INTEGRATION OF SPIRITUAL CARE IN PALLIATIVE CARE

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ABSTRACT
Based on the concept of palliative care, it becomes evident that integrality in palliative care means that support for the patient encompasses not only medical, social, and psychological perspectives, but also a spiritual approach to the person. Palliative care provides comprehensive support not only to the patient but also to their relatives, thus becoming holistic in nature - addressing the whole person with their physical, social, spiritual, psychological, and emotional characteristics, as well as their strengths, weaknesses, and the difficulties and challenges they encounter. Pastoral care integrates the understanding that each person is important and unique, and that every effort should be made to help the patient not only die peacefully but also live as fully and comfortably as possible until death. In many cases, the assistance of a pastoral care specialist is needed to understand the situation adequately and to help patients and their relatives view illness and the dying process as a natural and inevitable part of life. This study aims to identify the assumptions underlying the need to integrate pastoral care into palliative care for patients and their relatives. The object of the study is the integration of pastoral care in palliative care. Research methods: (1) analysis of scientific literature and documents using synthesis and comparative methods; (2) questionnaire survey and statistical data analysis.

Keywords: *pastoral care, integration, palliative care, patient.*

1. INTRODUCTION
Although spirituality is internationally recognised as a significant component of human well-being and quality of life, the practical implementation of the spiritual dimension within healthcare systems remains uneven and fragmented. Palliative care promotes a holistic, person-centred model; however, in practice, spiritual care often remains less structured than medical or psychosocial care. The growing attention of scientific research to spiritual interventions and their impact on patient well-being highlights the relevance of this field (Austin et al., 2025). Nevertheless, there is still insufficient understanding of how pastoral care is perceived within specific palliative care systems, of the assumptions that underlie its necessity, and of the organisational or structural factors that determine its development. In other words, a gap exists between the normative holistic care model established in policy documents and the empirically grounded understanding of how spiritual care is integrated in real-life contexts. Thus, the key question is no longer whether spiritual care is necessary, but rather how it should be systematically integrated into palliative care - whether pastoral care is perceived as an additional, optional activity or as an integral and strategically planned component of team-based practice. Considering this issue, it is necessary to empirically analyse the need for integrating pastoral care and the preconditions for its implementation. This article aims to reveal the assumptions underlying the need for integrating pastoral care into palliative care for patients and their relatives. The object of the study is the integration of pastoral care in palliative care.
Research methods: 1) analysis of scientific sources and documents using synthesis and comparison methods; 2) questionnaire survey and statistical data analysis.

2. SPIRITUALITY IN PALLIATIVE CARE THROUGH PASTORAL CARE

In palliative care, there is a striving to apply a person-centred approach that encourages seeing not the disease but the person, focusing on the patient's strengths rather than disabilities. Pope Francis (2022) stated that "new medical technologies allow the application of effective treatment and rehabilitation methods; however, none of this should ever overshadow the uniqueness, dignity, and fragility of every patient. The patient is always more important than the disease." Pastoral care integrates the principle that every person is important and unique, and that everything should be done so that the patient not only dies peacefully but also lives fully until death. This approach is grounded in the recognition of the sanctity of human life and in the respect for the dignity and uniqueness of the person, which allows compassion and love for one's neighbour to flourish. It also implies the ability and attitude to accept the patient's situation as it is. In many cases, the assistance of a pastoral care specialist is necessary in order to understand the situation adequately and help patients and their relatives perceive illness and death as a natural and inevitable part of life. In palliative care, pastoral care for patients is understood as spiritual care. The "spiritual" dimension encompasses a person's relationship with transcendence, including questions of ultimate meaning, religious and spiritual beliefs, values, and practices. The main concern of pastoral care is to respond to the patient's spiritual and religious needs, increase opportunities for spiritual or religious coping, and alleviate suffering. Pastoral care workers devote particular attention to spiritual needs and resources. Patient care integrates medical, social, psychological, and spiritual perspectives of the person. It relates not only to monitoring and supporting the patient's physical condition but also to existential questions that arise during illness, for example: "What is the meaning of life if I become dependent on others and a burden to them?" Documents regulating palliative care in Lithuania indicate the goals of integrated care: to reduce patients' physical suffering; to identify the psychological and social problems of patients and their relatives and help address them; to improve the quality of life of patients and their relatives; to support the patient's family and/or relatives during the bereavement period. Spirituality, defined by an international consensus group as "the way individuals seek and express meaning and purpose and experience their connectedness to the present moment, themselves, others, nature, and the significant or sacred," plays an important role in the context of serious illness (Balboni, 2023; Wei et al., 2025). Spirituality is a broad construct: although it includes communal forms of religious traditions, it also extends beyond them and encompasses diverse sources of meaning, connection, and transcendence (Balboni, 2023). Spiritual care is increasingly recognised as an essential component of palliative care. Given the growing body of literature on spiritual interventions, there is a need to systematically evaluate and synthesise the findings of prior systematic reviews (Austin et al., 2025). According to the World Health Organisation (WHO), spiritual care includes spiritual support intended to address the spiritual and/or religious needs of patients, their families, and members of the care team in all care settings. Spirituality and spiritual well-being are multidimensional constructs encompassing existence, values, and religion. The existential dimension relates to questions of identity, meaning, suffering, despair, guilt, shame, reconciliation and forgiveness, freedom and responsibility, hope, love, and joy. Values and attitudes refer to what is most important to each individual (relationships with oneself, family, friends, work, nature, art and culture, ethics and morality, and life itself). Religion is associated with faith, beliefs, and a person's relationship with God or a higher power. Palliative care

