defining the Context for Best Practices: Institutional Setting for Clinical Pastoral Care in Estonia,” *Journal of Religion and Health* 57(1, 2017): 328-332. <https://doi.org/10.1007/s10943-017-0462-5>

⁴ I. Saame, A. Reino and M. Vadi (2011) “Organizational Culture Based on the Example of An Estonian Hospital”. *Journal of Health Organization and Management* 25(5): 526–48. <http://dx.doi.org/10.1108/14777261111161879>

⁵ Eneken Titov, „Management Paradigm Values in Real and Propagated Level as Prerequisites of Organisational Success“ (PhD diss., Tallinn University of Technology, 2015).

⁶ Saame, “Organizational Culture.”

care service is neither uniformly understood nor evenly provided.⁷ A chaplain's institution in healthcare has been started, but still the need for conceptualization of the role and meaning of pastoral counsellor remains.⁸

To support the inclusion of pastoral care in Estonian healthcare institutions, we can see the need for a potentially adaptable model of interdisciplinary team-based pastoral care. Such a model was created as a theoretical construction, leaving open at that stage its actual application potential.⁹ The construction of the model draws information from pre-existing models in spiritual support provision and healthcare,^{10 11} teamwork and cooperation theories, research in healthcare and pastoral care, education in healthcare, Estonian socio-cultural and institutional background,^{12 13} Estonian situations in pastoral care,¹⁴ and the present developments in patient-centered care.^{15 16} As the current article deals with the issues of the model applicability, it also aims to adjust the model to be adaptable in different healthcare institutions. For this, the model would have to remain rather in guidelines to maintain the flexibility that respects the organizational culture of each institution.¹⁷

⁷ Liidia Meel, „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, doi: [10.1558/hsc.v4i1.28461](https://doi.org/10.1558/hsc.v4i1.28461)

⁸ Tõnu Lehtsaar, Kaido Soom, and Olga Schihalejev, “Suundumusi nüüdisaegses hingehoius” [“The developmental trends in contemporary pastoral counselling”], *Usuteaduslik ajakiri*, 1(2015): 83-98.

⁹ Liidia Meel and Tõnu Lehtsaar, “Interdisciplinary Team-based Pastoral Care: A Potentially Adaptable Model for Estonian Healthcare Institutions,” *Occasional Papers on Religion in Eastern Europe*, 37(3, 2017): 1-33.

¹⁰ Harold G. Koenig, “The Spiritual Care Team: Enabling the Practice of Whole Person Medicine,” *Religions* 5(4, 2014): 1161-74, doi: [10.3390/rel5041161](https://doi.org/10.3390/rel5041161)

¹¹ Glyn Elwyn et al., “Collaborative Deliberation: A Model for Patient Care,” *PEC*, 97(2, 2014): 158-64.

¹² Meel, „Socio-Cultural Aspects.”

¹³ Meel, “Defining the Context.”

¹⁴ Lehtsaar, Soom and Schihalejev, “Suundumusi.”

¹⁵ Sinisalu, “Patsiendikeskne käsitlus.”

¹⁶ Aro and Oolo, “Patsiendikeskus.”

¹⁷ Meel and Lehtsaar, “Interdisciplinary team.”

METHOD

A qualitative research was conducted in three Estonian hospitals that have included pastoral care provision each in a different organizational form. In these institutions, the pastoral caregivers are working as official members of the staff.

North-Estonia Medical Center has a palliative care team that reacts to the patient cases in the institution's different departments, and cooperating more deeply if the need is perceived with the staff in these units. The palliative care team includes among other specialists a chaplain and two pastoral counsellors, also one of the nurses has complementary education in pastoral care. Tartu University Hospital has included two pastoral counsellors and a chaplain in three different clinics. These pastoral caregivers, though working in their own units, may be occasionally invited to other clinics as well. Tallinn Diaconal Hospital of the Estonian Evangelical Lutheran Church has a chaplain covering all departments and also has a nurse with complementary education in pastoral care.

The expert sample consists of the pastoral caregivers (two chaplains and four pastoral counsellors) of these three institutions, and the staff members (two doctors, three nurses, three social workers, and two psychologists) who have continuously or have had an actual working contact with the pastoral caregiver of their institution. Sampling took into account that at least minimum cooperational contact with pastoral caregiver is needed as a prerequisite for any practical insight for including pastoral care in teamwork. In the case of North-Estonia Medical Centre, the respondents are those belonging to the palliative care team and can be expected to be knowledgeable in pastoral care as a part of interdisciplinary teamwork.

Sixteen semi-structured interviews were conducted between November 2016 to Nov. 2017. The questions addressed the model application in its different parts, i) professional

presentation, ii) main actors, iii) forms of cooperation, and iv) education / internal trainings.¹⁸ Following qualitative content analysis used the coding frame based on the initial propositions in each model part (in the main categories of *roles/tasks of the pastoral caregiver, team members, cooperation, indicators/need for pastoral caregiver, supporting the inclusion of the pastoral caregiver, hindering the inclusion of the pastoral caregiver*), that would inform the necessary adjustments to the model in the final proposals. The results are presented non-comparatively, not highlighting the pros and cons of the institutions' current pastoral care organizational forms, and not revealing to which institution the respondents belong. Research including the institutions with different organizational forms of pastoral care may provide more various insights due to the potentially different problems and solutions arising in these particular settings. The emphasis in presenting the results in the current article is on the qualitative information that respondents contribute to the model adjustment. The illustrative quotes are translated from the Estonian language.

RESULTS

Professional Presentation

Professional presentation of the pastoral caregiver covers the role and the tasks of the pastoral caregiver, what are the other specialists' expectations towards the pastoral caregiver, and whether these are in accordance with how the pastoral caregivers see themselves in the team. This helps us to shed light on what should be stressed and clarified while explaining in Estonian healthcare who the pastoral caregivers are and what they do.

The role of the pastoral caregiver was understood by respondents (including pastoral caregivers themselves) mainly in the context of holistic care. It was stressed that the pastoral caregiver is a team member who supports the patients, their close ones and the staff in

¹⁸ Meel and Lehtsaar, "Interdisciplinary team."

spiritual/religious, existential and emotional issues. Doing that, the pastoral caregiver is expected to cooperate with another specialist, for the pastoral caregiver is also seen as a mediator between the patient and another specialist, if necessary. In two cases (PC2, PC4), the pastoral caregivers themselves brought out another side—while included as the team members, their role still has an aspect of being an outsider, representing the Church, God, and the spiritual world. As such, the supportive role of the pastoral caregiver is to be someone who is not directly involved in the medical care and is ready to speak about anything. This outsider aspect of the pastoral caregiver's role was by the responding pastoral caregiver's perception to give an independence or autonomy.

