The Experience of Health System Leaders in Meeting Patients' Spiritual Needs

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The Experience of Health System Leaders in Meeting Patients’ Spiritual Needs

A DISSERTATION SUBMITTED TO THE FACULTY OF THE
COLLEGE OF EDUCATION, LEADERSHIP AND COUNSELING OF THE UNIVERSITY
OF ST. THOMAS
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By
Charisse Oland

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The Experience of Health System Leaders in Meeting Patients’ Spiritual Needs

We certify that we have read this dissertation and approved it as adequate in scope and quality. We have found that it is complete and satisfactory in all respects, and that any and all revisions required by the final examining committee have been made.

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March 30, 2017______________________
Final Approval Date
I am eternally grateful to my husband, Eivind, for his love and understanding throughout our life together, and especially throughout my doctoral experience. I thank our children, Ivy, Dave, Christian, and Gabe, as well as our extended family and friends for their support of my need to learn, for their tolerance, and for their unending love. I thank my colleagues, especially Roberta, who supported me when needed. I am forever indebted to Dr. Tom Fish, my dissertation committee chair, for his unparalleled faith in me, guidance, and encouragement to get to the finish line. He made all the difference. I am also grateful to committee members Dr. Kate Boyle and Dr. John Reiling for their time and enthusiastic support of the work. Their knowledge of spirituality and affirmation of this work is reassuring. I am blessed to work in the field of healthcare where I am daily surrounded by the mysteries and miracles of healing. I value and admire my colleagues in the healing profession who provide holistic care: mind, body and spirit, especially those who participated in this study and the now deceased Father Klimek who is the face of God to me. The inspiration for this dissertation began in the midst of my healthcare leadership career with a spiritual experience involving the passing of my father-in-law, Sig. The work ended with the birth of his namesake, our grandson, Sig. His birth prompted yet another spiritual awakening. I dedicate this dissertation to him.
ABSTRACT

The purpose of this phenomenological study was to explore the experience of multidisciplinary healthcare leaders in creating a culture that meets hospitalized patients’ spiritual needs. My major research questions were: 1) Does the spiritual experience of hospital/health system leaders affect an organization’s ability to meet hospitalized patients’ spiritual needs? 2) Does the spiritual training of multidisciplinary leaders affect an organization’s culture? 3) Does the spiritual training of various levels of leaders affect an organization’s culture? 4) Does an organization’s culture impact its capacity to meet hospitalized patients’ spiritual needs? I gathered information from in-depth interviews of 22 current and former healthcare leaders from multiple levels with direct and non-direct care responsibilities at one secular hospital/health system, and two hospitals within one non-secular health system. Participants had received RISEN program spiritual education/training. In the course of the study, themes emerged that gave meaning to the collective healthcare leader experiences. Overall, few differences were noted between secular and non-secular leaders. Spiritual embodiment by top leaders is essential, while other leaders emulate the top leader. Spiritual beliefs and values are intentionally embedded in cultures through intentional presence, aligned structures and systems of accountability. All healthcare members contribute to spirituality for patients in meaningful ways, with pastoral care professionals and nurses have the most direct effect. Engaging physicians has unique considerations. Intentionally investing in the spiritual development of individuals positively impacts the culture. An intentional approach to educating staff is necessary. The result is that health system leader’s experiences influence meeting patients’ spiritual needs.
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CHAPTER ONE: INTRODUCTION

Background

There are many highly competent professionals in hospitals providing care for their patients’ minds, bodies, and spirits. The challenge of meeting patients’ spiritual needs became more apparent to me in the course of a personal and professional odyssey that I undertook. While I was serving in a leadership role for a secular hospital and health system, working on a spirituality project and engaged in a spiritual formation program, a loved one of mine passed. He was served elsewhere and received little or no spiritual care until the final days of his life. It was traumatic for me personally and instructional professionally. Shortly thereafter, while serving as a leader in a non-secular hospital and health system, I had yet another learning experience related to providing spiritual care that conferred on me additional insight and wisdom. These juxtaposed experiences crystallized concerns for me about healthcare leaders’ ability to ensure the provision of spirituality within healthcare systems.

