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**MANAGEMENT OF HEALTHCARE ORGANIZATIONS – GOALS,
FUNCTIONS, METHODS AND SPIRITUAL SUPPORT.
A HOLISTIC APPROACH TO PATIENTS**

**AUTHOR’S ABSTRACT
of a doctoral dissertation**

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The dissertation was discussed and approved for public defense at an extended meeting of the Department of Theology at the Faculty of Philosophy and History of Plovdiv University "Paisii Hilendarski", held on 30.06.2026.

The dissertation comprises a total of 207 pages and includes an introduction, three chapters, conclusion, publications related to the research topic, bibliography, and appendices. The text contains 3 tables, 17 figures, and 8 appendices.

The bibliography includes 124 references, of which 36 are in Cyrillic and 88 are in Latin script, as well as normative documents, electronic resources, and scientific publications. The dissertation also includes a scholarly apparatus consisting of 266 footnotes.

The empirical part of the study includes 11 in-depth interviews, two survey studies, research conducted among 336 professionals, and research conducted among 129 users of healthcare and social services.¹

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¹ To ensure the readability and conciseness of this dissertation abstract, in-text citations and references have been omitted. For detailed references, please consult the full dissertation.

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GENERAL CHARACTERISTICS OF THE DISSERTATION

1. Relevance and Significance of the Research Problem

Under contemporary conditions, social policy, healthcare, and medico-social services occupy a central position within the system of public governance, as they are directly related to the protection of human dignity, quality of life, and social solidarity. Alongside the medical, social, and organizational dimensions of care, increasing attention is being paid to the spiritual dimension of human existence, particularly in situations involving illness, old age, disability, chronic suffering, palliative conditions, and existential crises.

Modern individuals do not experience illness merely as a physiological condition. Disease, loss of autonomy, dependence on the assistance of others, loneliness, and the fear of death affect the person in their entirety-physically, psychologically, socially, morally, and spiritually. For this reason, a holistic approach to patient care cannot be limited solely to diagnosis, treatment, and social support; it should also encompass care for the individual's inner peace, hope, sense of meaning, religious beliefs, and existential concerns.

The relevance of the present study is determined by several interrelated factors.

First, within Bulgarian practice, the spiritual dimension of care remains insufficiently institutionalized, despite the fact that the international scientific and professional community has long recognized spiritual care as an essential component of high-quality palliative, long-term, and integrated care. Most healthcare institutions and medico-social services still lack sustainable models of spiritual support, clearly defined mechanisms for cooperation with clergy, as well as legally regulated forms of spiritual care.

Second, the findings of the empirical study conducted as part of this research reveal a significant deficiency precisely in this area. A considerable proportion of respondents expressed a need for conversation, inner peace, existential support, and spiritual presence. At the same time, only a small percentage perceived that they actually received such support within institutional settings. The data indicate that 70,54 % of healthcare and medico-social service users expressed a need to talk with another person; 45,74 % wished to discuss the meaning of life, while the same percentage sought inner peace. Simultaneously, 41,86 % reported that, to varying degrees, they had no one with whom to discuss their fears and concerns, and 36,43 % experienced loneliness. Furthermore, 86,1 % of medico-social

services and 70,6 % of healthcare institutions lacked Orthodox chapels or prayer spaces, while conversations with clergy remained the least frequently available form of support.

Third, in the context of an ageing population, the increasing prevalence of chronic diseases, the growing demand for palliative care, and the rising institutional dependence of vulnerable groups, the absence of spiritual support can no longer be regarded as a secondary issue. It affects not only the psycho-emotional well-being of patients and service users but also the overall quality of care, trust in institutions, medical ethics, and society's understanding of human dignity.

From a theological perspective, this topic is of particular importance because it places the social mission of the Orthodox Church within a new contemporary context. Orthodox theology traditionally understands the human person as an inseparable unity of body, soul, and spirit. Consequently, the Church's responsibility towards those who are ill, elderly, or suffering extends beyond the administration of the sacraments and occasional pastoral visits. It also encompasses compassionate presence, pastoral care, and meaningful cooperation with healthcare and social institutions.

This raises the question of the need to rethink the relationship between medicine, psychology, social work, and theology, as well as the necessity of establishing a sustainable model of interdisciplinary collaboration in which spiritual support is regarded as an integral component of comprehensive human care.

The present doctoral dissertation seeks precisely to demonstrate that spiritual support is not an external addition to the therapeutic process but rather a fundamental element of the holistic approach to patients and users of medico-social services.

2. Object and Subject of the Research

The object of the present study is holistic care within healthcare and medico-social services in Bulgaria as a field of interaction between medicine, social work, ethics, psychology, and theology.

The study examines the healthcare and social care systems not merely as administrative and clinical structures, but as environments in which comprehensive human care is provided. Within this perspective, care is understood as a multidimensional process that encompasses not only medical treatment and social support but also attention to the patient's spiritual needs, inner resilience, and existential well-being.

The subject of the study is the place and role of spiritual support, and more specifically the involvement of the Orthodox clergy and organized forms of spiritual care in the process of caring for patients and users of healthcare and social services.

Particular attention is given to the possibilities for institutionalizing spiritual care through healthcare chaplaincy, multidisciplinary teams, dedicated spiritual spaces, referral mechanisms, and professional collaboration among healthcare professionals, social workers, and clergy.

The object and subject of the study, as defined above, provide a framework for both the theoretical conceptualization and the practical investigation of spiritual support as an essential component of contemporary healthcare and social care.

3. Main Aim and Objectives of the Research

The primary aim of the present dissertation research is to demonstrate the need for closer and more sustainable collaboration between the individual academic disciplines and theology, as well as between healthcare institutions, medico-social services, and religious communities, with the objective of developing a more comprehensive, humane, and ethically sustainable model of care for patients and users of social services.

The study is based on the understanding that high-quality care cannot be reduced solely to medical intervention, clinical outcomes, or the administrative organization of services. Contemporary individuals experience illness, suffering, dependency, and old age as complex conditions that affect not only their physical health but also their psycho-emotional well-being, social relationships, sense of meaning, and spiritual resilience. For this reason, the dissertation seeks to demonstrate that spiritual support constitutes an integral component of the holistic approach to patient care.

Particular attention is devoted to the possibilities for the institutional integration of spiritual care within the Bulgarian context, so that it does not remain merely a matter of sporadic personal initiative or individual religious practice, but is recognized as a professionally and ethically indispensable component of the healthcare and medico-social service system.

To achieve this primary aim, the following research objectives have been formulated:

1. To analyze the theoretical foundations by defining the concepts of healthcare organization, integrated health and social services, spirituality, chaplaincy, the holistic model of care, and the place of spirituality within medicine and social care.

