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THESIS SUMMARY

Patient-centred hospital pastoral care

Strategies for organising hospital pastoral care service in the Archdiocese of Alba Iulia

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Summary

The present doctoral dissertation addresses the organisation of patient-centred hospital pastoral care services in Eastern and Central Europe. Within this framework, we aimed to develop strategies for implementing such a service in hospitals located in the territory of a diocese. Through our research findings, our objective is to contribute to the realisation of hospital pastoral care presence and to the organisation of pastoral care work in the Archdiocese of Alba Iulia.

The dissertation is centred on the findings of a qualitative field study. During this field research four specific models for organising hospital pastoral care services were examined in Austria and Hungary. In both countries, we investigated services organised at the diocesan and institutional levels. Data were collected through non-participant observations in six hospitals and eighteen semi-structured interviews—five with the leaders of the services and twelve with hospital pastoral care staff. The analysis of the data collected during the field study led to the formulation of strategic guidelines and methods for the organisation of hospital pastoral care services, which can be regarded as the most important findings of the dissertation.

During the research, we followed the working method of pastoral theology – that is, we carried out criteriological, kairological, and praxeological investigations regarding the organization of hospital pastoral care services.[1] The structure of the dissertation follows this logical arc.

In the first part of the dissertation (Chapters 2 and 3), we conducted a criteriological investigation, with the aim of identifying the standards and criteria of this church practice. As a result, we examined the appropriateness of a hospital pastoral care service and determined the criteria and objectives along which such a service can be organized.

The most significant result of the criteriological research is the vision of a diocesan-level hospital pastoral care service that emerged during the vision-formation process. Within the framework of the criteriological investigation, we explored the necessity of hospital pastoral care services and examined the purpose that organizing such a service (Chapter 2). We engaged in theological argumentation regarding the relevance and significance of hospital pastoral care, which was substantiated by two main reasons: On the one hand, the world and society need the

[1] Paul M. ZULEHNER: *Pastorale Futurologie. Kirche auf dem Weg ins gesellschaftliche Morgen*, Patmos, Düsseldorf 1990, 40–41. Comp CSISZÁR Klára: *A pasztorális teológia a való világ kalandja*, in: https://romkat.ro/2020/10/08/a-pasztoralis-teologia-a-valo-vilag-kalandja/. Access date: 05/08/2024.

Church's service for patients and their caregivers. On the other hand, this service is inherently linked to the Church's own missionary nature, thereby enabling it to be truly the Church of Jesus Christ and to render God's love tangible for people.

Based on these considerations, we examined the issue from four approaches to explain why pastoral caregivers need to be present at the hospital bedside in the 21st century. The main insights can be summarised as follows:

(1) According to Pope Francis's theology, the patient and the person in need can be regarded as having shifted *from the periphery to the centre*. [2] The patient and the person in need, in the sense of Pope Francis' theology, can be seen as a periphery that has become a centre. In other words, the poor and the sick living on the periphery of society are placed at the centre of the Church's action. As Therese Lysaught describes it, these people are "locus sacramentum", through whom the suffering body of Christ becomes manifest in the world; thus, the Church organizes itself around them and the Eucharist.[3] This theory also holds for Pope Francis' ecclesiological vision. The vision organises ecclesial activity around two interfering poles: the Eucharist (as the centre) and the poor, the sick who bear the wound of Christ (as the periphery).[4] By making the suffering body of Christ present through them, the sick become the centre, they are recognised as the locus sacramentum and ecclesial activity is organised around them. The sick are not merely persons in need of physical care, but persons who themselves become Christ-bearers and evangelise the Church.[5]

(2) Pope Francis emphasizes that the basis of every pastoral activity of the Church is the *praxis of Jesus.*[6] The Church can accomplish this by listening to people's needs, responding to their needs, entering into their reality, and making God's love tangible for them.[7] The healing and redemptive action of Jesus is a model for the Church: meeting the sick, comforting the suffering, and lifting up the marginalized are the essential realizations of the Gospel. The sacramental logic of Pope Francis moves the

[2] LYSAUGHT, M. Therese: Las Periferias y El Pan: Pope Francis, the Theology of the People, and the Conversion of Catholic Bioethics*, Perspectivas Teológica Bioética* 51 (2019/3), 421–442.
[3] Ibid.
[4] LYSAUGHT: *Las Periferias*, 424–429.
[5] LYSAUGHT: *Las Periferias*, 431.
[6] LYSAUGHT: *Las Periferias,* 429. Comp. Rafael LUCIANI: *Pope Francis and the Theology of the People,* Orbis Books**,** Ossining 2017, 149.
[7] SZÁSZ I. Szilárd: *Csiszár Klára: Az egyház nem lehet egy önmaga körül forgó egyház*, in: https://romkat.ro/2021/10/31/csiszar-klara-az-egyhaz-nem-lehet-egy-onmaga-korul-forgo-egyhaz/. Access date: 29/06/2024.