refers to measures aimed at improving the quality of life of patients with life-threatening, incurable, progressive diseases and their relatives, seeking to alleviate suffering and address physical, psychosocial, and spiritual problems (WHO, 2020). Palliative care holistically integrates medical, psychosocial, social, and spiritual support for patients and their environment, involving not only specialists but also patients, family members, and volunteers on the care team. The main principles of palliative care include: respect for the patient as a unique person with intrinsic value; recognition of the patient as an inseparable unity of body, soul, and spirit; acknowledgement of the dignity and invaluable worth of every person until natural death (Wei et al., 2025). Palliative care encompasses not only the principle of non-euthanasia as a practical expression of respect for every human life, but also dimensions of teamwork, community, integration, dynamism, and pastoral accompaniment. Palliative care is provided to patients suffering from severe, progressive, advanced-stage diseases when life is approaching its end, as well as to family members and relatives during the bereavement period. The main goal of palliative care is to reduce pain and other symptoms and to provide emotional, spiritual, and practical support to patients and their relatives. Palliative care can be provided simultaneously with other treatments, such as chemotherapy or radiotherapy. However, when curative treatment options are exhausted, palliative care may become the primary form of care. Its purpose is to alleviate suffering and ensure the best possible quality of life for the patient.

3. EMPIRICAL STUDIES

In recent years, the scientific literature has increasingly focused on the role of the spiritual dimension in palliative care. Empirical studies indicate that spirituality is closely related to the search for meaning in life, the process of reconciliation, and the reduction of existential suffering, thereby becoming an important component of holistic care. Although spiritual care is recognised as an essential component of palliative care, its practical implementation across different healthcare environments remains uneven. The empirical studies presented in Table 1 reveal various aspects of pastoral and spiritual care in palliative and critical care settings. Batstone (2020), who conducted a systematic analysis of 19 electronic databases, found that palliative care nurses perceive spiritual care through a triadic model consisting of the spirit of nursing, the soul of care, and the body of care. The results showed that the spiritual care provided by nurses is grounded in an integrated, holistic worldview in which personal spirituality, life experience, and professional practice form a unified system. This confirms that spiritual care is not an incidental or supplementary activity but emerges from an integrated professional identity. Wei et al. (2025), in a systematic review and meta-synthesis of qualitative studies, identified five main themes describing the spiritual needs of adolescents with cancer: autonomy, connectedness, the search for meaning in life, a positive outlook, and confrontation with death. The study revealed that spirituality is an important part of patients' lives and significantly influences their spiritual health and quality of life. These results indicate that spiritual needs are not peripheral but constitute an essential dimension of the illness experience. Balboni (2025), in a case analysis examining an oncological emergency care situation, emphasises that existing palliative care quality guidelines identify spiritual care as a core domain of care. Integrating spiritual care into patient and family care strengthens holistic care and improves overall well-being. This study highlights that the spiritual dimension is relevant not only in long-term care but also in acute clinical situations. A case analysis by Karmakar et al. (2025) demonstrated

that, even in critically ill, intubated, but conscious patients, spiritual care remains responsive. A 67-year-old patient who reacted negatively to physical care responded positively to spiritual support. This suggests that spiritual needs may remain significant even when communication abilities are limited and the clinical condition is complex.

Table 1. Empirical studies

Author (Year)	Method	Sample / Object	Key Findings
Batstone (2020)	Systematic review of 19 databases; qualitative studies assessed using the CASP checklist; thematic deductive analysis.	Palliative care nurses.	Spiritual care was conceptualised through a triadic model: the spirit of nursing, the soul of care, and the body of care. Nurses' spiritual care practices are shaped by personal spirituality, professional identity, and clinical experience.
Wei et al. (2025)	Systematic review and meta-synthesis of qualitative studies from 11 databases (until March 2025).	Adolescents with cancer.	Five themes identified: autonomy, connectedness, search for meaning, positive outlook, and confronting death. Spirituality significantly influences patients' well-being and quality of life.
Balboni (2025)	Case analysis.	59-year-old female patient with metastatic small-cell lung cancer.	Palliative care guidelines identify spiritual care as a core domain of care. Its integration strengthens holistic care and improves patient and family well-being.
Karmakar et al. (2025)	Case analysis.	67-year-old critically ill patient on mechanical ventilation (GCS 10T).	Despite limited communication, the patient responded positively to spiritual care. Spiritual needs were assessed using yes/no questions, demonstrating the relevance of spiritual support even in critical conditions.