2. To examine international practices concerning spiritual support and chaplaincy within healthcare systems.
3. To develop research questionnaires and conduct an empirical survey exploring professionals' attitudes towards spiritual support, the existence of institutional practices for its provision, as well as the spiritual needs and level of satisfaction of patients and users of healthcare and medico-social services.
4. To identify the existing deficiencies in Bulgarian healthcare institutions and medico-social services with regard to the provision of spiritual care.
5. To identify and analyze the spiritual needs of patients and service users, together with their assessment of the spiritual support currently available.
6. To analyze the role of healthcare and social care professionals and to explore the possibilities for effective collaboration with the Orthodox clergy and other religious representatives in providing holistic care.
7. Based on the findings of the study, to formulate practical recommendations for the institutional integration of spiritual care and support within the Bulgarian context. This objective has a distinctly applied orientation and aims to develop managerial, organizational, and educational guidelines for establishing a sustainable model of spiritual support in hospitals, medico-social services, hospices, residential homes for older persons, and residential services for people with disabilities.

The formulation of these aims and objectives provides the study with both substantial theoretical depth and clear practical applicability, placing at its centre not only the organization of healthcare and social services but also the dignity of the human person as the fundamental value underlying holistic care.

4. Research Thesis

The central thesis of the present dissertation is that spiritual support is not an external addition to medical and social care but rather an inherent and indispensable component of the holistic approach to the human person, without which comprehensive care cannot be achieved in situations of illness, old age, disability, dependency, and existential crisis.

The dissertation is founded on the understanding that the human person cannot be regarded merely as a biological organism, a patient, a service user, or an administrative case. Every individual is a unique person with a personal history, values, fears, hopes, religious beliefs, and a search

for meaning. In situations of suffering, these spiritual and existential dimensions frequently become even more significant than medical treatment itself, as they shape the way individuals experience illness, participate in decisions concerning their own care, and preserve their dignity.

Within the Bulgarian context, the absence of systematically organized spiritual care represents a substantial deficiency in the quality of healthcare and medico-social services. The lack of institutionalized forms of spiritual support, the limited presence of clergy within healthcare institutions and medico-social facilities, and the insufficient preparation of healthcare and social care professionals to recognize and address spiritual needs create a significant gap in the provision of comprehensive patient care.

The dissertation argues that the institutionalized, voluntary, ethically safeguarded, and interprofessionally coordinated involvement of clergy, spiritual practices, and dedicated spiritual spaces would make a substantial contribution to improving the emotional well-being of patients and service users, reducing feelings of loneliness, fear, and existential distress, increasing satisfaction with the care provided, strengthening public trust in healthcare and social institutions, supporting families and informal caregivers, and affirming human dignity as a fundamental value of the healthcare and medico-social system.

The proposed thesis is grounded both in international scientific evidence and in established models of healthcare chaplaincy and spiritual care, as well as in the findings of the empirical research conducted within this dissertation. These findings clearly demonstrate a significant discrepancy between the actual spiritual needs of patients and service users and the extent to which healthcare and social institutions provide accessible, recognizable, and systematically organized spiritual support.

Accordingly, spiritual support should be understood not as a peripheral or optional activity but as an integral element of the very philosophy of care, representing a transition from treating disease to caring for the whole person in all dimensions of human existence.

5. Research Methodology

The methodology of the present dissertation research is aligned with the complex, interdisciplinary, and value-sensitive nature of the scientific problem under consideration. The study develops at the intersection of theology, medicine, social work, healthcare management, bioethics, and organizational sciences, and therefore requires an approach capable of addressing both the theoretical depth of the issue and its practical manifestation within the institutional environment.

For this reason, a mixed research approach has been selected, combining qualitative and quantitative methods, thus enabling both an in-depth understanding of individual experiences and the identification of broader patterns and tendencies within the healthcare and medico-social service system.

5.1. Theoretical Part of the Research

The theoretical part of the dissertation is based on a systematic analysis and synthesis of scientific literature devoted to the holistic model of care, spirituality in medicine, palliative medicine, chaplaincy, the organization of healthcare institutions, and the role of the Orthodox Church in social and healthcare support.

The following scientific methods have been employed:

Analysis and Synthesis

Through analysis, the principal concepts, scientific models, and existing theoretical frameworks related to spiritual care and the holistic approach are examined. Synthesis enables the construction of a unified conceptual framework connecting the medical, social, and theological understanding of the human being.

Historical and Comparative-Historical Approach

This method is used to trace the development of medical models - from the biomedical model to the biopsychosocial and biopsychosocial-spiritual models-as well as to examine the development of spiritual care in different healthcare systems.

Structural-Functional Approach

This approach is employed in the analysis of management models in healthcare organizations, the role of multidisciplinary teams, the place of chaplaincy, and the possibilities for institutionalizing spiritual support.

5.2. Empirical Part of the Research

The empirical part of the dissertation is designed to test the central research thesis through data obtained from professional practice and to identify the spiritual needs of patients and users of healthcare and medico-social services, as well as to examine how spiritual support is perceived by professionals working within these systems.

To achieve these objectives, the study employs a mixed-methods research design combining quantitative and qualitative approaches. The empirical research includes questionnaire surveys among healthcare

professionals, social care professionals, patients, and users of medico-social services, together with semi-structured interviews and an analysis of institutional practices.

Content analysis was applied to the interview data, institutional practices, and organizational models in order to systematize the qualitative findings, identify recurring patterns, and establish stable thematic categories. This methodological approach made it possible to interpret participants' experiences, perceptions, and attitudes regarding spiritual support, while also identifying the existing organizational mechanisms and institutional deficiencies related to its provision.

The combination of quantitative and qualitative methods provides a comprehensive understanding of the current state of spiritual care in Bulgaria and enables the validation of the dissertation's central thesis through empirical evidence obtained from both healthcare and medico-social practice.

5.3. Statistical Processing

The quantitative data were processed through descriptive statistics and correlation analysis, allowing the identification of relationships between individual indicators and supporting the main conclusions of the study.

5.4. Limitations of the Research

Alongside the undeniable scientific and practical value of the study, its limitations should also be clearly acknowledged.

First, the sample does not allow for full representativeness of all users of healthcare and medico-social services in Bulgaria. The study is focused mainly within the South Central Region and on specific institutions; therefore, its findings should not be mechanically generalized to the country as a whole.

Second, part of the data is based on self-assessment and personal experience, which implies the possibility of subjectivity, socially desirable responses, and individual interpretations.

Third, spiritual support is, by its very nature, a difficult category to measure, as it involves inner experiences, existential states, and personal religious attitudes that cannot always be fully objectified through standard research instruments.

Fourth, the study reflects the state of practices and attitudes during the period 2024–2025, that is, within a specific social, institutional, and regulatory context.