Church out of its comfort zone: the Church is no longer concerned with itself, but goes beyond itself to meet the real problems of society, to discover its own identity and mission, to discover how it should serve the poor and the sick.[8] The ministry of hospital chaplaincy in church practice can also be understood as a process of self-discovery of the church Through this ministry, the church is confronted with its own mission and reality, with those on the margins, with the poor.[9] The reality in which the Church must be at home and in which it carries out its mission cannot be known except from the periphery. The practice of Jesus is nothing other than being present in the world and at the bedside according to the needs of people in need, of the sick.[10]

(3) Through the ministry of pastoral care in hospitals, the Church can approach Pope Francis' ecclesiological vision of the Church as a field hospital.[11] Pope Francis uses the metaphor of a "field hospital" to describe the Church, which he sees as its primary task of healing the "wounds" of the world.[12] The Church must be present in the world as a field hospital in a war zone. The metaphor is particularly appropriate for hospital pastoral care: At the context of health care institutions with utilitarian logic. Pastoral care can be seen as a bastion for the spiritual needs of patients, for human dignity and for the sanctity of life in crisis situations.[13]

(4) Through pastoral care in hospitals, the particular dynamics of the outgoing church can be realized. This dynamic can be summarised briefly as follows. God sends the Church into the world with the task of making God's love experienced and tangible for people.[14] The Church, by the nature of its mission, can only become a truly missionary Church in a kind of self-transcendence, by going outside of itself. By discovering where there is suffering in the world, where God's creative and healing love is needed. That is why it is important for the Church to find the wounds of the world, to recognise marginalised groups of people. The perceived sufferings and wounds are filtered through the

[8] NÉMET László SVD – CSISZÁR Klára: *Gyógyító szeretet. Bevezetés a katolikus missziológiába*, Szent István Társulat, Budapest 2022, 87–88.
[9] PÁL-JAKAB Orsolya: Miért vagy itt? Az egyházak képviselőinek diaszpóra-tapasztalata a szekuláris egészségügyi intézményekben, in: *Studia Theologica Transsylvaniensia* 25 (2022), 177–195.
[10] Ibid.
[11] Ferenc pápa: Homily – Holy Mass for the Opening of the XIV Ordinary General Assembly of the Synod of Bishops (2015.10.04.), in: https://www.vatican.va/content/francesco/en/homilies/2015/documents/papa-francesco_20151004_omelia-apertura-sinodo-vescovi.html. Access date: 29/06/2024.
[12] NÉMET/CSISZÁR: *Gyógyító szeretet,* 85–91.
[13] PÁL-JAKAB: Miért vagy, 177–193.
[14] CSISZÁR Klára A.: *Már nem csupán opció a világiak bevonása. Néhány gondolat a legújabb vatikáni dokumentum kapcsán*, in: https://romkat.ro/2020/08/03/mar-nem-csupan-opcio-a-vilagiak-bevonasa-a-lelkipasztori-munkaba. Access date: 29/06/2024. Comp. The dogmatic constitution on the Church Lumen Gentium hereafter: LG), of Vatican Council II (hereafter: LG), in Acta Apostolica Sedis 57 (1965).

> Church's own missionary identity, through the teaching of Jesus Christ and its relationship with God. In this process, ecclesial visions are formed along with an action plan regarding how the Church can intervene in society by being present at its vulnerable points and conveying God's creative and healing love to humanity.

The importance and relevance of hospital pastoral care—and consequently the ecclesial practice within hospitals—lie in the fact that it actualizes the Church's missionary identity in practice, serving society and its patients. The hospital chaplains and pastoral caregivers work in the spirit of *missio ad vulnera* and *missio in misericordia*, which are inherent to the Church's nature. [15] Pope Francis invites all those who participate in the life and mission of the Church to do so in a synodal way, which means to walk together in the path of the People of God. The concept of synodality includes, alongside mission, communion and participation. In the context of hospital pastoral care, synodality means that the pastoral care ministry of patients, relatives and health care workers is not only the task of the hospital chaplain, but can be carried out as a church community with active participation.[16]

Following this, in Chapter 3 we conducted a vision-formation process using the criteriological working method. The vision is nothing other than the desired end-state toward which ecclesial practice strives. In this context, the vision of the pastoral care service represents the future end state that should guide the further development of this ecclesial practice in order to respond to the spiritual needs of those in hospitals. In the vision-formation process, we took into account three criteria: (1) the praxis of Jesus and the Church's social teaching; (2) alignment with the objectives of the healthcare system; and (3) feasibility. We concluded that it is necessary to organize a diocesan-level, patient-centred hospital pastoral care service.