Pastoral caregivers also noted that spiritual needs are often invisible and hard to notice by both the patients and by the other specialists, so it is the pastoral caregiver's job to recognize the invisible and intangible aspects of the human being and thus contribute to holistic care. One responding pastoral caregiver brought out that it is the pastoral caregiver's task to promote patient-centered care and to help the patient's active inclusion in their care, instead of the patient being an object of care. Another responding pastoral caregiver described the broad scope of their role—they are the specialists who most of all must keep the wholeness of human being continuously in focus; they must pay attention to spiritual, physical, psychological, and social aspects; communication is always a necessary tool but the pastoral caregivers must also delve into the deeper layers of communication where the motives of human behavior and also the background of physical reactions appear. One of the responding other specialists brought out that while all of the medical staff should be able to talk to some extent with the patients about spiritual/religious issues, they would have to notice when these questions cross the boundaries of their own competence and the inclusion of the pastoral caregiver is needed. Another respondent marked that these are often the issues that either scare the other specialist or where they feel that they do not have enough adequate

knowledge. So figuratively, the role of the pastoral caregiver is to take over in this point and tread with the patient the unknown paths of the invisible and intangible spiritual world (respondents especially naming the nearing death), complex and often incomprehensible religious landscape (respondents naming the difficulties understanding the choices of the patients and the diversity of religions) or face the overwhelming existential questions (especially the patients' question *why is it happening to me?* being pointed out in the interviews).

Additionally, the pastoral caregiver is seen as an informer who should make adequate referrals and also help the patients and their close ones to find, at least to some extent, the answers to the questions belonging to other disciplines. The cooperation was also stressed in explaining the role of the pastoral caregiver as a counsellor, whose task is to help the person to find both inner and outer resources for coping with their situation. In one case, the pastoral caregiver's role was primarily connected to religious rituals, and in two cases, to supporting these patients who have previously declared their religiousness and independently (not referred to) expressed the wish to talk to the pastoral caregiver. Two respondents from other professions understood the pastoral caregiver's role to mainly support the dying patients, although one of these respondents admitted to be merely accustomed to this attitude and not considering it particularly true. Pastoral caregivers themselves brought out that they have felt their importance grow in the case of a patient's recent or imminent death. One of the pastoral caregivers reported that particularly the psychologist sees pastoral care as counselling for dying people; two responding psychologists understood the pastoral caregiver's role to be counselling and supporting the patients emotionally and in spiritual and religious issues. One of the responding psychologists brought out the importance of the pastoral caregiver as a mediator of the patient's spiritual and religious needs, "translating" and explaining these to the other staff members so that these could be taken into account in the patient care. One of

the responding pastoral caregivers used an expression *profession of reconciliation* (PC2) to describe their role, applying it to different situations and relationships in their field. The pastoral caregiver was also seen as someone who alleviates the patient's loneliness and feeling of isolation by just taking the time to be there and satisfy the patient's need for communication. Alleviating the loneliness and isolation was indeed brought out, particularly in the cases of nearing death (especially a child's death).

Most of the respondents did not point out any actual problems rising from role confusion or role conflict between the pastoral caregivers and other supportive professions. Two respondents from different professions brought out problems rising from the pastoral caregiver's crossing the boundaries of competence and giving inadequate information to the patient in the matters belonging to another discipline. Three respondents reported some confusion about the expectations towards the pastoral caregiver and the psychologist—the pastoral caregiver is mainly expected to visit either dying or religious patients. One of the responding psychologists saw the pastoral caregiver as an important partner especially for the psychologist, for the pastoral caregiver may help the psychologist in monitoring the patient's emotional state. The unrealistic expectations towards the pastoral caregiver were named by the responding pastoral caregivers to be either to fix the patients up emotionally or make them comfortable for the medical staff; unrealistic is also expecting the results quickly, especially after only one visit. One of the responding pastoral caregivers explained that these unrealistic expectations are due to either: a) being founded on different criteria aiming the visible quick fix which cannot be the foundation to pastoral care; b) the problem itself is understood differently, in which case the pastoral caregiver can also address it differently both supporting and balancing the patients in their *picture* and the staff members in their *picture* (PC5).

The need was mentioned for some role clarification in the institutions, but greater in the society in general. The awareness-raising in the society was explained to be improving the foundations of future professionals' attitude. This applies also to the patients' attitude, for it was pointed out that the patients seem to know very little about the pastoral care service. It was noted that the patients often suspect the pastoral caregiver to be someone who would force upon them particular religious views, or someone who only visits the dying people. At the level of institutions, most of the respondents pointed out that the boundaries, possibilities, and focus of different professions are already or continuously clarified in actual cooperation through daily communication. In one case however, the pastoral caregiver did not feel sufficiently included in cooperation and proposed that different ways of awareness arising about the pastoral caregiver's role might improve the inclusion.

Both in daily communication and other ways of awareness-raising (e.g., internal trainings, informational meetings, and leaflets) must be considered that the professional self-presentation has to emphasize for clarifying the pastoral caregiver's role. One of the questions here is if the profession of pastoral care should stress either measurable outcomes¹⁹ or supportive presence.²⁰

In most cases, the supportive presence was considered to be essential in pastoral care. One respondent saw emphasizing supportive presence and measurable outcomes as equally important. Two respondents said that these could not be separated: *It seems to me for some reason that these are one and the same thing. That they get something positive out of it if they*

¹⁹ Research and defining the outcomes would be helpful for identifying and meeting the needs of the patients, and for explaining what pastoral caregivers actually do. Larry VandeCreek and Arthur M. Lucas, ed., *The Discipline for Pastoral Care Giving: Foundations for Outcome oriented Chaplaincy* (Binghampton: The Haworth Press, 2001); Larry VandeCreek, ed., *Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No* (Binghampton: The Haworth Press, 2002); Meel and Lehtsaar, "Interdisciplinary team."

²⁰ The idea of "hopeful presence" is considered to be a value with no prescribed but still observable outcomes. - Steve Nolan, „Re-evaluating Chaplaincy: To Be, or Not...“, *Health and Social Care Chaplaincy*, 1(1, 2013): 69-60, doi: [10.1558/hsc.v1i1.49](https://doi.org/10.1558/hsc.v1i1.49) ; Steve Nolan, *Spiritual Care at the End of Life: The Chaplain as a 'Hopeful Presence'*, London: Jessica Kingsley Publishers, 2012; Meel and Lehtsaar, "Interdisciplinary team."

want the pastoral caregiver to come tomorrow and the day after tomorrow. ... This in itself is an outcome already (S2). Most respondents pointed out the difficulties with measuring the outcomes, in two cases, it was declared to be impossible. The problem was especially brought out as the lack of systematic tools. The best possibility for measuring the outcomes was seen in simply quantitative registering of patient contacts, looking either at the overall contacts or concentrating on the repeated visits. Patient and family satisfaction was mentioned as one possible outcome for measuring, but it raised the question of how to measure the long-term effect or unconscious/subconscious effect. The question was noted to be also how to engage in the measuring process physically or mentally the most fragile patients who might benefit but not be able to report it. One of the responding pastoral caregivers pointed out that the outcomes of pastoral care are not actually measurable at all. Another responding pastoral caregiver explained the similar view: *Measuring would inevitably be narrowing our work, and this applies not only to the work of the pastoral caregivers, but also (for example) the doctors, by measuring we leave many things out* (PC5). One of the responding pastoral caregivers did not agree with the term *presence* (PC6), explaining that the work of the pastoral caregiver is an active process. On the other hand, the supportive presence was understood to have the greater scope than merely counselling the patients and their close ones—even just the knowledge about the existence of the professional in difficult existential, spiritual/religious and emotional issues was reported to be supportive for the staff as well.