These limitations, however, do not invalidate the results but rather clearly outline the framework within which they should be interpreted. On the contrary, they emphasize the need for future larger-scale research and for the continuation of scholarly work in this direction.

6. Theoretical and Practical Significance of the Research

The scientific and theoretical significance of the present study is determined by its interdisciplinary character and its attempt to overcome the traditional separation between medicine, social work, and theology.

The dissertation contributes to the advancement of existing knowledge concerning:

- the holistic model of care;
- the spiritual dimension of medicine;
- the role of the Orthodox Church in contemporary society;
- the opportunities for interdisciplinary dialogue between theology, medicine, and the social sciences;
- managerial models for the institutional integration of spiritual support within healthcare and medico-social settings.

The study argues that spiritual care should not be understood merely as a confessional or religious practice but as an anthropological, ethical, and organizational necessity that ought to be recognized as an integral component of the quality of institutional care.

Particular significance is attached to the development of a conceptual framework in which spiritual support is viewed as a professionally justified and managerially relevant component of healthcare and medico-social services, rather than as a peripheral or supplementary activity.

The practical significance of the research findings lies in their direct applicability to the development of policies, standards, internal regulations, and best practices concerning the provision of spiritual support within healthcare and medico-social institutions.

The findings of the study may be applied to:

- a) the development of institutional protocols for spiritual assessment and referral;
- b) the establishment of collaborative models between hospitals, healthcare and social institutions, and religious communities;
- c) the creation of dedicated spiritual spaces within healthcare and medico-social facilities;
- d) the development of educational and training programmes for nurses, social workers, healthcare chaplains, and volunteers;

- e) the preparation of internal policies and operational guidelines for hospitals, hospices, residential homes for older persons, and residential services for people with disabilities;
- f) the formulation of national policies in the fields of spiritual care and palliative medicine.

The practical value of the dissertation also lies in the fact that it provides a scientifically grounded foundation for the institutional integration of spiritual support within the Bulgarian context, taking into account both the actual capacities and the existing limitations of the healthcare and social service systems.

In this way, the dissertation represents not only an academic contribution but also a practical framework for managerial, organizational, and societal change aimed at promoting a more humane, equitable, and comprehensive model of care for people experiencing illness, suffering, and vulnerability.

BRIEF PRESENTATION OF THE RESEARCH

CHAPTER ONE. HEALTHCARE AND MEDICO-SOCIAL ORGANIZATIONS: FUNCTIONS AND PROVISION OF SPIRITUAL SUPPORT

The first chapter of the dissertation is devoted to the managerial, organizational, and structural dimensions of healthcare organizations and to the place of spiritual support within the system of contemporary institutional care. The primary aim of the chapter is to demonstrate that spiritual care should not be regarded as a peripheral or supplementary activity, but rather as an element of the strategic management of healthcare organizations themselves.

The study begins with an analysis of the strategic goals and managerial functions within healthcare organizations, examining the mission, vision, and value framework of medical institutions. It is argued that the mission of a healthcare organization is not limited to the provision of medical assistance, but constitutes a public commitment to the protection of human dignity, trust, and quality of care. In this regard, the vision of the organization should include not only clinical outcomes, but also the quality of human presence, empathy, communication, and spiritual sensitivity toward the patient.

Special attention is devoted to Avedis Donabedian's classical model of "structure - process - outcome," which allows the quality of healthcare to be viewed not merely as a clinical result, but as a consequence of the

organizational environment, interaction processes, and the patient's lived experience. The six aims of a quality healthcare system formulated by the Institute of Medicine - safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity-are also analyzed. Within the context of the dissertation research, these criteria are expanded through the inclusion of spiritual support as part of the quality of care.

Managerial functions-planning, organizing, leadership, control, and evaluation-are examined as a dynamic cycle in which quality is managed not solely through administrative mechanisms, but through a culture of trust, coordination, and meaningful presence. It is demonstrated that the strategic management of human resources plays a key role in the development of empathy, compassion, and sensitivity to the spiritual needs of patients. The study emphasizes that contemporary healthcare organizations should regard human resources not merely as executors of clinical activities, but as bearers of care.

The next thematic focus concerns the organization of healthcare institutions and structural models of management. The hierarchical structure - manager, medical director, heads of departments, and administrative personnel-is analyzed in relation to managerial accountability, distribution of responsibilities, and quality control. At the same time, it is emphasized that hospitals do not function as "pure" bureaucratic structures, but rather as professional organizations characterized by a high degree of autonomy among clinical specialists.

The dissertation employs the concept developed by Henry Mintzberg and Sholom Glouberman concerning the "four worlds" of the hospital-cure, care, control, and community - in order to demonstrate that healthcare organizations represent systems of interdependent, yet often fragmented, professional spaces. From this perspective arises the necessity for coordination between medical and non-medical specialists and for the establishment of a genuine multidisciplinary model of work.

A central place in the chapter is occupied by the analysis of spiritual care as part of the organizational structure. It is argued that spiritual support cannot be left to occasional manifestations of personal empathy or sporadic visits by clergy, but requires a formalized place within the structure of the institution. In this regard, the role of the chaplain or spiritual consultant as part of the multidisciplinary team is examined. International models of hospital chaplaincy are presented, together with the consensus documents of Christina Puchalski and professional standards for chaplaincy practice.

Particular attention is devoted to the analysis of healthcare institutions in Bulgaria and the existing managerial and spiritual deficits. The research

demonstrates that the Bulgarian system is dominated by a management model oriented toward clinical pathways, financial accountability, and administrative efficiency, while the spiritual needs of patients remain institutionally marginalized. Sustainable forms of spiritual support, normatively recognized chaplaincy, systematic interaction with clergy, and an organizational culture incorporating spirituality as part of service quality are largely absent.

As a particularly valuable comparative example, the model of the Romanian Orthodox Church is examined. The Church has developed an active network of palliative care centers, hospices, children's centers, and socio-medical institutions in which medical, social, psychological, and spiritual support are integrated into a unified system. This model demonstrates that the participation of the Church within the healthcare and social sphere can be institutionally organized, professionally legitimate, and socially beneficial.

The following section of the chapter addresses medical personnel and spiritual support. The study analyzes the need for developing competencies related to recognizing spiritual needs, communication skills in situations of existential distress, and training for ethical referral to spiritual support. It is emphasized that medical professionals should not assume the role of clergy, but should be prepared to recognize suffering beyond clinical symptomatology.

Special attention is also devoted to socio-medical services and institutions for people with disabilities, where spiritual care often acquires even greater significance due to the prolonged nature of dependency, loneliness, and the need for sustainable human presence. The possibilities for implementing spiritual support within residential services, homes for older persons, family-type accommodation centers, and palliative care services are analyzed.