The review of empirical studies shows that spiritual needs emerge in various clinical contexts—from paediatric oncology to intensive care. Spiritual care is associated with the search for meaning in life, reconciliation, emotional stability, and improvement in quality of life. The attitudes and personal worldviews of healthcare professionals play a significant role in the provision of spiritual care. Although the theoretical and normative justification of spiritual care is strengthening, its practical implementation remains uneven and often depends on institutional or organisational conditions. The body of scientific evidence supporting the benefits of spiritual and pastoral care is growing; however, the spiritual needs of patients in palliative care are still often addressed in an unsystematic manner. This reveals a gap between the theoretical model of holistic care and its practical integration within real healthcare systems. Therefore, it is relevant to empirically investigate the need for integrating pastoral care in specific palliative care settings. In particular, the following questions become important: What spiritual needs do palliative care patients experience? How do patients and their families evaluate the role of pastoral care? How do palliative care

professionals assess the integration of pastoral care? What barriers and opportunities exist for integrating pastoral care into the interdisciplinary team?
The analysis of these questions not only assesses the current situation but also contributes to strengthening a holistic model of palliative care in which the spiritual dimension is systematically integrated alongside medical, psychosocial, and emotional care.

4. RESEARCH METHODOLOGY

The study used a quantitative survey methodology. Data were collected through a structured questionnaire consisting of the following sections: sociodemographic questions, evaluation of the role of palliative care, and open-ended questions. A total of 146 respondents from Lithuania participated in the survey. The respondents represented different groups: palliative care and pastoral care professionals, as well as non-specialists. 51% of respondents were palliative care professionals, including physicians, nurses, and social workers, while 49% were family members or close relatives of patients. The gender distribution indicated that 95% of respondents were women and 3% were men. The age distribution was more differentiated: nearly half (45%) of the respondents were aged 51–60, 21% were aged 41–50, 19% were aged 61 or older, 10% were aged 31–40, and 5% were under 30. Professional experience in palliative care among specialists was heterogeneous and relatively evenly distributed across categories. Approximately one quarter of the specialists had less than one year of experience, another quarter had 1–5 years, a further quarter had 6–10 years, and the remaining respondents reported more than 10 years of professional experience in this field. This distribution indicates that both novice specialists and experienced practitioners participated in the study, allowing the results to reflect perspectives from professionals with varying levels of experience. The collected data were analysed using descriptive statistics: means (M), standard deviations (SD), minimum and maximum values, and percentage distributions of responses. The research instrument consisted of 25 statements (see Table 2), grouped into five theoretical dimensions that reflect different aspects of integrating pastoral care into palliative nursing. Each dimension contained five statements evaluated using a Likert-type scale, where: 1 – strongly disagree; 2 – disagree; 3 – neither agree nor disagree; 4 – agree; 5 – strongly agree. The spiritual needs dimension reflects the importance of patients' existential and spiritual experiences in palliative care. The statements address the need to discuss death, hope, and the meaning of life, the importance of being heard regarding spiritual concerns, and the intensification of spiritual and religious experiences during illness. In addition, a statement concerning the possible neglect of spiritual needs within medical care processes is included. This dimension assesses the relevance of the spiritual dimension in the patient's experience. The pastoral care role dimension focuses on the functional and therapeutic significance of pastoral care. The statements address its contribution to the process of accepting illness, reducing emotional and spiritual suffering, ensuring patient dignity, supporting families during bereavement, and emphasising the importance of pastoral care for comprehensive palliative care.
The integration dimension evaluates the practical and organisational advantages of integrating pastoral care into the interdisciplinary team. Statements address the inclusion of pastoral care in individual care plans, the participation of pastoral care specialists in team meetings, the establishment of a permanent role within the team, and the potential impact on the overall quality of palliative care and improved understanding of patient needs. The barriers-to-integration dimension identifies

potential obstacles. Statements refer to unclear role definitions, insufficient knowledge among team members, limited funding, lack of institutional recognition, and inadequate collaboration between medical and pastoral care professionals. This dimension allows the assessment of systemic and organisational challenges. The need for new solutions dimension reflects respondents' perspectives on potential strategies for strengthening integration. Statements address the need for methodological guidelines, team training, national regulation, the potential contribution of integration to the humanisation of services, and the strengthening of mutual trust among professionals.

Table 2. Dimensions of Palliative Care with Integrated Pastoral Care

Dimension (No. of items)	**Statements**
Spiritual Needs (5)	Patients consider it important to discuss death, hope, and the meaning of life; Patients value being listened to regarding spiritual concerns; Illness often intensifies spiritual and religious experiences; Patients seek opportunities to discuss existential questions; Spiritual needs may remain insufficiently addressed within medical care.
Role of Pastoral Care (5)	Pastoral care helps patients accept illness, reduces emotional and spiritual suffering, maintains patient dignity, and supports families during bereavement. Without pastoral care, palliative care is not fully holistic.
Benefits of Integration (5)	Pastoral care should be a permanent part of the palliative care team; Pastoral care specialists should participate in team meetings; Pastoral care should be included in individual care plans; Integration improves overall palliative care quality; It contributes to a better understanding of patient needs.
Barriers to Integration (5)	Lack of a clearly defined pastoral care role in palliative care; Insufficient knowledge among team members about pastoral care functions; Limited financial resources; Insufficient institutional recognition; Lack of collaboration between medical and pastoral care professionals.
Need for New Solutions (5)	Integration would facilitate the development of methodological guidelines; Training of team members would strengthen acceptance; Integration could enhance the humanisation of care services; It would strengthen trust between patients and care teams; Pastoral care integration should be regulated at the national level.

*Scale means were calculated when at least 60% of statements were answered.

The overall structure of the instrument comprises three main levels of analysis: the assessment of spiritual needs and the significance of pastoral care; the benefits and barriers of integration; and the need for potential solutions and systemic changes. In this way, the instrument enables a comprehensive evaluation of the value-based, organisational, and strategic aspects of integrating pastoral care into palliative nursing.