Supporting the staff was seen by all respondents as a part of the pastoral caregiver's role. However, the particular issues (e.g., only connected to the patient case; general problems connected to work; conflicts between the staff members; worries in personal life) where support might be offered were not agreed upon, except connected to the patient case. Some saw personal worries as potentially affecting the work and therefore an area where the institution's pastoral caregiver should offer support if needed. The others would prefer the

support in personal worries to be found outside their own institution to avoid the possible tension in their continuous working relationship. In particular, supporting the staff members in the case of conflicts were seen as too complicated—*eventually it would still end up in taking the sides* (PC3). Connected to the patient cases, the death of a child in a department was highlighted as most stressful for the staff, in which case, the pastoral caregiver's support might be most needed. In regards to supporting the staff, the pastoral caregiver's role was also as an advisor, whose task is to take part in preparing and giving internal trainings.

Main Actors

Main actors of the interdisciplinary treatment team were commonly agreed upon by the respondents as follows: doctors, nurses, social workers, psychologists, and pastoral caregivers. One of the responding pastoral caregivers stressed the importance of including at least one specialist with the background of family therapy. The caretakers in the departments were brought out as the important informers about the patients' needs. Occupational therapists, physiotherapists, and nutrition advisors were suggested to be included in certain cases depending on the hospital unit. It was also stressed that in order to provide holistic care, the voice of different specialists must be equally heard both in the team and in the service provision in general. One of the responding pastoral caregivers pointed out that the patients and their close ones are actually the team members in the patient case.

It was not commonly agreed who exactly from the discussed main actors should be the key actors managing most of the information and leading the patient case. While discussing the key actors, it was brought out that the situations are different and the cooperation in certain issues may be initiated by different specialists. In the case of North-Estonia Medical Center, it was pointed out that the palliative care team also has a coordinator, covering the general provision of palliative care service. In the concrete patient

cases, the key actors were mostly suggested to be either their doctors or nurses. It was stressed not as a hierarchical arrangement but based on the notion of who is treating the most acute problem and who is the closest to the patient. It was explained that if the doctors and nurses are opposing, inattentive, not interested or not knowledgeable enough, then it would be very difficult for any of the supportive personnel to reach the patients. In the case of solely palliative care, it was brought out that the key actor should be a nurse—a wise, polite, and emphatic nurse, who would know enough to map the needs and problems of the patient and to decide which other specialists to contact in this particular patient case. At the same time, the lack of time, the lack of knowledge, and the lack of interest among the nurses was pointed out as a problem, while discussing the possibility of the respective training of the nurses to also notice the patients' spiritual needs. The possibility of the pastoral caregiver to function as the key actor was seen in the certain patient cases if there was the need to connect with the patient's religious community members or a spiritual/religious leader.

The patient support groups were agreed to be potentially useful partners, especially for informing the interdisciplinary teamwork about the issues connected to the health conditions. Support groups consisting of former or current patients and their close ones would provide an insight that can be acquired only by personal experience. It was admitted that including the patient support groups would require thorough planning of how to do it most effectively—namely, which team members should deal with the informational exchange, since both the human and time resources are limited. The problem was also seen in the possible emotional reactions and the feeling of guilt if the information would be shared by the patients or their close ones individually concerning their personal cases for example during the internal trainings—*I understand that the purpose is that the patient would inform the nurse and the doctor about the actual experience. But I listen and I often feel under attack for everything I have left undone* (D2). This would cause the doctor to feel guilty for the flaws in

the system, while the patient or their close ones are ventilating their negative emotions. The solution was seen in gathering a written body of the patients' experiences with their propositions for service development. Also, the peer counsellors²¹ were said to be trusted with the issues that the patients don't dare to share with the doctors or nurses. As such, the peer counsellors can be useful informers and educators for the treatment team in different patient related issues, would these be physical, psycho-social, or spiritual/religious. To support the patients' close ones in the case of patient death, one of the responding pastoral caregivers also suggested establishing cooperation with grief support groups outside the hospitals.

The key actors were also discussed on the levels of cooperation outside the direct patient care. These were research and education that would inform the decision making in management, healthcare policies, and organizational matters in healthcare services. The question suggested one key actor in the interdisciplinary team who would collect the information (e.g., questions for research, propositions for internal trainings and education, problems in organizing the service provision) from actual practice and take it to the receiving instances, such as their own institution's management, healthcare research centers, or even further to the public discussion. In many cases, it was pointed out that the key actor on this level should certainly have a medical background (preferably a doctor) that would help them to: a) understand and present the information in adequate medical context; b) add authority to their voices. Here, both the work overload of the medical personnel and the need to finance the extra working hours were admitted as the opposing factors. In one case, however, the negative side was also seen in the doctors' greater authority, namely the supportive professions should gain as much authority speaking about the patients' needs. Preparation

²¹The cooperation with peer counsellors was reported to be better in one institution and not very good in another one. The current research leaves out the comparison between the institutions and does not further address this particular subject.

and personal traits of the key actor in this case were also pointed out: *It is important that this person would be educated in this sense that he/she has been interested in different fields, ... would value and respect the representatives of other disciplines as much as their own* (N1); *Conciliator, mediator, the ability to soothe emotions, bring people together,—it is not necessary to have medical education* (N3).