Conclusions from Chapter One

The first chapter demonstrates that spiritual support possesses not only theological and ethical significance, but also a clearly expressed managerial importance. The quality of healthcare cannot be reduced solely to clinical outcomes, but should also encompass the patient's overall experience, including their sense of security, trust, meaning, and human dignity.

The study shows that the absence of a formalized position for spiritual care reveals a structural deficit within the organization of healthcare institutions. The integration of a spiritual counselor or chaplain into the multidisciplinary team does not represent the mere "addition of a service,"

but rather a necessary correction of the organizational model through which the institution brings its mission of holistic care closer to actual practice.

Consequently, spiritual support should be regarded as part of the strategic management of healthcare organizations and as a fundamental component of quality, ethical, and human-centered care.

CHAPTER TWO. HOLISTIC APPROACH TO USERS OF HEALTHCARE AND MEDICO-SOCIAL SERVICES

The second chapter of the dissertation is devoted to the theoretical foundations of the holistic approach to the patient, the place of spirituality in medicine and social work, international practices of spiritual support, and the possibilities for the institutional integration of spiritual care within the Bulgarian healthcare and social system.

The primary aim of this chapter is to provide both scientific and practical arguments demonstrating that spiritual support is an inseparable part of quality human care and that the holistic model represents a necessary evolution in the contemporary understanding of health, treatment, and human dignity.

The study begins with an analysis of the theoretical foundations of the holistic model and spirituality in medicine. The historical development from the classical biomedical model to the biopsychosocial model of George Engel is traced, together with its later expansion into the biopsychosocial-spiritual model formulated by Daniel Sulmasy and further developed within contemporary palliative medicine.

It is demonstrated that, although the biomedical model has been of exceptional importance for the development of clinical medicine, it proves insufficient in explaining and addressing human suffering, since it views the patient primarily as a carrier of disease rather than as a person possessing psychological, social, and spiritual reality. The holistic model overcomes this limitation by placing the human being, in their wholeness, at the center of care.

Special attention is devoted to the understanding of suffering as a phenomenon that cannot be reduced solely to physical pain. In this regard, the concept of “total pain” developed by Cicely Saunders is examined, encompassing physical, psychological, social, and spiritual suffering. Within this context, spiritual support acquires substantial significance as a resource for hope, inner peace, acceptance, forgiveness, meaning, and a dignified experience of illness and the end of life.

The role of spirituality in contemporary medicine is also analyzed, with a distinction being made between religiosity and spirituality. It is emphasized that spiritual care is not limited to religious affiliation, but includes existential questions concerning meaning, suffering, hope, belonging, and inner resilience. This allows spiritual support to be understood as a universal human need rather than solely as a religious practice.

The next important focus concerns international practices of spiritual support within healthcare systems. Detailed attention is given to models in the United States, the United Kingdom, Germany, and Romania.

In the United States, spiritual care is institutionally developed through professional hospital chaplaincy, which is recognized as part of palliative medicine and multidisciplinary teams. The standards of the Association of Professional Chaplains are presented, together with the consensus report of Christina Puchalski concerning spiritual care as a fundamental component of quality palliative care.

In the United Kingdom, the model of NHS England includes hospital chaplains, spiritual consultants, and standardized tools for spiritual assessment, among which the FICA and HOPE models are of particular importance. Spiritual support forms part of comprehensive patient care and is integrated into hospital organization.

The German model is characterized by strong participation of church institutions within hospital and social care, especially in the fields of palliative medicine and long-term care.

Particular attention is devoted to Romania as the closest and most practically applicable comparative example for Bulgaria. The Romanian Orthodox Church has developed a sustainable model of cooperation with the healthcare and social system through palliative care centers, hospices, social institutions, and specialized programs for spiritual support. This model demonstrates that church participation can be institutionally organized without contradicting the secular character of the state.

Following the comparative analysis, the dissertation examines the situation in Bulgaria and the absence of systematically organized spiritual care. The study demonstrates that spiritual support within Bulgarian healthcare institutions and social services remains fragmented, dependent on individual initiatives, and lacking normative sustainability. The following deficits are identified:

- a) absence of hospital chaplaincy;
- b) lack of a normatively recognized position for spiritual counselors;
- c) absence of institutional protocols for spiritual assessment;

- d) lack of structured forms of cooperation between healthcare institutions and the Bulgarian Orthodox Church;
- e) absence of training programs for medical and social professionals in spiritual care.

This deficit is regarded not merely as an organizational problem, but also as an ethical deficit within the very philosophy of care itself.

An especially important part of the chapter is devoted to analyzing the possibilities for integrating spiritual support within socio-medical services. The ethical, legal, and cultural prerequisites in Bulgaria are examined, together with possible implementation models.

Mechanisms are proposed for:

- introducing institutional protocols for spiritual assessment;
- establishing prayer spaces and chapels;
- including clergy within multidisciplinary teams;
- staff training;
- developing national standards;
- partnership between the state, municipalities, and religious communities.

The chapter also examines instruments for evaluating spiritual support, including FACIT-Sp, FICA, HOPE, SDAT, and other internationally used methodologies that allow spiritual care to be objectified as part of service quality.

At the end of the chapter, concrete recommendations for the Bulgarian healthcare and social system are formulated. These include the necessity for strategic recognition of spiritual care, the development of a normative framework, inclusion of the topic within education in medicine, social work, and healthcare management, as well as the establishment of a sustainable model of institutional cooperation with the Bulgarian Orthodox Church.

Conclusions from Chapter Two

The second chapter demonstrates that the holistic approach does not represent an alternative or supplementary concept to contemporary medicine, but rather a necessary evolution in the understanding of quality care. Human beings cannot be treated solely as biological organisms, but should be understood as persons whose suffering encompasses physical, psychological, social, and spiritual dimensions.

International experience demonstrates that spiritual support can be successfully integrated into healthcare and social systems through sustainable institutional models, professional chaplaincy, and clearly defined managerial mechanisms.

Bulgarian practice still significantly lags behind in this regard; however, the comparative analysis proves that this deficit is not an inevitable condition, but rather a remediable situation provided there is consistent policy, professional training, and interinstitutional cooperation.

Consequently, spiritual care should be recognized as an essential component of the contemporary healthcare and social system, and its integration represents a necessary step toward a more just, humane, and sustainable model of patient care.

CHAPTER THREE. EMPIRICAL RESEARCH AND ANALYSIS OF SPIRITUAL NEEDS

The third chapter of the dissertation is of key importance, as it presents the empirical verification of the main research thesis and provides the practical evidential foundation of the dissertation. Through the conducted qualitative and quantitative research, the actual state of spiritual support within healthcare and social services, the spiritual needs of patients and service users, as well as the attitudes of professionals working within the institutional environment are analyzed.