We identified seven key characteristics that underlie the vision of a timely and purpose-appropriate hospital pastoral care service: (1) Comprehensiveness: by this, we mean that hospital pastoral care must be universally accessible to patients, their relatives, and hospital staff, regardless of religious affiliation or worldview. (2) Patient-Centredness: this signifies a human-centred approach, in which the pastoral caregiver is present in the service of the patient in accordance with the patient's situation and needs. (3) Pastoral care focus: this means that the

[15] CSISZÁR Klára: Kirche in Liebesdynamik – integrales Missionsverständnis mit praktischen Konsequenzen. Skizze einer existenzanalytischen Pastoraltheologie, in: *Studia Universitatis Babeş-Bolyai Theologia Catholica Latina* (2018/1), 57–58.
[16] The XVI Ordinary General Assembly of the Synod of Bishops, "The Synodal Church", chapter "1. Synodality: Experience and Understanding", subsection "Convergences", point g).

practice of pastoral care in hospitals focuses on personal pastoral care, listening and individual counselling. Through the personal attention of the pastoral care workers, the person being cared for can experience that they are not abandoned in a crisis state of illness. (4) Hospital integration: this refers to the fact that the pastoral care ministry takes place in a hospital setting and is integrated to some extent into the health and hospital systems. On the other hand, it indicates that this type of pastoral care has specific objectives, characteristics, methods, requirements and recipients. (5) Professional competence and professionalism: this refers to the competence and professionalism of the professionals involved, and to the fact that pastoral care in hospitals is a specific discipline, characterised by interdisciplinarity, with specific professional guidelines and a specific scientific background. (6) Regionality: by regionality we mean the territorial organisation of hospital pastoral care services, i.e. that the organisation of this service is carried out at diocesan level. (7) Free of charge: this means that pastoral care is available free of charge to the person receiving pastoral care, i.e. the salary or living wage of the pastoral caregiver is not paid directly by the patient at the bedside - resources are generated in other ways.

If we wish to further develop the current ecclesial practice in the area of hospital pastoral care along these visions, strategic planning and strategy formation are necessary. Also in Chapter 3, the meaning and functions of vision and strategy were defined. The vision sets the direction and motivates a clearly defined and considered course of action (toward the desired end state), while constructively critiquing the existing practice.[17] Thus, the indicators/characteristics of the vision serve as guides in the field regarding the direction in which the current ecclesial practice should be continuously optimized. Naturally, practice can only be optimized along the line of a vision in order to achieve a more efficient, future-oriented ecclesial praxis.[18] Regarding the relationship between strategy and vision, Hajnalka Fekete illuminates it as follows: “The strategy contains the concrete objectives and tasks for the realization of the mission and the vision.”[19] In other words, strategy can be seen as “the specification of the means necessary to achieve the objectives over a relatively long term.”[20] Strategic planning

[17] Paul M. ZULEHNER: *Pastoraltheologie I. Fundamentalpastoral*, Patmos, Düsseldorf 1991, 11–23.
[18] ZULEHNER: *Pastoraltheologie I,* 10–25.
[19] FEKETE Hajnalka: *Merre tart a hajó? A szervezeti stratégia, a struktúra és a kultúra hatásainak vizsgálata a vállalati teljesítményre*, PhD thesis, Pannon Egyetem, Gazdálkodás- és Szervezéstudományok Doktori Iskola, Veszprém 2011, 33. https://konyvtar.uni-pannon.hu/doktori/2012/Fekete_Hajnalka_dissertation.pdf. Access date: 29/06/2024.
[20] FEKETE: *Merre tart a hajó,* 17.

answers the question, “How shall the organization realize its fundamental objective?”[21] and is therefore built around a few main principles and actions.

After creating a vision for the hospital chaplaincy ministry, we will then undertake strategic planning in the later parts of the dissertation, in the praxeological chapters, to map the main principles and actions of implementation to the ministry goals. But before that it is necessary to examine the characteristics that define the present and the relevance of the service.

The kairological research, in which we have examined the actuality and timeliness of church practice and the context in which church practice is created and which it can shape, has been carried out in the second part of the dissertation (chapters 4 and 5).First, we explored the local ecclesial practice in the Archdiocese of Alba Iulia, and then we examined the broader context, namely the models of Central European hospital pastoral care services and the research methodologies through which these can be studied.

The narrow context of the topic – that is, the hospital pastoral care activities taking place in the Archdiocese of Alba Iulia – was investigated in Chapter 4 using the kairological working method. The research relied on three sources: (1) First, based on the closing document of the archdiocesan synod held in 2000,[22] we deduced that the importance of hospital chaplaincy had been recognized for more than twenty years ago, and forward-looking proposals were formulated about the organization of hospital chaplaincy services. The necessity of professional competence and professionalism was emphasized, as was the involvement of lay people in pastoral care giving for patients. (2) Subsequently, based on the results of a practical research explored in a previous Master's thesis,[23] it was concluded that the archdiocese is committed to hospital pastoral care, and that hospital pastoral care is occasionally implemented, mainly through the initiatives of hospital chaplains and persons with pastoral care training. However, in current practice, there is a lack of comprehensive conceptual organisation and systemic implementation of hospital pastoral care at diocesan level. The activities of pastoral care workers are not fully integrated into hospital systems and often operate on the periphery of the health care institution. This makes it difficult for chaplains to work effectively and to reach a