5. RESEARCH RESULTS

A total of 146 respondents participated in the study. Of these, 79 (54%) were specialists (members of palliative care teams or leaders of relevant organisations), while 64 (44%) were non-specialists (patients or their relatives). The graphical illustrations (Figures 1–5) present the distribution of respondents' answers reflecting the perceived significance of the statements in the context of palliative care. In the graphs, the response categories "agree" and "strongly agree" are combined, as well as

"disagree" and "strongly disagree," while the neutral responses "no opinion" are presented separately.

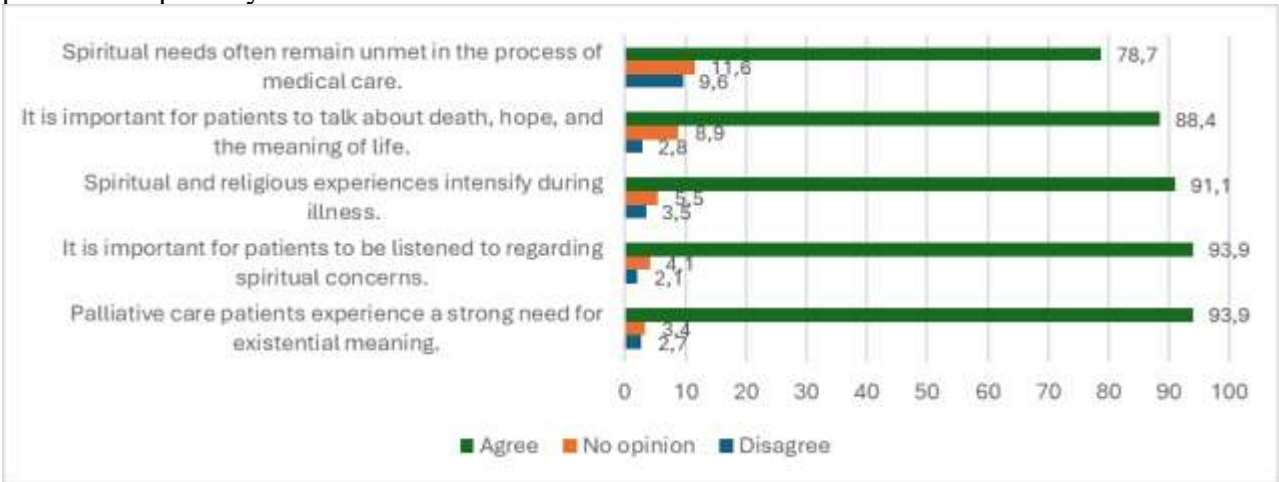

Figure 1. Percentage distribution of respondents' answers evaluating spiritual needs in palliative care.

The results presented in Figure 1 demonstrate a very high level of agreement with all statements concerning the importance of spiritual needs in palliative care. The highest proportion of respondents agreed that palliative care patients experience a strong need for existential meaning (93.9%) and that patients consider it important to be listened to regarding spiritual issues (93.9%). A similarly high level of agreement was observed for the statement that spiritual and religious experiences often intensify during illness (91.1%). A large proportion of respondents also agreed that patients find it important to discuss death, hope, and the meaning of life (88.4%). Although the statement that spiritual needs often remain unmet in the medical care process received slightly lower agreement (78.7%), 78.7% of respondents still supported it.

Negative evaluations were minimal across all cases, ranging from 2.1% to 3.5%, while neutral responses ranged from 3.4% to 11.6%, with the highest proportion observed for the statement on unmet spiritual needs. Overall, the findings indicate that respondents clearly recognise the importance of spiritual aspects in palliative care. The high level of agreement suggests a strong perception that existential, spiritual, and religious issues constitute an essential component of the patient experience and should be integrated into palliative care practice.

Figure 2 presents respondents' evaluations of the role of pastoral care in palliative nursing, highlighting its relationship with patients' spiritual needs and emotional well-being. The results demonstrate a very high level of agreement with all statements regarding the significance of pastoral care. The largest proportion of respondents agreed that pastoral care helps patients' families cope with the process of loss (93.8%) and reduces patients' emotional and spiritual suffering (92.4%). A similarly high level of agreement was found for the statements that pastoral care is important for ensuring patient dignity (91.1%) and helps patients more easily come to terms with their illness (89.7%). Although a slightly smaller proportion (83.6%) agreed with the statement that palliative care is not comprehensive without pastoral care, this still reflects the majority's clear position. The proportion of neutral responses ranged from 4.8% to 11.6%, while negative evaluations were very limited (1.4% to 4.1%).