The current section also raised a question about the early notice of the patient's spiritual needs, and whether there should be a particular person in the team to act as an additional link between the patient and the pastoral caregiver. Empathy and attentiveness of the staff was seen as the foundation for noticing the patient's spiritual needs. Although six respondents admitted that a nurse (for visiting the patients most often and being at the same time knowledgeable of the patients' health conditions) with some special training could act as an additional connection with the pastoral caregiver, they still pointed out the work overload of medical personnel as an opposing factor. However, it was not commonly agreed that the special training would make much difference. It was explained that if a person is empathic and attentive, the additional knowledge would be acquired in one way or the other, and it applies for the staff in general, in which case there would be no need for a particular specifically trained person. The responding pastoral caregivers noted that the important information often reaches them through the doctors, nurses and carers who have been talking to the patients and noticed their spiritual needs. This information exchange was reported to function well even without any special training, but would require time, interest, and attentiveness which has more to do with the working culture and the general attitude towards the patients. One respondent offered the solution of engaging volunteers in patient care, communicating with the patients and so being an additional pair of eyes to notice the patients' needs. On the other hand, it has been pointed out that in active care, the patients might be already overwhelmed with everything going on with them and around them, and not

wishing to have any additional persons to talk to. Including volunteers in hospitals might be seen as useful, but not generally, and only in certain patient cases where the need is previously either indicated or the patient's respective wish expressed during the daily contact with the staff.

Forms of Cooperation

Discussing the necessary conditions for including pastoral care in the teamwork, the respondents emphasized the following: a) the pastoral caregiver must be an official member of the permanent staff (if not, it must be someone with continuous working contact with the team and granted to come as soon as needed, which was seen to be more difficult to arrange); b) the pastoral caregiver must be physically present in team (also naming the arrangement of the working space); c) the other specialists must have some preparatory knowledge of the pastoral care profession, and the pastoral caregiver should know some basics about the other professions in the team; and d) the early agreements about the ways of sharing the important information. The team must know what the pastoral caregivers can offer and agree on the ways how to include them.

One of the responding pastoral caregivers pointed to the specific spiritual and religious context in Estonia that must be considered in the pastoral care service provision:

It would be necessary to develop the way of providing pastoral care service that is suitable for Estonia. Here, it should not be confession-based, we should rather try to understand the different forms of how spirituality manifests. Even in multicultural (society), certain lines appear, especially in Estonia these are extremely interwoven. This is a challenge for Estonian pastoral care, how to integrate a Christian approach in the context of spirituality that is intermingled in a very complicated way. (PC5)

All respondents agreed that hindering the pastoral caregivers' inclusion in teamwork is the fact that pastoral care is still new and quite unknown in Estonian healthcare institutions and in society in general:

Every new thing takes time, it demands finding our own way, we are still going through this process,—at first we hired the pastoral counsellor and then started to create the model of how they work. The myths—it (pastoral care) is associated with death, it takes time to change it. We haven't had such a system before. Everything must be tested through our own experiences. Rooting something new in healthcare institutions takes time and experiences, out of which trust can arise. (N2)

Particularly in the case of the role confusion between the pastoral caregivers and the psychologists, it was admitted that explaining and sharing the experiences clarifies the roles in time. The awareness-raising in all forms was considered to be helpful only if being continuous, for the reasons of: a) the medical staff changes, it has to be explained to the new ones; b) the lack of time and the work overload of the medical staff prevents them from paying attention and keeping in mind the new information that is not directly connected to their own work; and c) to root the pastoral care as a service that would be taken for granted. Jointly created written materials were proposed to be helpful for the other staff members to decide whether to invite the pastoral caregiver or the psychologist in certain cases.

The management's awareness about the pastoral care profession was considered to be important for avoiding solely calculations-based decisions. The attitude of the institution's management specifically towards teamwork (either supporting the cooperation or seeing the pastoral caregiver as more individual worker) was considered to have an influence in few important aspects, such as creating the possibilities for arranging the working space and approving the different ways of awareness-raising.

The possibility of including the pastoral caregiver, who is not an official member of the staff, was admitted in the case of the long-term working contact that would guarantee at least some stability. It would take time to learn the institutional culture and get to know the coworkers, so it would be also inconvenient for the team to include the pastoral caregivers solely as episodic visitors. It would be good if the pastoral caregiver would be *one and the same person with whom we grow together* (D1), it is important to have an opportunity for discussing the patient cases as a team and learn to think together in a way that enables the team to move in the same direction.

The responding doctors pointed out that while for example in haematology-oncology, pastoral care is a part of an already planned service provision (meaning also the higher awareness level of the staff), then in emergency units and intensive care, it would be occasionally needed but difficult to provide with our current limited resources. It was understood that even if many of these patients themselves would not be able to talk, the pastoral caregiver might be needed to support the family; nevertheless, it will take additional finances, awareness-raising, and organizational planning.

Discussing the difficulties in cooperation, the pastoral caregivers and other specialists admitted the differences between their professional languages. It was considered to be especially difficult for including the pastoral caregiver in the morning rounds with doctors and nurses. Deciding upon the forms of cooperation should also consider the differences between the units. For example, in some departments, the supportive personnel cannot go on independent ward-rounds, and it has to be commonly agreed in the unit, how the information about the patient case will reach the pastoral caregiver or how the knowledge about the pastoral caregiver will reach the patient. One responding pastoral caregiver particularly stressed the adequacy of the information about the particular patient cases—*what exactly does the treatment team perceive as a problem, why they want to include me. It doesn't have*

to be an academic diagnosis (PC1). Lack of knowledge about the pastoral care profession is hindering the cooperation with the pastoral caregiver, but there is also an additional nuance in that—even when the knowledge is acquired, the medical personnel is just not yet used to thinking about it, ...it just doesn't come up in their heads (D2). The latter does not concern solely the pastoral caregivers but the supportive personnel in general—On the one hand, yes, it might be the Soviet time influence, on the other hand, it is certainly the case that if (Estonian) people are not used to speaking about their own problems, they are also not ready to, or well, it doesn't occur to them that they could ask someone to help them in counselling the patient (D2).

Gathering the initial information about the patients' spirituality/religiosity was suggested as a way for supporting the cooperation and understanding the patient more holistically. It was agreed that the initial information would be helpful to indicate the potential need for the pastoral caregiver and to prepare the staff for the patients' special wishes (e.g., choice of food or preferences in their care). The questions about the patient's spirituality/religiosity were proposed to ask the worldview or religion, but also if the patient considers it important in their care, if they have any special wishes connected to this, and if they wish the pastoral caregiver to visit them. In one case, it was mentioned that such a questionnaire exists and is quite good, but is rarely properly filled.²² One of the responding pastoral caregivers suggested that these questions should explore the potential need for the pastoral caregiver by addressing the connections between the illness and life events and the meaning that is given to the illness. Gathering the initial information about the patients' spirituality/religiosity on the patient charts was also criticized: a) it might rule out the pastoral caregivers visit while it is actually needed or may be needed later; b) this information is too deep and personal to be addressed on charts; c) it could lead the staff to prejudice and wrong

²² The reasons for not filling the questionnaire were admitted to be either the lack of time or undervaluing the subject.

conclusions about the patient; and d) it is not reasonable to ask these questions if we have no resource to cover the needs that might appear in the answers. One of the responding pastoral caregivers and one of the responding psychologists offered the solution of asking the general open question about whether there is something connected to the patient's beliefs that they would like to be taken into account in their care.