[21] Ibid.
[22] Final documents of the Diocesan Synod of the Archdiocese of Alba Iulia, 24-29 September 2000, in: https://ersekseg.ro/hu/node/97. Accessed 05. 08. 2024.
[23] DANI Orsolya: *A kórházi lelkigondozás jelene és jövője a Gyulafehérvári Római Katolikus Főegyházmegye területén található városokban*, master's thesis, Babeş-Bolyai University, Faculty of Roman Catholic Theology, Cluj-Napoca 2021, 57-67.

wide range of patients. (3) Finally, an outlook has been identified on good practice in hospital chaplaincy at the institutional level in a county hospital in the territory of the diocese. We gathered information on this current and local practice through semi-structured interviews. The interviews were conducted with the hospital chaplain appointed by the diocese's leadership and with two nuns involved in hospital pastoral care; transcripts of these interviews are included in the dissertation appendices, marked with the codes HIJ5KL1, as well as HIJ5L13 and HIJ5L14.

In mapping out this good practice, numerous elements of hospital pastoral care services were identified; however, this practice is not system-wide, and further development may be necessary in order to fully realize the characteristics formulated in the vision. Overall, it can be stated that there is a need to organize a patient-centred, diocesan-level hospital pastoral care service in the Archdiocese of Alba Iulia. This would enable the integration of pastoral care into the hospitals at theritory of the diocese, ensuring spiritual support and pastoral care for patients, their relatives, and healthcare staff.

Also, during the kairological research (in Chapter 5) we established the practical research methodology necessary for examining Central European hospital pastoral care services. We presented the four pastoral care services examined in Hungary and Austria where the practical research took place.

The aim of the practical research was to collect data on the functioning and organizational modes of Central European hospital pastoral care services. Based on the collected data, strategies can later be developed (in the praxeological chapters) for organizing hospital pastoral care services in order to achieve the practical implementation of the seven characteristics as presented in the vision. Ultimately, the results of the practical research serve to help achieve the objectives of the dissertation – namely, the identification of strategic pathways and organizational directions that can be used for further developing hospital pastoral care activities in the Archdiocese of Alba Iulia and for facilitating the establishment of a diocesan-level hospital pastoral care service.

The practical research was guided by research questions such as: What characterizes the hospital pastoral care services organized according to the institutional model and the diocesan model? What is the difference between the practical implementation of hospital pastoral care services that, while realizing a similar/identical vision, are organized according to different models and different strategies? Along which strategic lines can the comprehensive nature,

patient-centredness, pastoral focus, hospital integration, professionalism, regional organization, and free-of-charge access of the hospital pastoral care service be realized?

The application of qualitative fieldwork methodology was necessary in order to investigate already operational hospital pastoral care services in Austria and Hungary. The main advantage of qualitative field research is that it allows us to examine hospital pastoral care services in their natural environment.[24] During the fieldwork, we applied two data collection methods: first, non-participant observations were conducted in hospitals where pastoral care services operate, in order to gather data on the functioning and organization of hospital pastoral care services; second, semi-structured interviews were carried out with hospital pastoral caregivers and service leaders to shed light on aspects of the organization that cannot be captured through observation alone. The information gathered from observations and the results of the interview analyses were channeled into a self-developed measurement tool. This tool is structured along the seven main characteristics formulated during the vision-formation process, enabling the structured collection of data based on 42 subthemes. In this tool, we recorded the field observations according to the four pastoral care services examined, as well as the codes and source references corresponding to the relevant sections from the interview transcripts. The audio recordings of the 18 semi-structured interviews were transcribed into written texts and anonymized; the interviews conducted in a foreign language were translated into Hungarian. Subsequently, using the MAXQDA text analysis software, we analyzed the interview texts content-wise, coding them according to the seven main characteristics (main codes) and their 42 subthemes (subcodes). The data collected during the qualitative research, along with the fieldwork measurement tool and the interview transcripts, are included in the dissertation appendices.