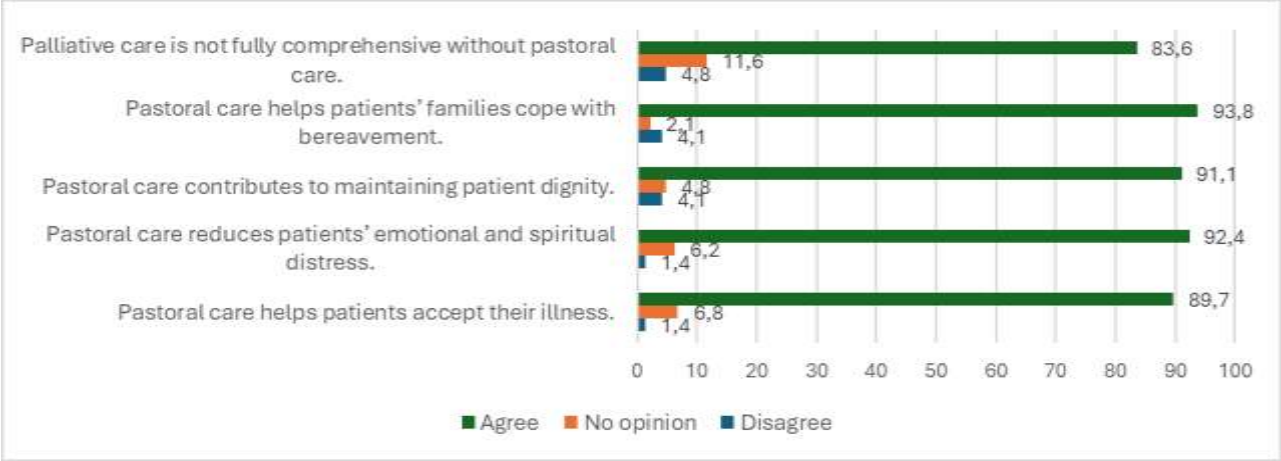

Figure 2. Percentage distribution of respondents' answers evaluating the role of pastoral care in palliative care.

The findings indicate that respondents associate the role of pastoral care with key aspects of palliative care, including emotional support, the preservation of patient dignity, the process of acceptance, and support for relatives. The high level of agreement suggests that pastoral care is perceived as an important component of holistic palliative care oriented toward patients' spiritual needs.

Figure 3 presents respondents' evaluations of the importance of integrating pastoral care into the palliative care team and its potential impact on the quality of services. The results show a very high level of agreement with all statements related to the integration of pastoral care. The largest proportion of respondents (94.5%) agreed that pastoral care should be a permanent part of the palliative care team. In addition, 91.8% agreed that pastoral care should be included in the individual patient care plan, while 91.1% stated that a pastoral care specialist should participate in team meetings. An equally high level of agreement (91.1%) was observed for the statements that integrating pastoral care would help the team better understand patient needs and improve the overall quality of palliative care. The proportion of neutral responses ranged from 3.4% to 6.2%, while negative evaluations were very limited (2.1–4.1%). These findings suggest that respondents perceive the integration of pastoral care as a significant factor in improving the quality of palliative care. Such integration may strengthen teamwork, better recognise patients' needs, and ensure more comprehensive care. The high level of agreement indicates that pastoral care is not viewed as an additional or peripheral service but rather as a potentially integral and structurally important component of the palliative care team.

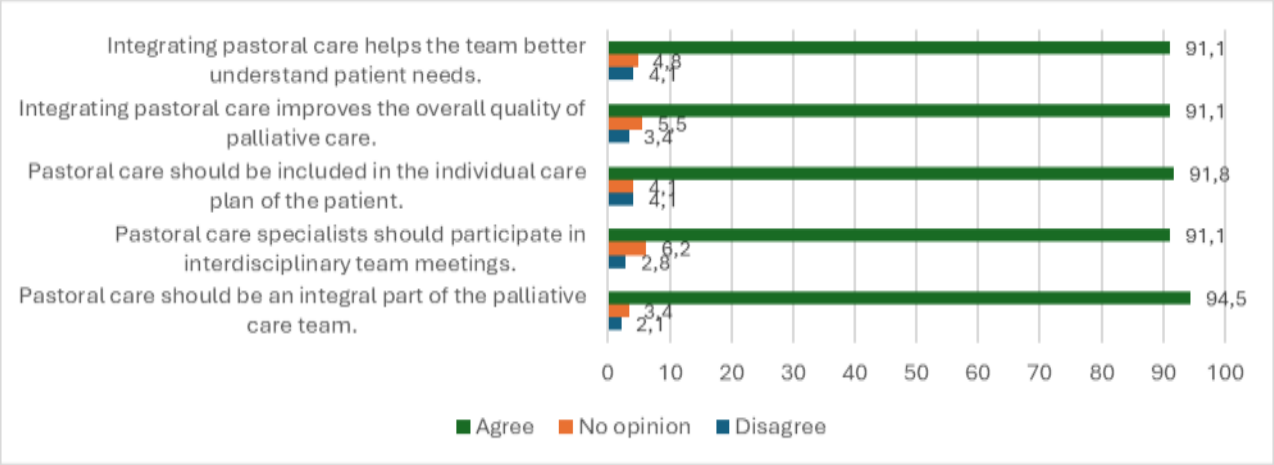

Figure 3. Percentage distribution of respondents' answers evaluating the integration of pastoral care into the palliative care team and its contribution to service quality.

Figure 4 presents respondents' evaluations of potential barriers that hinder the integration of pastoral care into palliative care. The results indicate that the majority of respondents recognise significant systemic and organisational barriers. The largest proportion of respondents agreed that the importance of pastoral care is insufficiently recognised at the institutional level (80.7%). Similarly high levels of agreement were observed for the statements that palliative nursing lacks a clearly defined role for pastoral care (79.5%) and that team members often lack sufficient knowledge of pastoral care's functions (78.0%). In addition, 77.4% of respondents agreed that there is insufficient collaboration between medical and pastoral care professionals. A slightly lower, yet still notable, level of agreement (64.8%) was observed for the statement that a lack of financial resources limits the integration of pastoral care. This statement also received the highest proportion of neutral responses (29%), which may reflect varying levels of awareness regarding financial aspects. Negative evaluations remained relatively low across all statements (3.5–8.9%), while neutral responses ranged from 13% to 29%.