To support the cooperation in extreme patient cases that require rapid intervention, the interview questions suggested commonly agreed indicators (e.g., suicidal thoughts, refusing the treatment, aggressiveness). Two respondents of other professions pointed out the delicate nature of these situations; whether it would be always right to include several specialists, and in these cases should be left open for further discussion. Other respondents agreed with the suggested indicators but complemented the list with additional ones naming apathy, changes in behavior or emotional state, not accepting the diagnosis, grief, economic and social coping issues, worries connected to the patient's family (also underaged children, disabled family members, different expectations of family members towards the patient's care), high anxiety, and depression. In connection to grief, economic and social coping issues and family worries, it was pointed out that we lack cooperation with supportive organizations and specialists outside the hospitals, being not systematic, and depending on the good will of the staff members. Changes in behavior or emotional state of the patient were explained to be an important indicator for prevention—*we don't have to wait until (the patient) actually climbs of the window sheet* (PC1). In these cases, it was noted that the patient's medication and changes in physical state should be considered as influential factors and that the pastoral caregiver must have some basic knowledge about those. One of the responding pastoral caregivers pointed out the differences between the hospital units: *It is difficult to create general indicators, often these would be specific in different fields...* (General could be) *Crises in life, unexpected change in illness or life* (PC5).

Daily informal communication was seen as a good way to avoid the possible duplication and conflicts between psychologists, social workers, and pastoral caregivers. However, it was admitted to work best in the small teams due to more personal contact than in bigger collectives. Jointly created internal trainings and informational meetings were also expected to prevent the problems of duplication, conflicts, and confusion. One of the respondents pointed out that the duplication is not something bad in its essentials; the problem with the duplication was seen as: a) the patient has to explain the same thing over to different specialists; and b) we have so few pastoral caregivers, they are not financed by the state budget and duplication is wasting the resource. Jointly created informational leaflets were considered to be potentially useful for getting attention, attracting interest, and clarifying the roles, but less beneficial than daily communication, internal trainings, and informational meetings. Two respondents pointed out that if people read the leaflets, they seem to remember the fact of the supportive personnel's existence, but further information is often preferred to be heard in contact.

Client-centered case consultation was stressed as the most important form of cooperation for including pastoral care in the teamwork. If arranged as team meetings, their benefits were seen in bringing out the different nuances in patient care, and pastoral care contribution, especially, to explain the patient's behavior. Both client and consultee-centered case consultations were found to be beneficial for learning from other specialists and getting professional and personal advice. However, two respondents brought out that consulting the staff members about their own work-related reactions and problems might be preferred to be done by someone outside the team or the institution, avoiding the daily working contact. Consultations for service development and management were merely admitted as useful in certain cases, especially for explaining the patients' needs that might seem unusual in healthcare institutions. By one respondent, the consultations for service development and

management were seen as a waste of the pastoral caregiver resource: (it) *should be used only very specifically and during very limited time. To ask advice or to ask if the pastoral caregiver sees any shortcomings in the current service development* (D2). Discussing the cooperation in the wards, one of the respondents stressed that the pastoral caregiver should be present when the patient is informed about ending the curative care.

Morning rounds were brought out as potentially beneficial but also raising complicated questions. The respondents had contradictory views of either: a) to include the pastoral caregiver in the morning rounds is a waste of resource due to the medic-centeredness, lack of privacy and hasty conduction; and b) to include the pastoral caregiver in the morning rounds is a good idea precisely for the same reasons. The explanations can be summarized as follows (though it was admitted that the morning rounds may be different):

- a) The doctors and nurses do most of the talking and mainly medical language is used; the pastoral caregivers may learn few important things but they also waste valuable time listening to the things they don't really need to know; there are too few pastoral caregivers to take part of the morning rounds—they physically cannot manage it; it would be more useful to train the medical personnel to recognize and pay attention to the different aspects of patient care; you cannot actually discuss all the different nuances during the morning rounds if there are over 30 patients in the unit; also the patients might not bring up the issues important for pastoral caregiver, due to the lack of privacy when different specialists are present at the same time; the patients will be talking mostly to the nurses anyway, so it would be more useful for the pastoral caregiver to regularly meet the nurses of the unit instead of going to the morning rounds.
- b) The pastoral caregivers may improve their understanding of the medical issues during the morning rounds; even if the pastoral caregivers do not understand all

the medical terminology, they do see the patients' reactions, get a lot of information and attend to the patient as soon as possible; during the quick morning round, some (for example very old or very timid) patients might not be able to even express themselves in time, the pastoral caregiver can notice this and talk to the patients and the doctors and nurses to clarify the issues that need more thorough explaining; the pastoral caregiver may also prevent the staff acting based on the stereotypes or assumptions (for example about the elderly that he/she doesn't hear anyway, while the patient is just slow in reactions); in some cases, the pastoral caregivers can remind the staff that it is not polite to talk around and over the patient's bed about the patient's things as if the patient was not there, instead they should be talking to the patient; morning rounds are one way of introducing the pastoral caregiver to the patients in a neutral way not specifically connected to their case.

Education and Internal Trainings

The section about education and internal trainings addressed the issue of informing the staff about pastoral care, informing the pastoral caregivers about other professions, and training for interdisciplinary cooperation.

The best ways for informing the staff about pastoral care and informing the pastoral caregivers about other professions were considered to be information sharing in daily contact, internal trainings, informational meetings, and some courses during the preparatory education. The leaflets were noted to be less useful, but necessary for sharing quick information about the existence of the pastoral caregiver. Two respondents also stressed the importance of sharing information in the institution's newspaper and intranet.

The pastoral caregivers were noted to be important partners in planning the internal trainings, also pointing out the need for their own initiative. The responding pastoral caregivers, themselves, stressed their responsibility to inform the other specialists of their willingness to give the trainings and of the possible subjects. The subjects for internal trainings in pastoral care were named as follows: the basics of pastoral care, the scope and possibilities of pastoral care, the basic knowledge of different religions, supporting the dying people and the patient's close ones, telling the close ones about the patient's death, communicating with difficult patients, dealing with hopelessness, burnout, and wholeness of the person. Learning about different religions was brought out as preventing and changing the stereotypes connected to different religious groups. Learning about the basics, scope, and possibilities of pastoral care was considered to be beneficial for using the pastoral care service as effectively as possible. This was placed especially into the light of limited resources and admitted that in many cases the possibility to talk to the pastoral caregiver is not proposed to the patient if the patient did not specifically insist. The other reason for not proposing the pastoral care contact was the fear of upsetting the patient (the possibility of perceiving the pastoral caregiver as someone who either deals with dying people or imposes their own religious views).