Confirming my personal experiences, research has revealed that patients served in hospitals across the nation are stating that their spiritual needs are not being met, leading to their dissatisfaction with this aspect of care (Koenig, 2007). Research further suggests that more can be done to recapture spirituality as an important element of the healing process for patients across all hospitals, regardless of spiritual affiliation (Chapman, 2009; Craigie, 2015; Koenig, 2012; Planetree, 2003; Samueli, 2015; Young & Koopsen, 2012). A leader’s role in the provision of spiritual care can make a difference.

Sig

My father-in-law, Sig, had a severe stroke and was hospitalized in a different state at a time when I was coordinating a project aimed at improving patients’ spiritual care in a hospital.
Enlightened by my involvement in the spirituality study, I grasped how the otherwise competent staff serving Sig and our family at this particular hospital was unaware of the importance of providing spiritual care as part of the healing process, or simply incapable of offering it.

Sig was not able to interact coherently with his caregivers. His frustration and anxiety manifested itself in many ways. Sleepless nights resulted in his being irritable. There was but miniscule evidence that he was forming meaningful relationships with the staff; indeed, they did not even call Sig by name, and only rarely offered him caring touches or words of hope. These robotic professionals, trained in biomechanics and clinical care, lacked humanity. This situation, compounded by my own inability to deal with my grief at the time, rendered in me a sense of helplessness. By the end of Sig’s battle he was transferred to a hospice service where loving staff and his own clergy provided the spiritual interventions that had been lacking. This prepared Sig and our family for his transcendence to a new world. As a result of my own need for spiritual healing, and my related work experiences at that moment, I succeeded in making meaning out of this very difficult situation (Bennis & Thomas, 2002).

Secular Hospital and Health System Spiritual Experience

The secular Midwestern hospital where I was coordinating the spiritual pilot during Sig’s passing was the flagship for a community health system (CHS). Despite its having overall patient satisfaction scores in the 90th percentile in a national database of similarly sized hospitals, its patient satisfaction scores had been lacking in one particular area: it had failed to meet patients’ spiritual and emotional needs for several years. These lagging spirituality scores, coupled with a desire to ensure a more holistic culture of care throughout the healthcare system, inspired its leadership to action. A multidisciplinary team of professionals spanning the breadth and depths of both the hospital and health system was appointed and tasked with improving spiritual care for patients. The team met weekly to improve the patient satisfaction scores for the survey question,
“To what degree were your spiritual and emotional needs met?” Research indicates that patients do not distinguish between spiritual and emotional needs (Press Ganey, 2003); therefore, spiritual needs became the singular focus. If the six-month project met or exceeded an established improvement goal in each of three distinct departments, including one non-direct patient care department, the spirituality enhancement strategies used successfully in the pilot study would be cascaded across the entire healthcare system. Although the study outcomes showed remarkable improvements in reaching the goal, the project was not expanded due to unforeseen circumstances and a change in top leadership within the organization at the time.

The CHS mission, vision and values, typical of most secular healthcare organizations, are accompanied by behavioral standards for employed staff. These values include such imperatives as the need to respond with service, respect and compassion, all of which are inherent in aspects of spirituality. The pilot project intentionally adopted additional standards of behavior to more explicitly reflect and describe spiritual behaviors such as being present, validating understanding, and meeting needs with love. CHS began a systems approach to reflect more holistic spirituality values based on the Samueli Institute’s Optimal Healing Communities (2015) and Radical Loving Care (Chapman 2006; 2009).