During the fieldwork, we aimed to investigate hospital pastoral care services organized at both the institutional and diocesan levels in both countries (Hungary and Austria). With regard to sampling, we employed expert-based and access-based sampling. Our objective was to examine services with an established operation and mature organizational structure – in other words, we sought services that had been in operation for at least twenty years. It was essential to include services organized on different levels: thus, we examined both hospital pastoral care services organized on a diocesan level and services that are implemented solely at the level of a specific healthcare institution. In Hungary, within the framework of the field research, we

[24] BABBIE, Earl: *A társadalomtudományi kutatás gyakorlata,* Balassi Kiadó*,* Budapest 2008, 319.

examined the hospital pastoral care service known as the "E1 model" (a diocesan-level service, Model 1) and the institutional hospital pastoral care service known as the "I4 model" (Model I4). In Austria, we examined the hospital pastoral care service known as the "E2 model" (a diocesan-level service, Model 2) and the mixed model designated as "IE3," which was organized partly on an institutional and partly on a diocesan level. In selecting interview participants, our aim was to speak with those responsible for the pastoral care services – whether it be the leader at the institutional level (or the leader of the pastoral care team) or the senior leader at the diocesan level. As a result, six leadership interviews were conducted. It was also intended that for every service, interviews be conducted with at least two to three paid hospital pastoral caregivers working within that service; consequently, 12 interviews with pastoral caregivers were carried out.

In the praxeological analysis presented in Chapters 6 and 7, we reveal the ways and the strategies in which hospital pastoral care services can be organized corresponding to the seven characteristics of the vision. In the praxeological research, we developed strategic directions and organizational tools that enable the impelmentation of a hospital pastoral care service in line with the vision. Consequently, the final outcomes of the praxeological research can be formulated along the following conclusions based on the characteristic dimensions:

(1) Comprehensiveness

By comprehensiveness of the hospital pastoral care service, we mean that the support and care provided by hospital pastoral caregivers are universally accessible. One key dimension of this is the identification of the target groups for hospital pastoral care. Firstly, it must be stated that pastoral care should be available not only to patients, but also to their relatives and to hospital staff. Secondly, the care provided by hospital pastoral caregivers should be accessible to those who request the service regardless of their religious or ideological affiliation.

The practical research highlights that, in defining the scope of those entitled to pastoral care, the connection to the hospital is the most important principle. In other words, persons who are in some way connected with the hospital are eligible for the services provided by hospital pastoral caregivers: hospital staff, hospital patients, relatives of hospital patients, or relatives of patients who have died in hospital. Defining such a wide scope of eligibility enables the service to be accessible to everyone concerned, irrespective of religious or ideological affiliation.

To ensure access to pastoral care, several modes of access must be established: including the caregiver's offering of the service, the initiative of the care receiver, referrals by healthcare staff, and automatic alerts incorporated into care protocols. For the groups entitled to hospital pastoral care (patients, relatives, and hospital staff), different access channels have proven to be effective. The application of these methods increases both access to the service and the availability and efficiency of the pastoral caregivers.

Factors positively influencing the realization of comprehensive hospital pastoral care include increasing the visibility of pastoral caregivers within the institution and ensuring that they can be approached personally. The introduction of a ward-based pastoral care system—where each ward has a designated responsible caregiver who is present daily/weekly, meets newly arriving patients, and establishes personal connections with healthcare staff—facilitates comprehensive access. However, it is also necessary to take into account negative factors such as a lack of team working among pastoral caregivers, the assignment of tasks related to sacramental care to pastoral caregivers, and deficiencies in communication regarding the scope of pastoral responsibilities, which may hinder the comprehensive presence of the service.

(2) Patient-Centredness

In the context of hospital pastoral care, patient-centredness means that the pastoral caregiver is present for the patient in a manner that corresponds to the patient's unic situation and needs. A hospital pastoral caregiver provides individualized, human-centred support according to the specific spiritual and psychosocial needs expressed by the care receiver.

An important element of this is patient-centred information regarding the care offered by hospital pastoral caregivers. The research highlighted that it is crucial for patients, their relatives, and healthcare staff to learn about the possibilities and modes of access to pastoral care through multiple channels. The personal offering by caregivers, recommendations by healthcare staff, and the use of informational materials all contribute to ensuring that pastoral care is available to those who need this support.

Patient-centredness can also be realized by scheduling pastoral care meetings when the patient needs them and when such care is appropriate for the patient. The timely access to pastoral care for patients depends on the service's ability to respond quickly and flexibly to pastoral care needs, prioritizing requests according to urgent needs (for example, in cases of crisis intervention). Ensuring urgent access, introducing an on-call pastoral care system, and

establishing prioritization protocols make it possible to respond promptly to spiritual needs. In organizing the timely access to pastoral care, the working hours and mental well-being of the caregivers must always be taken into account.

Taking into account the individual needs of those receiving pastoral care further strengthens patient-centredness. The research identified the criteries that must be considered when taking into account the unique needs of care receivers: ensuring continuity of care (i.e. that the same pastoral caregiver accompanies a patient throughout the care process), creating an appropriate environment, and being sensitive to the needs related to religious practice all contribute to patient-centredness. Additionally, responsiveness, the acceptance of feedback, and handling complaints allow for the continuous improvement of the service and the enhancement of its patient-centred nature.

Overall, the practical implementation of patient-centredness in pastoral care not only serves the well-being of the care recipient and enhances the quality of pastoral care, but also contributes to strengthening the patient-centred approach of the health care institution and increasing patient satisfaction.