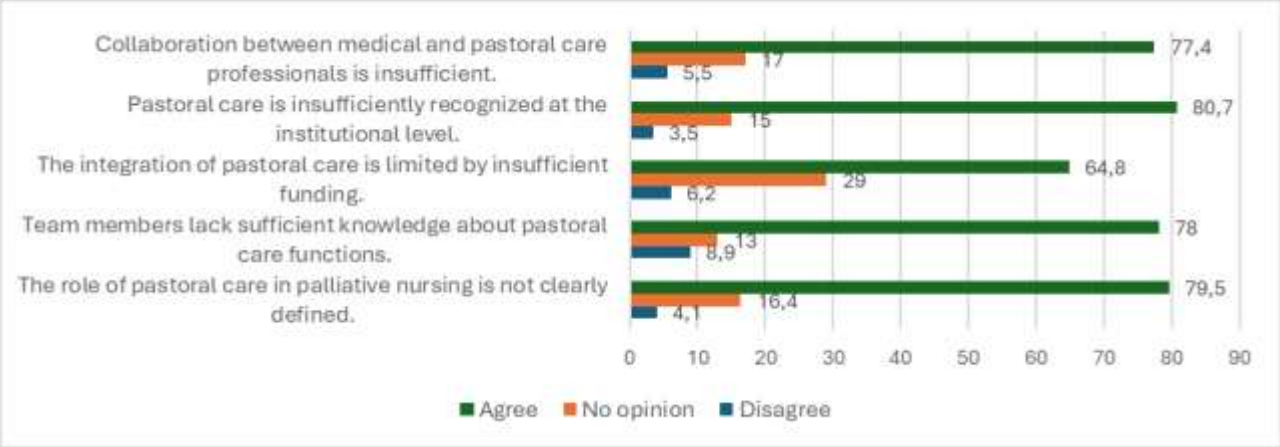

Figure 4. Percentage distribution of respondents' answers evaluating barriers to the integration of pastoral care into palliative nursing.

Figure 5 presents respondents' evaluations of possible solutions and additional measures that could strengthen the integration of pastoral care into palliative nursing. The results demonstrate a very high level of agreement with the proposed strategies for enhancing integration. The largest proportion of respondents (97.2%) agreed that

clear methodological guidelines would facilitate the integration of pastoral care. In addition, 95.1% of respondents agreed that training for team members on pastoral care would increase its acceptance in practice. More than nine out of ten respondents (93.8%) stated that the integration of pastoral care should be regulated at the national level. A similarly high level of agreement (93.1%) was observed for the statements that integrated pastoral care would strengthen mutual trust between patients and care teams and enhance the humanisation of healthcare services. The proportion of neutral responses remained relatively low across all statements (3.4–6.9%), while negative evaluations were minimal (1.4–4.8%). These findings indicate that respondents clearly express the need for systemic solutions and structural development. The greatest emphasis is placed on methodological clarity, professional training, and national-level regulation. Overall, the results suggest that integrating pastoral care is perceived as a process that requires not only value-based support but also a well-developed institutional, methodological, and educational infrastructure.

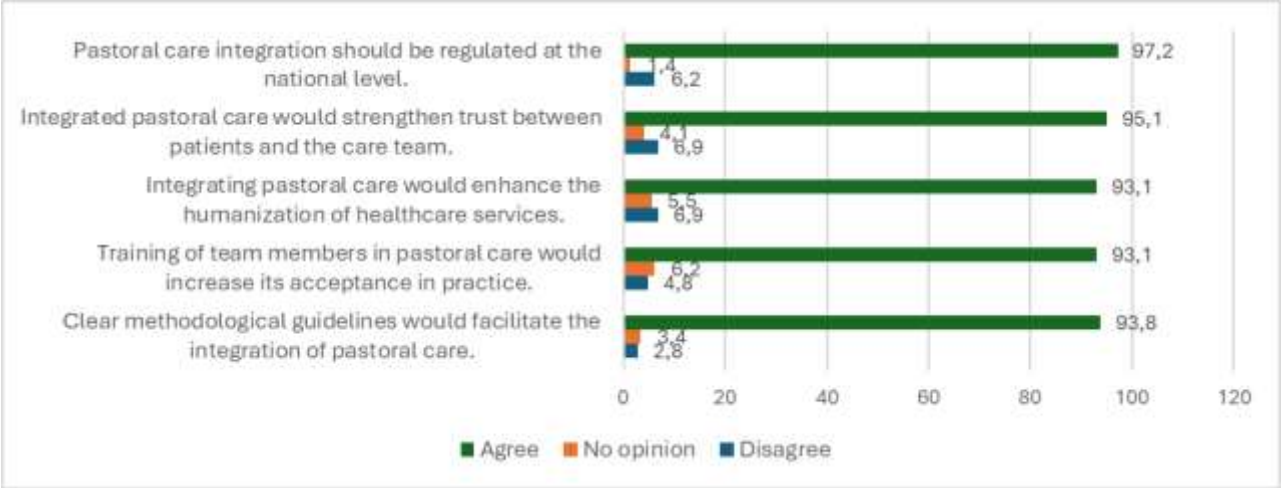

Figure 5. Percentage distribution of respondents' answers evaluating the need for additional integration opportunities and new solutions.