In order to instill spiritual values in the organization, 50 employees per year are offered an optional spiritual formation program, commonly known at RISEN, an acronym for Reinvesting Spirituality and Ethics in Our Networks. This is a nationally recognized program of applied spirituality for health care organizations. The overall objective of the program is to enable participants to become more conscious of, and committed to, their own spiritual growth in order to facilitate the healing process in others (Center To Be, 2014). The system sponsors an active parish nursing outreach program in a predominantly Catholic community. A pastoral care
department of approximately five and a chapel/meditation room representing all world religions are located near the entry of the flagship hospital where the pilot was conducted.

To reflect all staff’s contribution to meeting patients’ spiritual needs, the interdisciplinary team appointed to lead the project included leaders and staff of both direct and non-direct caregivers from all levels of the system/hospital. Three distinct departments were identified as the pilot sites in which to test practical strategies: one medical and one surgical inpatient unit representing direct, hands-on caregivers, and the central registration department, representing non-direct caregivers who meet patients telephonically only.

Over the six-month period of intense focus on this spiritual initiative, the staff met its stated goal for improvement in two of the three areas. The leadership team, invigorated by remarkable progress, anticipated that staff members would sustain the spiritual practices they learned in the pilot into a second phase. At the conclusion of the first phase, I then joined a non-secular hospital, continuing my own spiritual formation.

**Non-secular Hospital and Health System Experience**

The large non-secular hospital I then joined is also part of a health system located in yet another Midwestern community of similar size and Catholic faith traditions. This regional flagship Catholic hospital is likewise known for having extraordinary patient satisfaction—above the 90th percentile. Although patient satisfaction on the same standardized survey question as CHS was not problematic, this hospital and its health system has its own concerns about maintaining a robust spiritual culture, with fewer and fewer religious leaders available to serve a growing population. While non-secular sponsors once dominated US hospitals, the number of non-secular sponsorships has dwindled in this century to fewer than one in five (AHA, 2010). Given there are fewer religious leaders to serve, one wonders how non-secular hospitals will maintain spirituality in the caregiving and healing process.
After more than a century of religious leadership, this non-secular health system only recently appointed a lay leader as CEO. The system headquarters lie on the immense, sprawling main campus and convent, now home to only a dozen or so elderly sisters. The bustling corporate headquarters and training center for its several hospitals, the system is guided by a mission that emphasizes values of compassion, justice, and reverence for life as a healing ministry. This mission is integrated into its everyday activities. Franciscan principles and statements of intent describe standards of behavior, environment and service to guide staff as they serve patients.

The regional flagship hospital where I worked hosts an empty convent, now converted to other use, with two remaining nuns retiring from the chaplaincy program. A godlike 80-year-old monsignor who lived and worked in the hospital around the clock recently died. One new priest joined the hospital, and four lay chaplains who visit all patients maintain important spiritual traditions. Many signs and symbols of faith serve as reminders of the hospital’s spiritual intent. Daily mass is offered in an attached chapel frequented by hospital staff, guests, and community members. Calming voices share prayers over the intercom each morning. Meetings begin with a reflection, blessing or prayer.

In hopes of maintaining spiritual values, an extensive Franciscan faith formation program is mandatory for leaders and available to staff. Additional leadership training and orientation is offered at the system headquarters. Like CH, staff at this non-secular hospital are offered an option to participate in the RISEN program as a means of personal development and faith formation.

While there are differences between non-secular and secular hospitals’ approach to enhancing spiritual care provided to patients, there are also distinguishable similarities and
intentional efforts by health system and hospital leadership to ensure holistic care where spirituality is not lost.

**All Hospitals and Leaders Responsibilities**

A statistically small but meaningful difference in patient satisfaction exists between religious and non-religious acute care hospitals (Press Ganey, 2003). Press Ganey (2003) hypothesized that religiously affiliated hospitals are more predisposed to having dedicated pastoral care departments and resources. Their anecdotal evidence suggests patients who select religiously affiliated hospitals expect a higher degree of spiritual and emotional care, and hold staff to a higher standard. Regardless of affiliation status, many authors (Chapman, 2009; Frampton et al., 2003; Press Ganey, 2003; Williams et al., 2011) agree that more can be done across all hospitals to recapture spirituality as an important element in the healing process.