(3) Pastoral Care Focus

Whether it is a diocesan or an institutional hospital pastoral care service, maintaining a pastoral care focus means that in organizing the activities and defining the tasks, efforts are made to ensure that a higher proportion of pastoral activities than other activities.

The strategic objective of a hospital pastoral care service should be that pastoral caregivers devote a significant part of their working time – at least 70–80% in diocesan models and 80–90% in institutional models – to direct pastoral care activities. To this end, it is necessary to delimit the proportion of other tasks (e.g., administration, event organization) and to apply work organization strategies that enhance the presence of pastoral caregivers in the hospital wards.

Establishing proper frameworks for documentation activities is indispensable for the effective operation of the service and for quality assurance, while keeping in mind that documentation and administration should serve pastoral care work. The primary aim of documentation is to monitor pastoral care activities and facilitate the coordination of tasks, while paying special attention to data protection and the handling of confidential information.

Strengthening the pastoral caregiver identity of those who provide the service contributes to maintaining a pastoral focus. This identity includes the empowerment granted by the Church to perform pastoral care, professionalism, a personal relationship with God, and a sense of vocation. Regular professional reflection, profesional community building within the pastoral care team, and shared prayer and religious practices are indispensable for experiencing and expressing this pastoral caregiver identity.

The ecumenical approach in hospital pastoral care also supports maintaining a pastoral focus. An ecumenical perspective in pastoral care contributes to ensuring that the service is open to all patients, relatives, and healthcare workers regardless of their religious affiliation, and it recognizes the pastoral needs of individuals from different denominations or spiritual needs of non-believers. Cooperation with pastoral caregivers and chaplains from other denominations strengthens the effectiveness of the service through task sharing and contributes to meeting the spiritual needs of patients.

From a strategic point of view, work organisation is essential for the efficient functioning of the service. The distribution of tasks between chaplains and clergy, cooperation between pastoral care workers of different denominations, and the organisation of work within the pastoral care team all contribute to maintaining the focus on pastoral care and providing patients with high quality pastoral care.

(4) Hospital Integration

The integration of the hospital pastoral care service into healthcare institutions is a multi-dimensional process with two main aspects: first, the integration of the pastoral caregivers into the hospital community; and second, the incorporation of the service they provide – that is, the pastoral care activities – into the range of care offered by the hospital.

The loyalty of pastoral caregivers to the hospital is fundamentally important for integration. This may be manifested in the form of pastoral caregivers and chaplains respecting hospital rules and schedules, cooperating with healthcare staff, and actively participating in the community life of the hospital. The presence and activities of pastoral caregivers contribute to enriching and shaping the organizational culture of the hospital.

Interdisciplinary cooperation between pastoral caregivers and healthcare workers is indispensable for integration. Involvement of pastoral caregivers in the work of multidisciplinary healthcare teams, participation in visits and case discussions, as well as

involvement in crisis intervention and grief counselling are all significant for integration and contribute to the holistic care of patients. The presence, expertise, and visibility of the service increase the trust and willingness to cooperate among healthcare workers.

A good level of healthcare literacy is also an important factor in integration. Pastoral caregivers expand their healthcare knowledge through their work, which facilitates cooperation and communication with healthcare staff and increases the efficiency of their work. Areas in which professional knowledge and expertise are required include mental health, psychopathology, bioethics, crisis intervention, thanatology, and understanding of interdisciplinary teamwork within hospitals.

One indicator of hospital integration is whether there is data exchange between the pastoral care service and the hospital. The existence of such data exchange is essential in the long term for the efficiency of pastoral care. Proper data protection and confidentiality agreements enable pastoral caregivers to access necessary patient information and care organization data, thereby better supporting patients, their relatives, and healthcare workers. The research also highlights the importance of the service having protocols regarding the sharing, storage, and eventual destruction of data received from the hospital and generated during its own operations.

The sense of mission and vocation of pastoral caregivers is closely linked to hospital integration, as it reflects how they perceive their role and status within the healthcare institution. In addition to their relationship with the Church and with God, pastoral caregivers emphasize their pastoral role and the scope of their tasks within the institution. Their mission includes providing pastoral support to patients and relatives, promoting holistic care, and offering pastoral and mental health support to healthcare workers. The societal engagement of pastoral caregivers contributes to reducing the taboo surrounding death and illness and promotes community building within the hospital.

Understanding the organizational culture of the hospital enables pastoral caregivers to effectively integrate into the hospital environment and contribute to its enrichment. In the context of the hospital's organizational culture, the activities of pastoral caregivers are seen as gap-filling and as having a value-creating effect. By applying appropriate strategies, pastoral caregivers can integrate effectively into the hospital environment and, through their work, enhance the well-being of patients, relatives, and healthcare workers.

(5) Professional Competence and Professionalism

By professional competence and professionalism, we refer to the expertise and preparedness of those providing the service, and we indicate that hospital pastoral care is considered a distinct field with its own specific professional guidelines.