In the research instrument, respondents were also presented with two open-ended questions: why pastoral care should (or should not) be integrated into palliative nursing and what changes would be necessary for pastoral care to become a fully developed component of palliative care.

Table 3. Structured distribution of responses explaining why pastoral care should (or should not) be integrated into palliative nursing.

Thematic Category	**Description**	**Frequency (n)**	**Orientation**
Holistic approach (body–soul unity)	The patient is perceived as a whole person integrating body, mind, and spirit.	≥40*	Strongly supportive
Importance of spiritual needs	Emphasis on spiritual support, faith, meaning, and hope during illness.	≥30*	Strongly supportive
Psychological and emotional support	Pastoral care is seen as a source of emotional security and support.	≥10*	Supportive
Strengthening teamwork	Emphasis on interdisciplinary collaboration within the care team.	≥15*	Supportive

Perceived non-necessity / doubts	Statements suggesting that pastoral care is unnecessary or should remain optional.	≥3	Critical minority
Other individual opinions	Individual or difficult-to-categorise responses.	≥38	Diverse

* Some responses were assigned to multiple categories; therefore, totals may exceed the number of respondents.

The motives emerging from respondents' answers (see Table 3) reveal a distinctly holistic view of the human person. The dominant paradigm reflects a holistic understanding of the person, as illustrated by statements such as: "A human being is not only a body but also a spirit" and "Palliative care must be comprehensive." These responses indicate that respondents perceive pastoral care as a natural component of comprehensive care. Respondents also recognise spiritual needs, which they associate with hope and existential concerns. As one respondent noted, "In critical moments of a person's life, the need for faith or spiritual accompaniment emerges." This finding aligns with the quantitative analysis, which demonstrates a strong correlation between the perceived importance of spiritual needs and support for integrating pastoral care. Respondents also emphasised the importance of emotional security for the patient and support for relatives, particularly during moments when assistance is needed in processes of reconciliation and loss. Responses regarding security, support, and reconciliation may therefore be interpreted as indicators of the practical usefulness of integrating pastoral care. The strengthening of a multidisciplinary model is also clearly reflected in respondents' statements, for example: "Integrated pastoral care would strengthen teamwork and collaboration among different specialists"; "Teamwork would be more effective if spiritual aspects were addressed systematically rather than occasionally"; and "Pastoral care could become a full member of the team, contributing to the overall treatment plan." These statements suggest that some respondents perceive the integration of pastoral care not merely as an individual form of assistance but as a structural element of team-based practice. In this context, pastoral care is conceptualised as an equal component of the multidisciplinary team, complementing medical, nursing, and social care and contributing to the comprehensive response to patients' needs. Only a very small proportion of respondents expressed doubts about the necessity of pastoral care in palliative care. These respondents indicated that pastoral care should remain optional, as reflected in statements such as: "Pastoral care should not be mandatory; it should be a personal choice", and "It is not relevant for all patients." Such views are grounded in the principle of patient autonomy rather than in the rejection of integrating pastoral care. Thus, they represent a position favouring individualisation rather than opposition to pastoral care itself. The analysis of responses also revealed a clear anthropological assumption: the human person is perceived as an integral unity of body and spirit. Respondents justify the integration of pastoral care not through institutional or religious arguments but through the existential principle of human wholeness. In this perspective, palliative care is constructed as more than a medical intervention; it becomes a process of existential accompaniment that reflects a holistic model of care. Consequently, pastoral care integration is perceived as a natural rather than an additional or external function.

Many responses frame the end-of-life situation as an existential crisis, reflected in recurring semantic categories such as meaning, hope, reconciliation, and peace. This suggests that respondents associate pastoral care with the alleviation of existential distress rather than solely with religious practice. Importantly, this motif is consistent

with the quantitative findings, which showed that the importance attributed to spiritual needs significantly predicted support for integrating pastoral care. Open-ended responses frequently referred not only to patients but also to their relatives, indicating that respondents perceive palliative care as a systemic form of care that includes the family unit. In this context, pastoral care is understood as a mechanism for emotional support, bereavement assistance, and a space for mediation and reconciliation. Some responses extend the discussion to the organisational level, highlighting the strengthening of teams, improved collaboration, and the need for systematic integration. This suggests that some respondents view pastoral care not only as an individual intervention but also as a structural component of care quality. Overall, the analysis of respondents' answers reveals a dominant orientation toward a holistic model of care in which pastoral care is perceived as an essential element of comprehensive palliative care. Critical attitudes were minimal and were primarily based on the principle of freedom of choice rather than rejection of integration.

Table 4. Structured distribution of responses explaining what changes would be necessary for pastoral care to become a fully integrated component of palliative care.