Hospital leaders are responsible for carrying out a hospital’s mission of serving and healing patients. A servant’s heart embraces the spiritual needs of patients, and is important not only for the CEO, but for all leaders within healthcare organizations (Chapman, 2009). While not all leaders are exceptional, those who are possess attributes and values that nurture spiritual needs which, over time, have the potential to improve the organization as a whole (Chapman, 2009; Craigie, 2015; Greenleaf, 2011; Samuei, 2015). Understanding the important role of all leaders with both direct and indirect patient care roles, in all hospitals regardless of affiliation, may provide valuable insights.

**Statement of the Problem**

Spirituality is important to patient healing and a peaceful death. Many people seek hospital care in their most vulnerable moments of life, providing a unique opportunity to render exceptional spiritual care when patients want and need it most. Yet research-to-date shows that hospital efforts are often less than effective in meeting patients’ spiritual needs (Buryka et al.,
2008; Koenig, 2007; Williams et al., 2011). On the whole there is only a slight distinction between the spiritual care provided in secular versus non-secular hospitals (Press Ganey, 2003). Regardless of affiliation status, many authors (Chapman, 2009; Watson, 2005; Young & Koopsen, 2012) agree that more can be done across all hospitals to resuscitate spirituality as an important element in the healing process. This is a leadership challenge.

All leaders have a responsibility as providers of care. Exceptional leaders have the potential to improve an organization (Chapman, 2006, 2009; Greenleaf, 2003, 2011; Hunter, 1998, 2004). Young and Koopsen (2011) recommend a holistic, interdisciplinary approach to care that incorporates spirituality. The role of leaders in the direct-caregiving departments of nursing and chaplaincy is well documented. Yet no research studies exist that inquire about the efforts of multidisciplinary leaders in various levels of a healthcare system to enhance spiritual care for patients in a hospital setting. If a multidisciplinary approach is desirable for providing optimal patient care, and leaders have the potential to usher in such an approach, then understanding the experience of all leaders to enhance spiritual care for patients fills an important gap in knowledge.

Research Question

My research is informed by my personal and professional experiences. The major research question to be answered is, “What is the experience of multidisciplinary healthcare leaders in creating a culture that meets hospitalized patients’ spiritual needs?” All healthcare leaders—including those whose staff is removed from direct patient care—have a responsibility to fulfill their mission and, therefore, to meet patients’ spiritual needs. Other than key direct caregivers, such as nurses and chaplains who are often cited in the literature, the voices of multidisciplinary leaders at multiple levels of a hospital/health system are absent from the
literature, representing a gap in knowledge. To shed light on this problem, I will offer answers to the following questions:

Does the spiritual experience of hospital/health system leaders have an effect on an organization’s ability to meet hospitalized patients’ spiritual needs? If so, how?

Does spiritual training of multidisciplinary (direct care and non-direct care) hospital/health system leaders have an effect on an organization’s culture? If so, how?

Does spiritual training of various levels of hospital/health system leaders have an effect on an organization’s culture? If so, how?

Does an organization’s culture have an impact on its capacity to meet hospitalized patients’ spiritual needs? If so, how?

Key Search Terms:

Spirituality; spiritual education; hospital; patient satisfaction; and organizational culture.

**Definition of Terms**

For purposes of this study, the following terms were defined as:

*Holistic Care:* Healthcare for patients that meets the needs of the whole person, including mind, body and spirit.

*Direct Caregivers:* Hospital and healthcare system staff who provide direct medical care to patients. Such staff include physicians, nurses, aides, social workers, therapists, and chaplains.

*Non-direct Caregivers:* Hospital and healthcare system staff who oversee or indirectly provide services that enable medical care for patients. These staff include administrators, directors, managers, supervisors, and marketers.

*Patient Satisfaction:* A patient’s degree of satisfaction with the care/services provided to him or her.