The research highlighted that, in the case of pastoral caregivers, it is expected that they have received university-level theological and specialized training – for example, clinical pastoral education or pastoral counseling training – which provide a solid foundation for their professional competence. When recruiting new staff, not only professional qualifications are crucial, but also personal competences such as empathy or the ability to work in a team, as well as aspects such as a living relationship with God and a life of faith. In multi-member pastoral care teams, specialisation and a targeted division of tasks facilitate the specialisation of pastoral care workers and the professionalism and efficiency of the ministry.

Regarding operational licensing, the ecclesial mandate or the contract between the Church and the institution ensures the official authorization of pastoral caregivers for the service. The internal regulations of the pastoral care service provide a framework for professional functioning, including the delineation of competency boundaries, behavioral norms, procedures, documentation requirements, and data protection regulations. These regulations contribute to patient safety and the responsible conduct of pastoral caregivers.

Professional ethical guidelines are indispensable; it is therefore advisable that there be an ethical code or other guidelines – whether from the Church or the hospital – which are known and accepted by pastoral caregivers. One of the key areas of professional ethics is confidentiality, which is fundamental in maintaining the trust of those receiving pastoral care during pastoral conversations. Clear protocols must be established for handling ethical breaches, ensuring appropriate procedures and taking steps to prevent future errors.

Precisely defining and communicating the scope of pastoral caregiving is necessary for interdisciplinary cooperation. The work of pastoral caregivers extends to providing care to patients, relatives, and healthcare staff, offering mental health support, crisis intervention, as well as conducting ceremonies and religious services and organizing chaplain visits. It is also important that pastoral caregivers are aware of the scopes of competence of other professionals working in patient care, so that they can successfully refer patients to one another and clearly identify their own responsibilities.

Quality assurance is an essential aspect of professional functioning. According to the research, the most common tools for ensuring the quality of pastoral care activities include the supervision of pastoral caregivers, regular case discussions, the organization of continuing education, and the establishment of internal regulations. For both institutional and diocesan services, it is important that pastoral caregivers continuously develop professionally and that the quality of care is monitored, with pastoral care activities being regularly evaluated. Both individual and group supervision, as well as regular contact with professional leaders, contribute to maintaining a high standard of pastoral care.

The organization of volunteer work strengthens the professional functioning of the service, provided that the scope of responsibilities for volunteers is clearly defined and that they receive proper training. The tasks of pastoral helpers and volunteers assisting with pastoral care differ, but in both cases it is essential to have a clear description of duties, adherence to ethical and data protection guidelines, and professional supervision of the volunteers' activities.

(6) Regionality

By regionality, we mean the territorial organization of hospital pastoral care. Our research revealed that whether a pastoral care service is organized on a diocesan or institutional level, its strategic objectives include ensuring territorial coverage and extending the presence of pastoral care within its designated area. The territory covered by pastoral care may be the area of a diocese or may encompass the different locations and wards of a hospital (in case of services organised at institutional level).

In diocesan models, a strategic objective is that the pastoral care service should be present in all hospitals within the diocese. This can be achieved through negotiations and cooperation agreements between the diocese and the management of the hospitals in its territory. In addition, it is necessary to employ lay pastoral caregivers who are present daily in the hospitals. The tasks related to hospital pastoral care in these models are performed by diocesan priests, who are coordinated by the diocesan leader of the service. This organization is advantageous from the perspective of human resource optimization and cost-effectiveness. In institutional models, the pastoral care service is organized within the framework of the given healthcare institution. Their aim is to ensure that the support provided by pastoral caregivers is accessible at every site and wards of the institution for patients, relatives, and healthcare staff.

During the research, various founding models were identified along with their main characteristics, based on the observed models: a) top-down construction, which is primarily characteristic of diocesan models; b) bottom-up founding strategy – this could be identified in both diocesan and institutional models. The foundation of institutional services is mostly a confluence of bottom-up initiatives by experts and institutional leaders.

The leadership of hospital pastoral care services encompasses complex tasks, which may differ partially between diocesan leaders and institutional leaders. The main tasks of the leaders include the operational management of the service, strategic direction, resource management, the development and professional supervision of pastoral caregivers, quality assurance, and liaison with various organizations. In diocesan models, the leadership is closely linked to the diocesan hierarchy, whereas in institutional models the direction of the service is determined by the pastoral team leader and the leadership of the sustaining institution.

In both models, maintaining close contact with the Catholic diocesan leadership, local ecclesial communities, chaplains of other denominations, and surrounding pastoral care services is particularly important. Relationships with the diocesan leadership and local Catholic communities facilitate the response to sacramental needs and other requirements related to religious practice, as well as the provision of various resources necessary for the service, and they greatly contribute to ensuring that pastoral care services are aligned with ecclesial objectives and values. An ecumenical approach and cooperation with other denominations further support improved access to pastoral care and the specialized professional development of hospital pastoral caregivers.