Thematic Category	**Content**	**Level**	**Frequency**
Institutional regulation	Legal definition of pastoral care roles, formal recognition of positions, and funding mechanisms.	Systemic	Very frequent
Clear definition of pastoral care roles	Specification of competencies, responsibilities, and professional functions.	Structural	Frequent
Specialist training	Education and training of team members regarding the role and functions of pastoral care.	Educational	Frequent
Interdisciplinary collaboration	Strengthening teamwork and cooperation among professionals.	Organizational	Moderate
Public awareness	A broader understanding of pastoral care as a professional field.	Social	Moderate
Resource allocation	Provision of financial and human resources.	Administrative	Moderate

The analysis (see Table 4) revealed that respondents perceive the integration of pastoral care into palliative care as purposeful and necessary; however, its full implementation requires systemic, structural, and cultural changes. First, respondents emphasised the need to establish an institutional framework, including legal regulation, the formal recognition of pastoral care positions within the healthcare system, and adequate funding. Respondents stressed that without official recognition and structural legitimisation, pastoral care would remain fragmented or dependent on individual initiatives. This perspective is reflected in statements such as: "Clear legal recognition and regulation of pastoral care within the healthcare system are needed"; "A formal position and funding for this function should be established"; "Without official recognition, pastoral care will remain only an additional initiative"; "Pastoral care must be integrated into the team rather than function separately"; "Collaboration between medical professionals and pastoral care representatives must be systematic." Second, respondents highlighted the importance of a clear definition of pastoral care functions and competencies to avoid role duplication and ensure smooth interdisciplinary collaboration. This reflects the intention to strengthen professional identity and integrate pastoral care as an equal member of the multidisciplinary team. For example, respondents stated: "A clear definition of pastoral care within palliative care is needed" and "It is important to define the competencies and responsibilities of

pastoral care." These responses indicate expectations for a shift from value-based recognition toward structural institutionalisation. Third, respondents emphasised the educational dimension, particularly the need for team members to be trained to recognise spiritual needs and to understand the role of pastoral care in palliative practice. This reflects the need to foster a supportive organisational culture and expand understanding of the importance of the spiritual dimension in care. As respondents noted: "Team members need more training in recognising spiritual needs" and "Education would help professionals better understand the significance of pastoral care in practice." The emphasis on training suggests that integration is associated not only with structural solutions but also with cultural change within healthcare organisations. Fourth, respondents stressed the importance of public awareness, noting that patients and their families should be informed about the availability of pastoral care services to make informed choices about this form of support. Representative responses include: "There is a need to provide more information to society about the pastoral care profession" and "Patients should know that this type of support is available." Overall, these responses indicate that respondents perceive pastoral care integration as a characteristic of a mature multidisciplinary care system. Integration is viewed as an indicator of care quality. The full implementation of pastoral care in palliative care is associated not only with value-based recognition but also with consistent institutionalisation, a clear professional structure, and a strong interdisciplinary culture. Respondents' perspectives demonstrate a shift from the question "whether pastoral care should be integrated" to "how it can be integrated systematically and sustainably."

6. CONCLUSIONS

The results of the empirical study reveal a clear interest among respondents in integrating pastoral care into palliative care. These findings confirm the assumption presented in the theoretical section that palliative care, grounded in a holistic understanding of the human person, inevitably includes the spiritual dimension as an integral part of the patient's experience. Respondents' perspectives reinforce the study's central tendency: the integration of pastoral care is perceived as both necessary and meaningful. However, its implementation should be responsible, ethical, and systematic. The empirical findings highlight three key dimensions of pastoral care integration within palliative care.

1. Structural–institutional dimension. Integration should be clearly regulated and professionally structured. The functions and responsibilities of pastoral care must be clearly defined in order to avoid role duplication or ambiguity. This finding aligns with the principle of integrality discussed in the theoretical framework, which holds that all dimensions of palliative care must be systematically coordinated and embedded within organisational structures.
2. Ethical–autonomy dimension. Pastoral care should remain a matter of personal choice rather than coercion. This conclusion aligns with the principles of palliative care, which emphasise patient dignity, freedom, and individuality. Even respondents who strongly support integration highlight the importance of patient autonomy, reflecting contemporary bioethical principles and patient-centred care models.
3. Organisational–practical dimension. Integration requires concrete organisational solutions, sufficient resources, and effective interdisciplinary collaboration. This confirms the theoretical assumption that although spiritual care is conceptually recognised, its implementation in practice often faces institutional, financial, or competency-related limitations.

Overall, the findings demonstrate the dominance of a holistic care perspective, in which pastoral care is an essential component of comprehensive palliative care. Critical attitudes were minimal and were primarily based on the principle of freedom of choice rather than rejection of integration. These results empirically confirm the theoretical premise that spirituality, understood as an existential and meaning-oriented dimension, plays an important role in serious illness. Pastoral care integration is perceived not as an additional or external function but as a natural component of palliative care, associated with reducing existential distress, facilitating processes of reconciliation, and strengthening emotional support. Respondents also perceive palliative care as a systemic model that encompasses not only the patient but also the family unit. In this context, pastoral care is conceptualised as a mechanism of emotional support, assistance during bereavement, and a space for mediation and reconciliation.

The findings confirm that the spiritual dimension constitutes an integral component of palliative care. According to respondents' perspectives, the question of whether pastoral care should be integrated is no longer central—attention instead shifts to the practical challenge of ensuring systematic, sustainable, and well-coordinated integration. Consequently, the inclusion of pastoral care can be viewed as a strategic direction in the development of palliative care systems, requiring clear regulation, methodological guidelines, interdisciplinary collaboration, and the strengthening of professional competencies.

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