The primary aim of this chapter is to determine whether there exists a real discrepancy between people's spiritual needs and the extent to which healthcare and social institutions recognize and meet those needs.

The research is based on a mixed methodological approach combining qualitative and quantitative methods. This allows for the simultaneous analysis of respondents' individual experiences and internal attitudes, while also identifying broader tendencies and patterns.

The first part of the chapter presents the research methodology, including 11 in-depth interviews, two survey studies, and an analysis of institutional practices in specific healthcare institutions and social services within the South Central Region of Bulgaria.

The conduct of 11 in-depth interviews is justified by the need to ensure a sufficiently representative qualitative sample of individuals with different health conditions, disabilities, chronic illnesses, and diagnoses who are actual users of healthcare, medico-social, and social services. The selection of respondents was purposeful in order to include different groups of service users from various forms of institutional care- healthcare institutions, residential services, socio-medical services, and long-term support. This made it possible to trace both general tendencies and specific experiences related to spiritual needs, emotional states, and attitudes toward spiritual support.

The number of interviews is sufficient for qualitative analysis, as it provides saturation of information and enables the identification of recurring patterns, attitudes, and problems. Through these interviews, the real needs for existential support, conversation, hope, and inner peace become evident, together with the significance of spiritual presence and the potential positive influence of clergy on psycho-emotional well-being, adaptation to illness, and the treatment process. This provides a reliable basis for drawing conclusions regarding the necessity of institutionalizing spiritual support as part of holistic care.

In the second stage of the study, conducted between August 2024 and June 2025, two questionnaire-based surveys were carried out. The questionnaires were developed by the author on the basis of an analysis of internationally validated instruments for assessing spiritual needs (FICA, HOPE, SDAT, and FACIT-Sp), as well as a comprehensive review of the scientific literature on spiritual care. Prior to their final implementation, the questionnaires were reviewed and discussed with the academic supervisors and sociology experts to assess their content validity, terminological clarity, and applicability within the Bulgarian context. Following this review, the wording of several items was revised to improve comprehensibility and eliminate potential ambiguity.

The first survey was conducted using the Google Forms platform and distributed to more than 1 000 e-mail addresses provided by the National Association of Municipalities in the Republic of Bulgaria. The mailing list included representatives of all 265 municipalities, members of the Association's Standing Committees on Healthcare and Demographic and Social Policies, as well as healthcare and medico-social organizations. Within the specified survey period, 336 valid responses were received. The survey aimed to identify the presence of Orthodox chapels and other prayer spaces within healthcare and medico-social institutions in the Republic of Bulgaria and to examine the characteristics of institutional practices related to spiritual care. The questionnaire consisted of 10 questions and was intended for municipal administration employees, healthcare professionals, social workers, and other specialists involved in the provision of healthcare and medico-social services.

The survey collected information on the availability of Orthodox chapels and prayer rooms in healthcare and medico-social institutions, their accessibility to different groups of users, the ways in which these spaces are utilized, and the types of spiritual activities conducted within them. Furthermore, it explored employees' perceptions regarding the influence of such spiritual spaces on the emotional well-being of patients and service

users. In addition to demographic variables (age, educational level, and professional experience), the questionnaire also gathered information about the characteristics of the healthcare and social services in which respondents were employed. The complete questionnaire used in the survey on the existence of dedicated Orthodox chapels and other prayer spaces in healthcare and social institutions in the Republic of Bulgaria is included as an appendix to the dissertation.

The second survey was administered individually through the SurveyMonkey platform to patients and service users in five healthcare and medico-social organizations. During the designated data collection period, 129 respondents completed the questionnaire. This survey focused on the individual attitudes, needs, and expectations of healthcare and social service users regarding spiritual self-development and spiritual support. The questionnaire consisted of eight questions, the majority of which employed a Likert-type scale, enabling respondents to indicate their level of agreement with specific statements or the frequency with which they engaged in activities related to spiritual self-development and spiritual support. This approach allowed for the quantitative assessment of participants' attitudes, preferences, and practices, as well as their perceptions of the impact of spiritual support on their emotional well-being. The complete questionnaire investigating the need for spiritual self-development among individuals using healthcare and social services in the Republic of Bulgaria is included as an appendix to the dissertation.

The qualitative analysis first presents the socio-demographic profile of the respondents and the context of their participation in the healthcare and social service system. The analysis demonstrates that a significant proportion of participants belong to groups in situations of heightened vulnerability-chronically ill individuals, older persons, people with disabilities, and users of residential services, among whom existential questions and spiritual needs are particularly pronounced.

Particular emphasis is placed on the assessment of institutional care and emotional well-being. A significant number of respondents share experiences related to loneliness, anxiety, lack of existential support, and feelings of emotional isolation. This demonstrates that even where medical and social assistance are available, the need for human presence, attentive listening, and spiritual closeness often remains unmet.

The study establishes that 70,54 % of respondents express a need to speak with another person, 45,74 % indicate a need to discuss the meaning of life, and the same percentage report a desire for inner peace. These findings demonstrate that spiritual and existential needs are not peripheral,

but rather constitute an essential part of the experience of illness and dependency.

At the same time, 41,86 % of respondents report that, to varying degrees, they have no one with whom to share their fears and concerns, while 36,43 % experience loneliness. These results reveal a serious deficit in the emotional and spiritual support provided within the institutional environment.

The following section analyzes the religious attitudes and spiritual needs of the respondents. It is established that, for a significant proportion of participants, faith, prayer, and spiritual conversation represent real resources for coping with suffering, anxiety, and feelings of helplessness. Nevertheless, the institutional environment rarely creates conditions for meeting these needs.

Particular attention is devoted to the role of Orthodox chapels and clergy. Respondents positively assess the presence of prayer spaces and opportunities to meet with clergy, perceiving them as sources of peace, hope, and inner stability. At the same time, the data indicate that 86,1 % of social services and 70,6 % of healthcare institutions lack Orthodox chapels or other prayer spaces.

The least represented practice remains conversation with clergy-58,14 % of respondents have never had such contact since the beginning of their placement or treatment. This clearly demonstrates the absence of systematic organization of spiritual care and its dependence on occasional or informal circumstances.

The quantitative analysis among professionals demonstrates that a large proportion of medical and social personnel acknowledge the importance of spiritual support and its positive influence on emotional well-being, adaptation, and patients' trust. More than 60 % of specialists assess the presence of chapels and prayer spaces as a factor with beneficial influence on service users.

At the same time, there is a recognized lack of training, normative clarity, and organizational mechanisms for work in this direction. Professionals often recognize the problem, but do not possess the necessary tools for action, referral, and professional interaction with clergy.