The further development of the services involves strategic directions that are variable and depend on the visions of the leaders of the service, their value-based decisions, and the long-term goals set by the sustaining bodies. Development may be aimed at extending pastoral care activities to other institutions, such as social care institutions. It may also involve expanding the scope of responsibilities of pastoral caregivers or increasing the number of staff, or even improving the quality and accessibility of pastoral care in accordance with the recognized needs.

The research findings indicate that successful implementation of regional organization contributes to fulfilling the societal and ecclesial roles of pastoral care services within the area covered by the service.

(7) Free-of-Charge Access

By free-of-charge access, we mean that the services provided by pastoral caregivers and hospital chaplains are available to those receiving care at no direct cost. At the same time, creating a financing model for the service and securing the resources necessary for its operation is indispensable for the sustainability of hospital pastoral care.

Our research shows that in both institutional and diocesan models, a hybrid financing strategy has proven to be the most effective. This means that the financing of the service comes from multiple sources, including the diocese/the sustaining religious order, the healthcare institution, and state support, or even other alternative means of resource generation.

In institutional models, the financing of the pastoral care service is often divided between the healthcare institution and the Church. The advantage of hybrid financing is that the hospital feels a stronger sense of ownership over the pastoral care service, which facilitates the integration of the service and provides expanded scopes of responsibility for the pastoral caregivers. However, exclusive reliance on institutional financing may render the service vulnerable, as the economic condition of the healthcare institution and the priorities of the hospital management greatly influence the level of financing.

In the case of diocesan models, hybrid funding is provided through a cooperation agreement between the churches and the state, and through the contracts of the diocese with certain hospitals. In addition to state support and contributions from hospitals, the diocese must assume part of the pastoral caregivers' salary and operating costs and play the role of employer. A gradual approach – which first aims at permitting the presence of pastoral caregivers and proving the value of the service, and later negotiates participation in financing – has proven to be an effective strategy in establishing cooperation between dioceses and hospitals.

The contribution of those receiving pastoral care may primarily take the form of donations to finance the occasional expenses of the service. However, it is important that pastoral caregivers do not ask for or accept direct monetary contributions in exchange for pastoral care, and that clear ethical guidelines and internal regulations are established regarding the acceptance of gifts.

The costs and resources of the service include personnel costs (such as the salaries of pastoral caregivers, administrative staff, and leaders) as well as material costs (such as office supplies, technical equipment, and the infrastructure required for the operation of the service). The

mutual involvement of hospitals and churches is key to providing resources. Their cooperation agreements should detail which party will provide the resources and reimburse the costs.

Infrastructure and technological support are also essential elements for the effective operation of the service. The availability of dedicated pastoral care rooms, a chapel, or spaces designed for prayer and community programs is crucial. Providing appropriate information and communication technologies and other necessary tools enhances the professional delivery of pastoral care. Long-term infrastructural development goals include the integration of pastoral care into the hospital's electronic medical system, which facilitates access to necessary information, improves cooperation with healthcare staff, and enhances the efficiency of the pastoral care service.

In summary, the characteristics of financing hospital pastoral care services and ensuring their free-of-charge access is a complex issue that requires careful planning and strategic cooperation among the Church, healthcare institutions, and state bodies. The application of hybrid financing models enables the sustainability and quality of the service while providing care free of charge to those in need.

The conclusions outlined above regarding the results of the qualitative research are summarized in the final (Chapter 7) section of the dissertation. Furthermore, this chapter presents the expert recommendations formulated for the Archdiocese of Alba Iulia, which evaluate the strategies and steps for establishing hospital pastoral care services. The recommendation presents two main organizational strategies: the top-down strategy and the model hospital strategy, both of which are relevant for the Archdiocese of Alba Iulia if the objective is to establish a diocesan-level pastoral care service.

The *top-down strategy* allows for the rapid and comprehensive introduction of hospital pastoral care activities in all hospitals within the diocese. However, this approach requires significant resources: it involves agreements with healthcare institutions or the health ministry, financing of the service, recruitment of qualified professionals, and the establishment of a leadership structure. Although this strategy is considered effective—since hospital pastoral care activities are established in a timely manner in every hospital within the territory of the diocese—it has the drawback of being risky, as the lack of certain preconditions may endanger its implementation.

The *model hospital strategy* enables a gradual build-up. A model is developed and tested in a selected hospital, after which it can be extended to other hospitals within the diocese. This approach requires fewer resources at the outset and provides a safer, more flexible foundation for organization, although it takes a longer time to implement than the top-down strategy. The expert recommendation indicates that if the prerequisites for the top-down strategy are not available, it is advisable to adopt the model hospital strategy. Nevertheless, the implementation of either strategy ultimately results a patient-centred hospital pastoral care service in a diocesan-level, which enables the establishment of a pastoral care presence in hospitals in the territory of the Archdiocese of Alba Iulia.