*Religion:* An organized system of beliefs, behaviors, traditions, rituals, and ethical principles, usually grounded within a specific community and conveyed over time (Canda & Furman, 1999).
Spirituality: An aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred (Puchalski & Ferrell, 2010).

Summary

Personal and professional experiences as a healthcare leader in both secular and non-secular hospitals led to key questions about the experience of health system leaders in meeting hospitalized patients’ spiritual needs. In the following chapter I will review relevant literature on the subject of spirituality in healthcare organizations and in meeting the spiritual needs of hospitalized patients. This review is intended to identify strengths and gaps in knowledge. In chapter three I will describe the methodology used to create a valid qualitative phenomenological study designed to answer the questions posed. In chapter four I will describe the findings of the research. In chapter five I will analyze the findings of the research. Finally, in chapter six, I offer recommendations to enhance the spiritual care of hospitalized patients.

CHAPTER TWO: LITERATURE REVIEW

Introduction

I have conducted an ongoing selective review of literature to inform this study. The purpose of the review was to gain a better understanding of the experience of hospital staff in meeting patients’ spiritual needs. Research about spirituality and its connection to health has exploded in quality and substantially increased in sophistication in the past 20 years (Craigie, 2010). Empirical evidence of this connection can be seen in cross-sectional studies of health variables in defined populations, longitudinal studies, meta-analytic reviews, and interventional studies. Topics for this review include: (1) the meaning of spirituality for patients; (2) spirituality
and healing in healthcare delivery; (3) organizational culture and organizations that incorporate spirituality; (4) the role of staff in providing spiritual care; and (5) spirituality training in healthcare and the workforce. This literature review is divided into these five categories.

The Meaning of Spirituality for Patients

In the first section I explore the spiritual needs of people with severe or chronic illness. Many are at the end of their lives and grappling with existential concerns. I reviewed multiple definitions of spirituality that speak to the diverse thinking on the subject. Moreover, I discussed how both spirituality and religious beliefs impact the way people cope during these difficult times. Finally, I assessed the impact of addressing the spiritual needs of patients as part of the healing process.

At the close of life and while dealing with severe or chronic illness, people tend to want to deal with existential questions connected to the meaning of life beyond oneself and life beyond death (Puchalski & Ferrell, 2010; Sulmasy, 1999). These people undergo spiritual journeys with profound questions about who they are, what life means and what will become of them during illness or after death. Physician Naomi Remen indicates that, contrary to her scientific training, the things that are most real may not be expressed in either numbers or words, but only directly known (Puchalski & Ferrell, 2010, p. xv). Sometimes life-threatening illnesses may be transformative. Spirituality also mediates choices and health behaviors, as well as frames the way people cope with adversity (Craigie, 2010).

Patients are clear: they want better spiritual care. They want health care professionals to address their spiritual needs in hospitals, especially when they are acutely ill or have a life-threatening illness (Buryska et al., 2008; Craigie, 2010; Koenig, 2007; 2012; Press Ganey, 2010; Sulmasy, 1999; Williams et al., 2011). Both spirituality and religious beliefs have been shown to
impact how people cope during these times. Understanding what patients mean when they describe these spiritual needs is important. Healthcare workers have the unique privilege of being part of these most intimate moments in people’s lives such as births, deaths, sexuality, loss of bodily functions or mental well-being (Cragie, 2010). By increasing their knowledge of spirituality, they can more effectively impact patients’ recovery and wellness.

Being spiritual is part many people’s identity. It forms the root of who they are as human beings and gives life meaning and purpose (Koenig, 2007; Koenig, Pargament, & Nielson, 1998, Puchalski & Ferrell, 2010; Sumalsy, 1999). Spirituality is found in all cultures and societies, and plays an important role in the healing process (Association of American Medical Colleges, 1999; Carson, 1989; Chapman, 2009; Elkins et al., 1988; Folio & Brody, 1988; Frampton, Gilpin, & Charmel, 2003; Joint Commission Resources, 2005; Koloroutis, 2004; Miller & Thoresen, 2003; Press Ganey, 2010; Puchalski & Ferrell, 2010; Watson, 2005).