For preparatory education of the staff, the respondents suggested lecture courses about pastoral care and religious studies for soon-to-be doctors, nurses, and carers. Also, for preparatory education and internal trainings, suggested practical approaches involved case studies, sharing the patient stories, and practical exercises of teamwork. One respondent explained that actual patient examples would attract the attention of these specialists who would otherwise undervalue the importance of the subject.

The subjects for preparing the hospital pastoral caregivers were mainly basic knowledge about the patients' physical symptoms. Responding doctors and nurses explained

that knowing the basic particularities of different illnesses would enable the pastoral caregiver to understand the patients on a physical level and to notice the patient's physical discomfort. It was explained that the preparatory knowledge of the hospital pastoral caregivers about other professions do not have to be very specific or deep; in addition to the physical symptoms, the respondents suggested the general overview of Estonian health and social care system, basics of first aid, and how the illness may affect the person's psychological state.

One of the responding pastoral caregivers stressed learning through ongoing cooperation and not trying to add all the necessary subjects to formal education: *Everything informational is useful, the most useful is personal contact. I would not load the preparatory education of the pastoral caregivers any more in its volume. Every place has its own specifics, in which it is the pastoral caregivers' own responsibility to educate themselves. All forms of cooperation open the world of another person—the partner in cooperation and contribute to mutual understanding* (PC5).

DISCUSSION AND PROPOSALS

The presented qualitative research addressed the application potential of the interdisciplinary team-based pastoral care model in Estonian healthcare institutions. The initial theoretical model (Meel & Lehtsaar 2017) was constructed drawing the information from pre-existing models in spiritual support provision and healthcare, teamwork and cooperation theories and research in healthcare and pastoral care, and education in healthcare. It also took into account Estonian socio-cultural and institutional background, and Estonian situations in pastoral care and patient-centered care.

The discussion and proposals address each of the initial theoretical model's²³ sections, concentrating especially on these parts where adjustments were needed considering the model's application potential in Estonian healthcare institutions. The model adjustments are based on the insight given by the respondents and no additional theoretical background is included. The flexibility of the model is also considered, aiming to give the guidelines that do not eliminate the possibility of differences in service provision due to different organizational culture²⁴ or the possible changes in the current state of funding the pastoral care service²⁵.

Adjustments to the Model Section of *Professional Presentation*

In the beginning of the theoretical model construction, the authors assumed that pastoral care in Estonia has to be mainly outcomes-oriented. The assumption was based on the context analysis that indicated the need for pastoral caregivers to support their work with research and express their working outcomes to coworkers and management.²⁶

Yet based on the ethical principal of decent institutions,^{27 28} the initial model stated that the professional presentation of the pastoral caregiver has to be:

*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 organisational planning.*²⁹

²³ Meel and Lehtsaar, "Interdisciplinary team."

²⁴ For example the working space in different hospitals or in different units of one hospital,--the pastoral caregiver either shares a common space with the team or has a separate room; the ways of information sharing about the patient cases in the unit; how exactly the team meetings are organized, etc.

²⁵ For example, with the state budget funding the inclusion of the pastoral caregivers can be increased and the pastoral caregivers in hospitals might be expected to conduct the research and consult the management decisions and the service provision about the patient spiritual needs.

²⁶ Meel and Lehtsaar, "Interdisciplinary team."

²⁷ Avishai Margalit, *The Decent Society*. (London: Harvard University Press, 2009).

²⁸ Clemens Sedmak, "Challenges for humane hospitals" (paper presented at the ENHCC 13th consultation *Open for the future: Envisioning Chaplaincy in the midst of transition*, Salzburg, Austria, May 28 - June 1, 2014). URL: http://enhcc.eu/salzburg14_notes.pdf

²⁹ Meel and Lehtsaar, "Interdisciplinary team."

The research findings ruled out the authors' initial assumption that the pastoral care profession in Estonian healthcare institutions needs be mainly outcomes-oriented. Quite the opposite, the respondents' answers confirmed the authors' ethics-driven proposal for the professional presentation of the pastoral caregiver to, first of all, stress the importance of their supportive presence. The respondents also pointed out the problems with measuring the outcomes and the limited resource of pastoral caregivers in the hospitals. The model adjustment in this part proposes not to stress the measurable outcomes in the professional presentation of the pastoral caregiver in Estonian healthcare institutions, in order to avoid the misconceptions about the pastoral caregivers' tasks in the institutions under the circumstances of limited human resource and underfunding of the pastoral care service. That is not to undervalue the importance of research that informs the pastoral care practice, but not to add to the current work overload of the few pastoral caregivers that the hospitals or hospital units can afford without the help of the state budget funds. Based on the minimum standards for humane hospitals,³⁰ the adjustments in this point specify the ethical minimum of pastoral care provision as: *the pastoral caregiver's presence at least according to the patient's or their close ones' expressed wish and the possibility of inviting the pastoral caregiver if the need is perceived by other staff members*. Also, using the term "spiritual support" in the model causes difficulties, for the word "*vaimne*" in Estonian language has two different meanings, either "spiritual" or "mental/intellectual," and "spiritual support" as a term was rarely used by the respondents while the term "pastoral care" was understood to also integrate social and psychological spheres. Therefore, the adjustments to the model replace spiritual support with pastoral care.

³⁰ In the pastoral care perspective considering the opportunity for discussing the question *Why*, and room for individual thinking and expression. - Sedmak, "Challenges."

The results confirmed the initial proposal of *highlighting the pastoral caregiver's proficiency in spiritual/religious issues and existential questions*,³¹ as the respondents pointed out some confusion about the roles of the pastoral caregivers and psychologists. The initial proposal of *stressing the complementary nature of acquired knowledge in other disciplines for better teamwork*³² was also confirmed. The pastoral caregivers' inadequate advice in other disciplines was seen as potentially harmful to the patients and to the working relationship in the team; at the same time, the basic knowledge in other disciplines was seen as supporting cooperation. The respondents considered the role of the pastoral caregiver to also be the educator of the staff and to join in planning and giving the internal trainings.

Adjustments to the Model Section of *Main Actors*

Main actors of the interdisciplinary team were agreed upon by the respondents to be doctors, nurses, social workers, psychologists, and pastoral caregivers. It was also suggested to include a specialist with the background of family therapy, and carers as informers in the departments. Other specialists (e.g., occupational therapists, physiotherapists, and nutrition advisors) were suggested depending on the hospital unit. Only one respondent pointed out that the patients and their close ones should be considered as the team members in the patient case. The latter doesn't necessarily mean that the patient is in other cases generally seen as an object of care, whose only active input is to agree during the decision board and to follow the doctor's orders. However, it does show that the understanding of patient-centered care in Estonia hasn't yet rooted enough for the patients and their close ones to be thought of as partners in official terms, speaking about the healthcare service. For example, the other respondents brought out the patient-centeredness in their answers but did not name the patient

³¹ Meel and Lehtsaar, "Interdisciplinary team."