The second survey, focused on spiritual self-development among users of healthcare and social services, further confirms the necessity of spiritual support as part of comprehensive care. The data demonstrate that the need for meaning, hope, acceptance, and inner resilience is particularly strong during periods of illness, old age, and dependency.

Conclusions from Chapter Three

The empirical research fully confirms the main thesis of the dissertation, namely that there exists a clearly expressed discrepancy between the actual spiritual needs of patients and service users and the extent to which institutions provide recognizable, accessible, and systematic spiritual support.

The results demonstrate that spiritual needs are not an abstract or secondary category, but a real factor influencing quality of life, emotional resilience, trust in institutions, and human dignity. The absence of chapels, prayer spaces, opportunities for conversation with clergy, and institutional mechanisms for spiritual support reveals a systemic deficit both within healthcare institutions and social services.

At the same time, the positive attitudes of professionals toward spiritual care and the demonstrated needs expressed by service users indicate that there is a genuine foundation for the development of a sustainable model of institutionalized spiritual support.

Consequently, spiritual care should be recognized as a necessary component of quality healthcare and social services, and its integration represents not an additional opportunity, but a professional, ethical, and social necessity.

SCIENTIFIC AND APPLIED CONTRIBUTIONS OF THE DISSERTATION

The present dissertation possesses both scientific-theoretical and scientific-applied significance, deriving from its interdisciplinary character and its commitment to establishing a meaningful connection between theology, medicine, social work, healthcare management, and the practice of institutional care.

The principal contribution of this study lies in its well-founded argument that spiritual support constitutes an inherent and indispensable component of the holistic approach to patients and users of social services, as well as in the development of both a conceptual and a practical framework for its institutional integration within the Bulgarian context.

The scientific and applied contributions of the dissertation may be summarized as follows:

1. Development of an interdisciplinary conceptual framework for holistic care

The dissertation develops a comprehensive theoretical model that integrates medicine, social work, bioethics, healthcare management, and Orthodox theology into a unified concept of holistic care.

The study extends the traditional biomedical model by incorporating the biopsychosocial-spiritual perspective and demonstrates the necessity of understanding the human person as an integrated unity of body, mind, social belonging, and spirituality.

Accordingly, spiritual support is presented not as a confessional supplement but as an anthropological and ethical necessity.

2. Demonstrated managerial significance of spiritual support in healthcare organizations and medico-social services

One of the major scientific contributions of the dissertation is the examination of spiritual care not only from theological and ethical perspectives but also as an essential element of the strategic management of healthcare and medico-social organizations.

The study argues that the quality of healthcare should not be assessed solely through clinical indicators but should also encompass patients' experienced dignity, trust, sense of meaning, and inner resilience.

Furthermore, it establishes the relationship between the structure–process–outcome model, organizational culture, human resource management, and the need for institutionalized spiritual support.

3. Comparative analysis of international models of spiritual care and healthcare chaplaincy

The dissertation presents a comparative analysis of well-established international practices in the United States, the United Kingdom, Germany, and Romania, where spiritual support forms an integral part of official healthcare and social care systems.

Particular attention is devoted to the Romanian model, which demonstrates a practical and successful framework for institutional cooperation between the state, healthcare institutions, and the Orthodox Church.

The comparative analysis shows that the current deficiencies within the Bulgarian system are not inevitable but may be overcome through coherent public policies and appropriate professional training.

4. Identification of specific deficiencies within the Bulgarian healthcare and social care system

Based on both the theoretical analysis and the empirical research, the study identifies several institutional deficiencies within Bulgarian practice, including:

- a) the absence of hospital chaplaincy services;
- b) the lack of a formally recognized position for spiritual care providers or healthcare chaplains;
- c) the absence of institutional protocols for spiritual assessment and referral;
- d) the limited availability of chapels and designated prayer or meditation spaces;
- e) insufficient cooperation between healthcare and social institutions and the Bulgarian Orthodox Church;
- f) inadequate education and training of healthcare and social care professionals in identifying and responding to spiritual needs.

These deficiencies are demonstrated to represent significant gaps in the quality of healthcare and social care provision.

5. Conduct of an original empirical study on spiritual needs

A substantial contribution of the dissertation is the implementation of an original empirical study comprising:

- 11 in-depth interviews;
- two questionnaire surveys-the first involving 336 healthcare and social care professionals, and the second including 129 users of healthcare and medico-social services.
- Analysis of documentary and archival sources related to the studied research objects.

The empirical findings provide robust evidence supporting the central thesis of the dissertation and clearly demonstrate a discrepancy between individuals' actual spiritual needs and the extent to which healthcare and social institutions provide spiritual support.

6. The social mission of the Orthodox church in the contemporary health and medico-social system

The dissertation also contributes to theological scholarship by examining the social mission of the Orthodox Church within the context of contemporary healthcare and social care systems.

It argues that care for individuals who are ill, elderly, vulnerable, or suffering extends beyond the administration of the sacraments and includes

institutional presence, pastoral accompaniment, and meaningful participation in the system of public care.

In this way, spiritual support is presented as a bridge between theology and contemporary social practice.

In conclusion, the scientific and applied contributions of this dissertation lie in the development of a new perspective on human care as a comprehensive, ethically grounded, and institutionally responsible process, in which spirituality is understood not as a peripheral concern but as an essential determinant of quality of life, healing, and the preservation of human dignity.

7. Proposed Organizational and Management Model for the Institutionalization of Spiritual Support in Healthcare and Medical-Social Organizations

Based on the theoretical analysis, international experience and the results of the empirical research conducted, the present dissertation proposes a model for the gradual institutionalization of spiritual support as part of holistic care for patients and users of healthcare and medical-social services.

The proposed model does not imply the creation of a new independent system, but rather the upgrading of existing organizational mechanisms through normatively regulated interaction between healthcare institutions, medical-social services, the Bulgarian Orthodox Church and the other traditionally recognized religious denominations, while strictly observing the principles of voluntariness, freedom of conscience and the religious autonomy of every individual.

➤ *Institutional partnership*

It is necessary to establish a national coordination mechanism between the Ministry of Health, the Ministry of Labour and Social Policy and the Bulgarian Orthodox Church, through which the principles, conditions and procedures for providing spiritual support in healthcare and medical-social organizations can be defined.

This mechanism should be normatively regulated through the development of common guidelines or a methodology defining the rights and obligations of the participants, the conditions for the access of clergy to healthcare and social organizations, as well as the rules for protecting personal dignity, personal data and the patient's freedom of choice.

➤ *Organizational level*

Each healthcare or medical-social organization should develop internal rules for the provision of spiritual support, including: designation of a person responsible for coordinating the activity; establishment of official

contacts with the local metropolitanate or the respective religious denomination; procedures for referring patients after they have expressed such a wish; and regulations regarding visits by clergy.