A 1997 Gallup survey of 1,212 randomly selected American religious and non-religious adults indicated the subjects’ desire to reassert their own spirituality when nearing death. At least half of the respondents identified four things as "very important": 1) having someone with whom they could share their fears and concerns; 2) simply having someone with them; 3) having the opportunity to pray alone; and 4) having someone pray for them. They want relationships with healthcare providers who will listen to their fears and concerns, pray with them, help them to feel forgiven, and say good-byes to loved ones. They seek comfort in being assured that after death their lives will be remembered through relationships, accomplishments and good works. They want to believe they have done their best in life and will be with a loving God or Higher Power after life (Gallop, 1997).
Several studies attest to a deficiency in hospital staffs’ attempts to meet patients’ spiritual and religious needs (Buryska et al., 2008; Koenig, 2007; Williams et al., 2011). A study by Williams et al. (2011) of 3,141 patients enrolled at the University of Chicago found that 41 percent of patients wanted to discuss religious or spiritual concerns with someone while in the hospital, but only half of these patients had such discussions. The patients did not care who spoke with them about these concerns. What mattered most was simply having a discussion. In this study 61 percent of patients spoke with a chaplain, 12 percent with a member of their own religious community, 8 percent with a doctor and 12 percent with other people. Half of the patients who wanted a discussion (20 percent overall) did not get to have one. At the same time, one in four who said they did not want a conversation about spiritual issues had one anyway (p. 1270). Williams et al. (2011) concluded that many more patients desire to have conversations about religion and spirituality than are actually granted them. This fact suggests health care professionals might improve the patients’ overall experience and satisfaction while hospitalized by addressing this unmet need.

Addressing spiritual beliefs can aid the healing process (Burgener, 1999; Koenig, 2007; Koenig et al., 1998; Puchalski & Ferrell, 2010). Spiritual practices can foster coping resources (Boyatzis & McKee, 2005; Delgado, 2007; Frampton et al., 2005, Koenig et al., 2001; Puchalski & Ferrell, 2010), generate forgiveness and feelings of love for self and others, and provide social support (Burgener, 1999). Contrarily, addressing spiritual beliefs can create tremendous distress as well as increase the burden of illness or trauma (Koenig et al., 1998). Feelings of guilt, shame, or fear occur for things past, such as not having followed religious practices, or having failed to meet the expectations of others.
Turning to spirituality may help healthcare professionals alleviate the physiological responses patients experience when suffering from fear, distress or a medical condition out of their control. Such symptoms include a racing heart rate, increased adrenaline and sweating palms (Boyatzis & McKee, 2005; Frampton et al., 2005). Manifestations may also include: psychological depression, anxiety, or sense of hopelessness; social isolation or disintegration of relationships; physical pain; religious and existential distress such as anger at God or a faith crisis (Puchalski & Ferrell, 2010, p. 6). The reactions vary based on the individual’s social history and ability to cope.

**Definitions of Spirituality in Healthcare**

Spirituality is derived from the Latin word “spiritus,” which means “breath of life” (Brillhart, 2005). Spirit is a word often used to define an individual’s behavior and well-being, as in “being in good spirits or highly spirited, having an indomitable spirit or lost spirit, or losing the will to live” (Taylor in Jenkins, 2008, p. 17). The sense of energy, hope, harmony and connectedness may change or grow during phases of heightened personal awareness.

Spirituality is broadly defined as “that which gives meaning and purpose to life” (Puchalski & Ferrell, 2010, p. 4). It is often a central issue for patients at the end of life. Multiple definitions include concepts surrounding values and beliefs, personal meaning, connectedness and/or transcendence (McEwan, 2004). Religion may or may not be included in individual interpretations. Additionally, spirituality implies different things to different people, with layers of meaning that depend upon their experience and worldview (McSherry & Cash, 2004). These characteristics may cause it to lose significance. The challenge for healthcare professionals is to understand exactly what the term “spirituality” means to their patients.