³² Meel and Lehtsaar, "Interdisciplinary team."

and their close ones as team members. In other words, it may mean that even if in practice (in the concrete cases), the patient and their close ones are seen as active partners, our healthcare staff has not generally used them to address the subject. It also indicates two different views about the team: a) the team is seen as case-based (including the patient/close ones) and b) the team is seen as a constant group working daily side by side.

For adjusting this model section, the main actors of the interdisciplinary team are proposed as follows: doctors, nurses, carers, social workers, psychologists, and pastoral caregivers as constant members of the team. It was not agreed upon who from the named main actors should be the key actors in the patient cases. In the model proposals, this will be left open to be decided in the concrete patient cases.

For upholding the idea of patient-centered care, the proposals for the main actors in the initial model were:

*Patient and close ones, pastoral caregiver, doctors and nurses, 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.*³³

The feedback by respondents after conducting the interviews pointed out the lack of clinical psychologists, the psychologists working in the hospitals do not always specialize in clinical psychology. The adjustment to the current point and further in the model does not specify the psychologists as clinical, and also adds the carers to the proposed list.

For early notice of the patient's spiritual needs, the initial model proposed nurses with respective will and training to recognize the patients' spiritual distress and act as the complementary link between the patient and the pastoral caregiver.³⁴ The respondents noted that empathy and attentiveness of the staff is the foundation for noticing the patient's spiritual needs, but the necessity of specific training in the matter was not agreed upon. The work overload of the medical personnel was also explained to be an opposing factor for giving the

³³ Meel and Lehtsaar, "Interdisciplinary team."

³⁴ Meel and Lehtsaar, "Interdisciplinary team."

nurses this additional task. Noticing the patients' spiritual needs was also understood as the general responsibility to be shared by all of the staff members. The model adjustment leaves out the current point and adds the noticing of the patients' spiritual needs to the section of education/internal trainings, as a subject for internal trainings. In the section of the main actors the initial model also proposed the following:

*Pastoral caregiver, nurses, institution's psycho-social support as mediators balancing the traditional authority of doctors' expertise and patients' values and preferences.*³⁵

The need for the balancing mediator between the doctor's authority and the patient's values and preferences in the case of possible disagreements was seen in the connection with the patient's background, beliefs, and worldview. As such, it was brought out as the role of the pastoral caregiver. The model adjustment in the current point proposes the pastoral caregiver as the mediator, leaving out the nurses, social workers, and psychologists. It does not mean that the nurses, social workers, and psychologists may not act as the mediators in these cases if needed and capable. It does suggest that it is the professional role of the pastoral caregivers, without adding it necessarily to the roles of other specialists.

The initial model proposition that the pastoral caregiver is a specialist and staff educator especially in spiritual matters and Estonia's spiritual/religious diversity³⁶ was confirmed. All the respondents either directly stated or indicated their own and their coworker's will to learn and the need for internal trainings given by the pastoral caregivers. The proposed subjects for interval trainings are brought out in the section of education / internal trainings.

In the current section, the initial model also proposed patient support groups to be included as an additional support to patients in certain cases, respective to the patient's

³⁵ Meel and Lehtsaar, "Interdisciplinary team."

³⁶ Meel and Lehtsaar, "Interdisciplinary team."

wish.³⁷ The respondents also noted peer counsellors and different specialists attending to the patients' different needs in different units. Based on the respondents' answers, the list of additional support to the patients is proposed as follows: occupational therapists, physiotherapists, and nutrition advisors to be included, according to the patient's needs in different units, peer counsellors, and patient support groups to be included, according to the patient's wish in particular cases.

Adjustments to the Model Section of *Forms of Cooperation*

The results highlighted the importance of the pastoral caregiver being an official member of the permanent staff. It was explained that for including pastoral care in teamwork, the pastoral caregiver must be physically present in the team, and to be one certain person who the other team members can learn to trust. If the pastoral caregiver is invited from the outside, they must have continuous working contact with the team and granted to be available when needed. The latter was pointed out to be difficult to arrange with someone outside the institution. These results confirmed the initial proposal in this section:

*Pastoral caregiver as an official member of the staff for enabling better cooperation; if the pastoral caregiver is invited from the outside, it should not be random but a potentially long-time working relationship, that would allow to engage them in team.*³⁸

However, as the respondents pointed out the difficulties of inviting the pastoral caregiver from outside the institution (must be the same person, must be available, no daily contact), the adjustments in this point solely propose the pastoral caregiver as an official member of the staff for enabling better cooperation.

³⁷ Meel and Lehtsaar, "Interdisciplinary team."

³⁸ Meel and Lehtsaar, "Interdisciplinary team."

The respondents saw the client-centered case consultation (both individual and during the team meeting) as the most important form of cooperation with the pastoral caregiver, also educating the staff in the spiritual/religious sphere of holistic care. Daily cooperation was also seen as the best way for awareness-raising about the pastoral care profession. The client and consultee-centered case consultations were considered to be beneficial for learning and getting professional and personal advice. Consultations for service development and management were admitted to be useful, but under the current circumstances (without the state budget funding), there are too few pastoral caregivers working at the hospitals to be regularly engaged in service development or management consultations. Again, this is not to say that it must not be done at all but must be done considering the lack of working pastoral caregivers, and limited to asking specific advice in certain cases (e.g., palliative care, supportive services or quiet space). The same applies to engaging the pastoral caregiver directly in the decision-making process at the will of the patient and that all patients must be informed about this possibility, which would currently be utopian and is therefore left out from the adjusted model. Morning rounds were brought out as potentially beneficial but the respondents had contradictory views of it as it would be beneficial for getting the information about the patients and if the pastoral caregiver can actually give any useful input to the morning rounds. Therefore, the proposals for consultations as the forms of cooperation are adjusted as follows: *client and consultee-centered case consultations and educational consultations as platforms for awareness-raising about the pastoral care profession and about the possibilities of engaging the pastoral caregiver in team meetings and morning rounds.*

The results partially confirmed the initial model's proposal: *coordination between the pastoral caregiver, clinical psychologist, and social worker for avoiding overlapping,*

duplication, and contradictions,³⁹ as the respondents pointed out not only the staff's confusion about the roles of the pastoral caregiver and the psychologist, but also the role confusion between these specialists themselves. No role confusion between the pastoral caregiver and the social worker was reported, except for the possibility of giving inadequate advice if crossing the borders of own competence. Therefore, the social worker is left out of the current proposal.