In this way, spiritual support will not depend on incidental initiatives or personal contacts, but will become part of the organizational policy for quality care.

➤ *Accessibility of spiritual support*

Organizations should provide conditions for free access to spiritual support through:

- a) the establishment or designation of prayer areas and chapels;
- b) ensuring their accessibility around the clock;
- c) providing information about the possibility of meeting with a clergy member;
- d) enabling the patient or their relatives to request spiritual support independently.

The existence of such spaces has not only religious but also therapeutic significance, as it creates an environment for silence, hope, reflection and inner peace.

➤ *Referral to spiritual support*

Medical professionals, social workers and psychologists need to be trained to recognize the spiritual needs of the patient.

In the presence of signs such as a sense of hopelessness, existential crisis, severe loss, terminal illness, or a desire for conversation about faith and meaning, the professional may offer the possibility of a voluntary meeting with a clergy member, without exerting any influence on the patient's choice.

➤ *Staff training*

National training programmes in spiritual competence should be developed for medical and social professionals. The aim is not for the employee to perform the role of a clergy member, but to acquire skills for recognizing spiritual needs, respectful communication, referral to an appropriate specialist and work within a multidisciplinary team.

➤ *Volunteer models*

Volunteer groups may be established within healthcare institutions and medical-social services, involving representatives of religious communities who have undergone training for work in hospital and social care environments. This would allow broader access to spiritual support without a significant increase in financial costs.

➤ *Theological contribution of the research*

- a) it systematizes the Orthodox understanding of spiritual care in an institutional environment;

- b) it substantiates the possibility of integrating pastoral care into secular healthcare and medical-social organizations without violating their autonomy;
- c) it develops an applied field of Orthodox social theology.

As a next stage in the development of institutional systems, the following policies may be implemented:

- 1) development of a national standard for spiritual support in healthcare and medical-social organizations;
- 2) inclusion of spiritual assessment in the holistic assessment of the patient;
- 3) development of a unified algorithm for interaction between healthcare institutions, medical-social services and the Bulgarian Orthodox Church;
- 4) creation of university programmes for the training of hospital and social chaplains;
- 5) introduction of pilot models in university hospitals, hospices, institutions for people with disabilities and residential services;
- 6) establishment of a national register of trained clergy who can provide spiritual support in an institutional environment.

As an element of the proposed model for the institutionalization of spiritual support, the present dissertation proposes the introduction of the organizational function of “Spiritual Support Coordinator” in healthcare and medical-social organizations. This proposal does not imply the creation of a new staff position, but the assignment of coordination functions to a designated employee — a social worker, psychologist, nurse or another specialist — who has undergone appropriate training regarding the spiritual needs of patients and the organization of interaction with clergy. In this way, the model will not depend on individual initiatives, but will become a sustainable organizational mechanism.

PROPOSAL FOR AN ORGANIZATIONAL AND MANAGEMENT MODEL FOR INSTITUTIONALIZING SPIRITUAL SUPPORT IN HEALTH AND MEDICAL-SOCIAL ORGANIZATIONS

THE MODEL IS BASED ON THE PRINCIPLES OF VOLUNTARINESS, FREEDOM OF CONSCIENCE AND RELIGIOUS AUTONOMY.

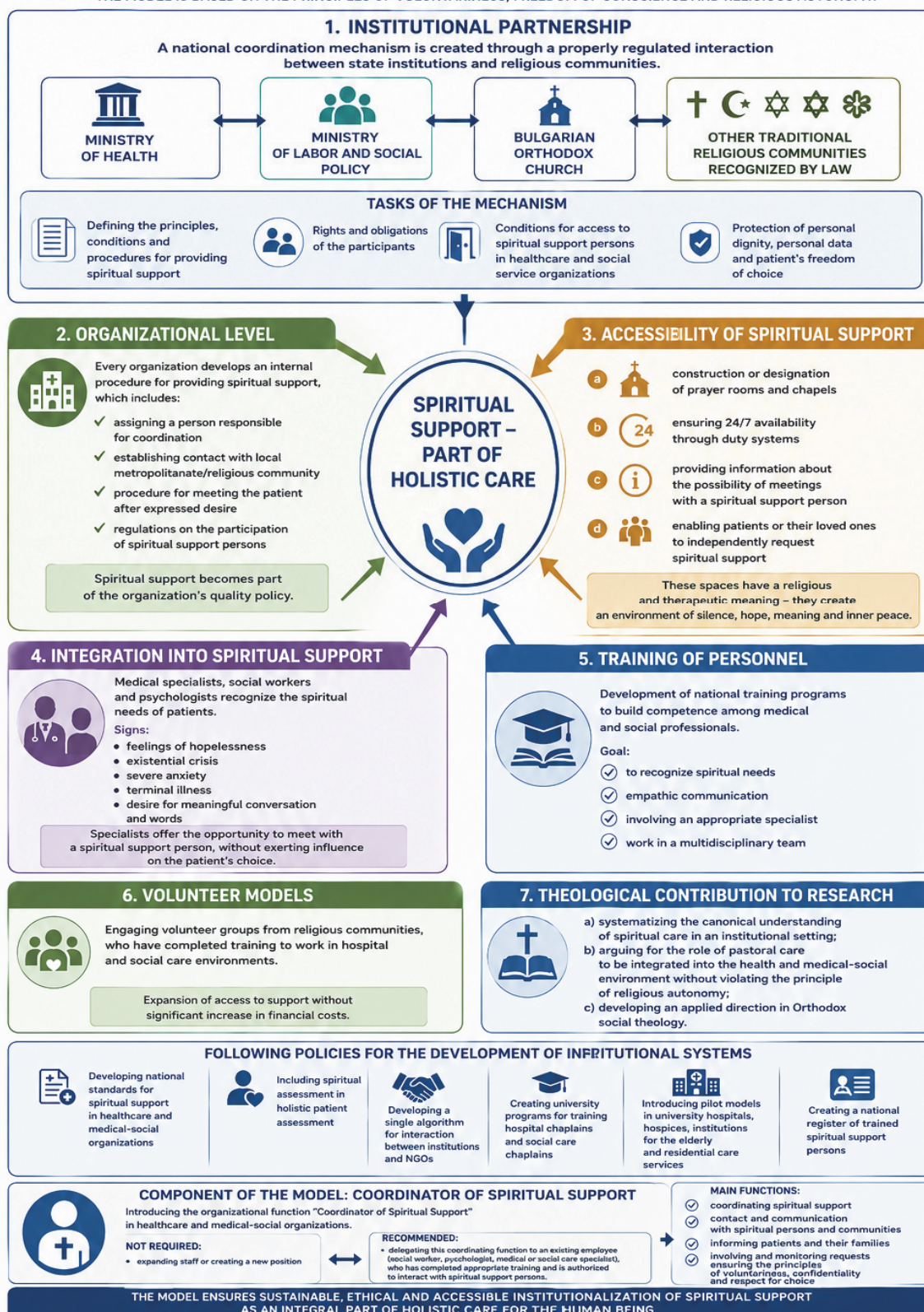


Figure 1. Proposed Organizational and Management Model for the Institutionalization of Spiritual Support.