Spirituality as a way of being and experiencing comes about through the awareness of a transcendent dimension (Carson, 1989; Elkins, Hedstrom, Hughes, Leaf, & Saunders, 1988;
Frampton et al., 2003). Carson (1989) attempted to simplify the notion of an individual’s spirituality by deriving a model from many researchers. His model includes concepts on both horizontal and vertical dimensions. The vertical dimension deals with a relationship beyond and/or outside the self, known as transcendence, where a person relates to a higher being. The person’s perception of the transcendent influences their views of life and coping abilities in a time of crisis. The horizontal dimension of Carson’s model reflects how one’s relationship with the higher being is lived through one’s beliefs, values, lifestyle, quality of life, and interactions with self, others, and nature.

Healthcare organizations generally adopt spirituality definitions espoused by regulatory agencies and related professional organizations. Researchers in patient satisfaction (Press Ganey, 2003) updated their literature on the subject, quoting a Miller and Thoresen definition of spirituality as “an individualized, subjective experience of and from which a person derives meaning, purpose and hope.” Joint Commission (2005), an accrediting body for hospitals, describes spirituality as a broad concept including the above, adding morality in the context of relationships with self, others, the universe, and ultimate reality. The Association of American Medical Colleges notes that spirituality is often linked to an individual’s search for meaning as well as participation in religion, belief in God, family, naturalism, rationalism, humanism, and the arts (1999, p. 16). It affects the way professionals and patients perceive illness and how they interact with one another.

The matter of defining spirituality in healthcare in the new millennium was the subject of a 2009 conference of palliative care experts (Puchalski & Ferrell, 2010). Challenged to find an agreed-upon definition of spirituality, they used a reductionist method to arrive at a conclusion. The consensus definition was the following: “Spirituality is the aspect of humanity that refers to
the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred” (p. 25).

**Spirituality and/or Religion**

The term *spirituality* is often considered synonymous with religion. Many experts agree that one’s religion may be closely related to one’s spirituality but is not necessarily the same (Bazan, 1999; Carson, 1989; Frampton et al., 2005; Mohlzahn & Sheilds, 2008). An individual may see himself/herself as spiritual but not religious, or vice versa (Nelson-Becker, 2003). Accordingly, spirituality is universal and religion is not. Bazan (1999) simplified the idea, suggesting that religion is meant to serve our spirituality, not vice versa. We have a common spiritual nature but not necessarily a common religious tradition (p. 16). Addressing both religious and spiritual needs is important, and influences patients’ ability to cope, to say nothing of their medical decisions and outcomes (Koenig, 2007, p. 22).

Religions have in common a belief in some higher power or transcendent reality. Fromm (1956) suggest that across all religions, God (a higher power) stands for the highest values and greatest good. The specific meaning of God varies greatly and depends on what is most desirable good for an individual. The concept of God is different for each person; therefore, one must understand the character of the individual worshiper.

Religion generally refers to an organized system of beliefs, behaviors, rituals and ethical principles shared by a community and conveyed over time (Canda & Furman, 1999). Religion may manifest itself through religious institutions in which the members have a shared ideology of the divine or sacred (Burke, 2006). The Joint Commission (2011) refer to religion as an external belief system that might include church, prayers, traditions, rites, and rituals.
There are compelling reasons to support patients’ endeavors to have their religious and/or spiritual needs met while hospitalized (Koenig, 2007). Religious or spiritual involvement does not, however, always have positive effects on health. Not all personal questions are answered, nor do patients always reach an understanding of the underlying reasons for their suffering, or indeed their existence in the world. While new studies are underway, there is still substantial evidence to suggest that religion, health, and medical outcomes are related.