In this section, the initial theoretical model also proposed *consultations and internal trainings as platforms for clarifying the indicators that should trigger mutual referrals between different specialists*.⁴⁰ The interview questions in this point presented the examples of possible indicators for the patient cases where rapid intervention on different levels could be needed: the patient's suicidal thoughts, refusing the treatment, and aggressiveness. The results were confirmed, specified, and added to the list. Additions were proposed as follows: apathy, changes in behavior or emotional state, not accepting the diagnosis, grief, economic and social coping issues, worries connected to the patient's family (also underaged children, disabled family members, different expectations of family members towards the patient's care), high anxiety and depression, crises in life, and unexpected changes in illness or life. The model adjustment proposes the named examples and the additions as the general indicators for mutual referrals and possible intervention through cooperation on different levels, including pastoral care. Specifications were as follows: a) delicacy of these cases prevents automatic inclusion of several specialists; b) the need to consider also the patient's medication and changes in physical state as influencing factors; and c) differences between the hospital units (some indicators can be specific in different fields). The model adjustments in the current point rephrase: *consultations and internal trainings as platforms for clarifying*

³⁹ Meel and Lehtsaar, "Interdisciplinary team."

⁴⁰ Meel and Lehtsaar, "Interdisciplinary team."

the specific indicators that should trigger mutual referrals between different specialists; and add the list of the proposed general indicators.

Adjustments to the Model Section of *Education and Internal Trainings*

The results, which indicate the best ways to inform the staff about pastoral care and to inform the pastoral caregivers about other professions, are as follows: a) information sharing through daily contact, b) internal trainings; c) informational meetings; d) some courses during the preparatory education; and e) the leaflets for sharing quick information about the existence of the pastoral caregiver.

The pastoral caregivers were seen as important partners in planning and giving the internal trainings. The initial model in this section proposed *engaging the medical staff in creating joint and mutually beneficial internal trainings*,⁴¹ and the subjects for training the staff in spiritual support as follows:

- *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.*⁴²

The respondents named additional subjects for trainings as follows: the basics of pastoral care, the scope and possibilities of pastoral care, the basic knowledge of different

⁴¹ Meel and Lehtsaar, "Interdisciplinary team."

⁴² Meel and Lehtsaar, "Interdisciplinary team."

religions, supporting the dying people and the patient's close ones, telling the close ones about the patient's death, communicating with difficult patients, dealing with hopelessness, burnout, or wholeness of the person. The adjustments to the model in the current point rephrase: *possible subjects for internal trainings by the pastoral caregiver*, and add the respondents' suggested subjects to the initial list.

In addition to the internal trainings proposed in the model, the pastoral caregivers must be ready for the chance to be invited to give lecture courses for soon-to-be doctors, nurses, and carers. Case studies, sharing the patient stories and the practical exercises of teamwork were suggested as best methods for both internal trainings and preparatory education.

CONCLUSIONS

The current article addressed the application potential of an interdisciplinary team-based pastoral care model in Estonian healthcare institutions. To support the inclusion of pastoral care in Estonian healthcare institutions, the initial model was created as a theoretical construction.⁴³ The current article dealt with the model applicability and aimed to adjust the model to be adaptable in different Estonian healthcare institutions. For this, the initial model was created rather in guidelines to maintain the flexibility that respects the organizational culture of each institution, the final model follows the same principle.

The discussion and proposals addressed each of the initial theoretical model's section. The model adjustments were based on the insight given by the respondents (the expert sample of pastoral caregivers, doctors, nurses, social workers, and psychologists). The flexibility of the model was considered, not eliminating the possible differences in service provision due to different organizational culture or the possible changes in the current state of funding the pastoral care service.

⁴³ Meel and Lehtsaar, "Interdisciplinary team."

The final model is presented in the table as follows:

1. Professional presentation	<p>1.1. Stressing the importance of supportive presence for granting the ethical minimum* of pastoral care provision.</p> <p>1.2. Highlighting the proficiency in spiritual/religious issues and existential questions.</p> <p>1.3. Stressing the complementary nature of acquired knowledge in other disciplines for better team work.</p> <p>1.4. Outlining the needs and possibilities for internal trainings and personal continuing education.</p> <p>*The pastoral caregiver's presence at least according to the patient's or their close ones' expressed wish and the possibility of inviting the pastoral caregiver if the need is perceived by other staff members.</p>
2. Main actors	<p>2.1. Doctors, nurses, carers, social workers, psychologists, and pastoral caregivers as constant members of the team.</p> <p>2.2. Patient and close ones, pastoral caregiver, doctors, nurses, carers, and institution's psycho-social support (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.</p> <p>2.3. Pastoral caregiver, as a mediator balancing the traditional authority of doctors' expertise and patients' values and preferences.</p> <p>2.4. Pastoral caregiver as a specialist and staff's educator particularly in the matters of pastoral care and Estonia's religious/spiritual diversity.</p> <p>2.5. Occupational therapists, physiotherapists, and nutrition advisors to be included according to the patient's needs in different units, peer counsellors and patient support groups to be included according to the patient's wish in particular cases.</p>
3. Forms of cooperation	<p>3.1. Pastoral caregiver as an official member of the staff for enabling better cooperation;</p>

	<p>3.2. client- and consultee-centered case consultations and educational consultations as platforms for awareness-raising about pastoral care profession and about the possibilities of engaging the pastoral caregiver in team meetings and morning rounds;</p> <p>3.3. coordination between the pastoral caregiver, clinical psychologist for avoiding overlapping, duplication and contradictions;</p> <p>3.4. consultations and internal trainings as platforms for clarifying the specific indicators that should trigger mutual referrals between different specialists.</p> <p>General indicators for mutual referrals in different hospital units: the patient's apathy, changes in behavior or emotional state, not accepting the diagnosis, grief, economic and social coping issues, worries connected to the patient's family (also under aged children, disabled family members, different expectations of family members towards the patient's care), high anxiety and depression, crises in life, unexpected change in illness or life.</p>
4. Education / Internal trainings	<p>4.1. Engaging the medical staff in creating joint and mutually beneficial internal trainings.</p> <p>4.2. Possible subjects for internal trainings by the pastoral caregiver:</p> <ul style="list-style-type: none"> • the basics, scope and possibilities of pastoral care; • spiritual/religious issues connected to death, grief and illness related crises; • supporting the dying patients and their close ones, telling the close ones about the patient's death; • communicating with difficult patients, dealing with hopelessness; • valuing life (passed life, joy of life) personal wholeness and the need to change and learn; • the issues connected to starting or ending the active treatment; • the indicators for triggering mutual referrals; • preventing the burnout;

	<ul style="list-style-type: none"> • spiritual screening and assessment tools for helping the referrals; • ethical and organizational questions in interdisciplinary cooperation; • Estonian religious/spiritual diversity and the basic knowledge of different religions for helping the staff to value the importance of the patients' different backgrounds.
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CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

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