In summary, the scientific and applied contributions of this dissertation lie in establishing a new perspective on understanding care for the human person as a holistic, ethical, and institutionally responsible process, in which spirituality is not a peripheral consideration but an essential component of quality of life, healing, and human dignity.

CONCLUSION

The present dissertation is devoted to a highly significant and contemporary issue-the place of spiritual support within the system of healthcare and medico-social services as an essential component of holistic care for the human person.

The study is based on the understanding that contemporary care for patients and users of healthcare and social services cannot be confined solely to biomedical interventions, diagnosis, treatment, and social assistance. Human beings experience illness, suffering, old age, disability, and dependency not merely as physical conditions but as deeply personal and existential experiences that affect the whole person-the body, mind, social identity, moral integrity, and spirituality.

It is precisely in situations of illness, chronic suffering, palliative care, loneliness, and the fear of losing autonomy that spiritual needs become particularly significant. The need for meaningful conversation, hope, inner peace, purpose, faith, and compassionate human presence becomes a determining factor in quality of life, the preservation of dignity, and the individual's capacity to endure suffering.

The theoretical analysis undertaken in this dissertation demonstrates that contemporary international scholarship has long recognized spiritual care as an integral component of high-quality palliative, long-term, and integrated care. The evolution from the biomedical model to the biopsychosocial and subsequently the biopsychosocial-spiritual model clearly confirms that effective healthcare cannot be achieved without addressing the individual's inner experiences, existential concerns, and spiritual resilience.

The comparative analysis of international practices in the United States, the United Kingdom, Germany, and particularly Romania has shown that sustainable institutional models already exist in which spiritual support is professionally organized, normatively regulated, and fully integrated into healthcare and medico-social services. Hospital chaplaincy, spiritual care professionals, prayer and meditation spaces, and interdisciplinary collaboration between healthcare professionals and clergy are not

exceptional practices but internationally recognized standards of quality care.

The comparative findings further demonstrate that the current deficiencies within the Bulgarian system are not inevitable but can be overcome through consistent public policies, clear regulatory frameworks, professional education, and effective interinstitutional cooperation.

The empirical research provides the strongest evidence supporting the central thesis of this dissertation. The in-depth interviews, the two questionnaire surveys conducted among professionals and service users, and the analysis of institutional practices reveal a clear discrepancy between the actual spiritual needs of individuals and the extent to which these needs are recognized and addressed by healthcare and medico-social institutions.

The scientific contribution of the dissertation lies in its interdisciplinary integration of theology, medicine, social work, and management sciences within a unified conceptual framework of holistic care. The study broadens the understanding of spiritual support by presenting it not merely as a confessional or religious practice but as an anthropological, ethical, and institutional necessity.

From a broader societal perspective, this research raises the question of restoring the human dimension of care. It argues that patients and service users should not be regarded merely as clinical cases, administrative units, or social categories, but as persons with their own histories, suffering, hopes, faith, and inherent dignity. Consequently, integrating spiritual support into healthcare and medico-social services should not be viewed as the provision of an additional service, but rather as a profound rethinking of the very philosophy of care. It represents a transition from institutional service delivery to genuinely person-centred care, from fragmented treatment to comprehensive human presence, and from the formal fulfilment of professional duties to care grounded in the dignity of the human person.

The central message of this dissertation is that high-quality care begins where the individual is recognized not merely as a patient, but as a person. It is precisely at this point that spiritual support ceases to be an optional addition and becomes an essential necessity.

PUBLICATIONS RELATED TO THE TOPIC OF THE DISSERTATION

The principal concepts, research findings, and scientific conclusions developed in the present dissertation have been validated through participation in scientific forums, conferences, and publications related to the issues of spiritual support, the holistic approach in medicine and social care, as well as the necessity of integrating the spiritual dimension into the system of healthcare and medico-social services.

List of publications related to the dissertation topic “Management of Healthcare Organizations – Goals, Functions, Methods and Spiritual Support. A Holistic Approach to Patients”:

1. Boteva, V. “Hospital Chapels as a Center for the Performance of Works of Mercy in Healthcare Institutions.” In: Proceedings of the Scientific Conference “Knowledge, Science, Technologies, Innovations,” ISSN 2815-3472 (Print), ISSN 2815-3480 (CD), Veliko Tarnovo, 2024, pp. 151–160.
2. Boteva, V. “The Holistic Approach in the Treatment of Patients.” In: *Thought, Word, Text*, Vol. 20 (26), ISSN 2815-2816, Plovdiv University Publishing House, Plovdiv, 2024, pp. 78–88.
3. Boteva, V. “Analysis of Data from Empirical Studies on the Influence of Clergy on the Emotional Condition of Patients in Palliative Care.” In: Proceedings of the Scientific Conference “Knowledge, Science, Technologies, Innovations,” 2025, ISSN 2815-3480, pp. 229–242.
4. Boteva, V. “Integration of Spirituality into Healthcare Practice – Philosophical and Ethical Dimensions.” In: *Thought, Word, Text*, Vol. 30 (35), ISSN 2815-2816, Plovdiv University Publishing House, Plovdiv, 2025, pp. 174–193.
5. Boteva, V. “The Need for Spiritual Self-Improvement among Persons Using Healthcare and Social Services in the South Central Region of Bulgaria.” In: Proceedings of the XXXI Bishop Konstantin Readings, 15–16 May 2025, Konstantin Preslavsky University of Shumen, Shumen, 2025 (in press).

Participation in an International Competition

1. Diploma “Motherland: Society, Security, Ecology” (dedicated to the 80th Anniversary of Victory in the Great Patriotic War), Third Degree Award, awarded to Veselina Petrova Boteva, PhD student (scientific supervisor: Assoc. Prof. Adriana Lyubenova, Department of

Theology, Faculty of Philosophy and History), Plovdiv University “Paisii Hilendarski”, Plovdiv, for the work: “The Need for Spiritual Self-Improvement among Persons Using Healthcare and Social Assistance Services in the South-Central Region of Bulgaria.” Order No. 6 of 27 June 2025, Kirov, Russian Federation.

The listed publications and scientific participations demonstrate the consistent validation of the principal ideas of the dissertation and their presentation before the academic community. They confirm the relevance of the topic, its scientific significance, and the potential for the further development of the research in both theoretical and practically applicable dimensions.