Koenig (2007) found more than twelve hundred studies during the twentieth century that examined the relationship between religion and health, with the majority finding a significant positive association. In general, these studies found that religious people demonstrated the following: increased coping and decreased depression; lower rates of suicide and substance abuse; positive emotions such as joy, hope, and optimism; larger and more supportive social networks; and more positive emotions with less isolation (Koenig, 2007, p. 29). These were all associated with better functioning immune systems and cardiovascular health. Additionally, religious persons spend less time in the hospital, possibly because they are healthier and have more support within their communities.

Different faith traditions use similar processes to encourage spirituality, though they use distinct names for these processes. A study of the five major religions of the world indicates that spirituality often enhances health regardless of differences in the person’s faith, rituals or beliefs (Johnstone, Yoon, Cohen, Schopp, McCormack, et al., 2012). Surveys of 160 individuals of Muslim, Buddhist, Catholic, Protestant, and Jewish faiths found that a greater degree of spirituality was related to better mental health, including lowering levels of neuroticism and increasing extraversion. Mental health may be impacted by religious participation, with individuals reducing self-centeredness and developing a greater sense of belonging to a larger
whole. While spirituality may equip believers with coping mechanisms, it may also predispose them toward viewing a health problem as a curse. Spiritual interventions recommended include counseling, medication, and forgiveness protocols to potentially enhance spiritual practices and coping mechanisms.

Fromm (1956) contrasted various cultural views of religion and the love of God. Religions in Western cultures view the love of God as a cognitive experience bound up with virtues of love and justice; Eastern cultures with mystic religions view God’s love as an intense feeling and an experience of oneness expressed in daily actions. Theistic, non-theological and mystical systems assume there is a spiritual realm that transcends man, “giving meaning and validity to man’s spiritual power and desire for salvation” (Fromm, 1956, p. 67). Non-theistic systems do not share the views of spirituality or transcendence. In this system love exists because man has evolved over time, developing the powers of reason and justice. The only meaning to life in non-theistic systems is that which man gives to it and that which he gives to help others. Giving to others as a great good is a shared concept overall.

In general, there is a continuing need for research on spirituality and the overall health of patients, according to a 2012 analysis by Koenig. He noted that prior to 2000 there were over 1000 quantitative studies examining the relationship between religion/spirituality and health. By 2010 the number of studies had tripled to more than 3,000 original data-based reports on associations with mental and physical health, as well as use of health services. While the volume increased, Koenig (2012) observed ongoing criticism of the value and interpretation of what the research findings mean. He urged continued research on religion and spirituality, advocating for better understanding of the psychological, social, and behavioral forces behind them.
Spirituality and Healing in Healthcare Delivery

In this second section, I review historical links among spirituality, religion, and medicine, and more recent trends in spirituality as part of healing in healthcare delivery today. Spirituality played a significant role in hospitals at the turn of the twentieth century, when their focus was primarily on caring for the sick and dying. A shift from caring to curing began as science and technology evolved and hospitals grew in number to meet the technological needs of patients. The section concludes with a discussion about twenty-first-century healthcare industry reform, which includes a closer look at patient satisfaction measures and a return to more holistic approaches to care, blending Western and Eastern medicine philosophies.

Spirituality, religion, and medicine have been linked in many cultures (Frampton et al., 2005; Koenig, 2000), from ancient prehistoric times until the Middle Ages, when these concepts began to separate. Mental and physical illnesses were once thought to be caused by evil spirits and were often treated as one and the same. Rituals and spiritual and/or natural remedies such as herbs or potions were used for cures (Koenig, 2000). In Western medicine, the church provided care for the sick and poor for almost 1000 years. Physicians of the Middle Ages were monks or priests. Nuns served as the first nurses. Medicine men and women were often spiritual healers of the day (Koenig, 2011). As the state began to license physicians at the beginning of the Renaissance, and more scientific discovery occurred, medicine and religion became uncoupled more dramatically, and had separated almost completely by 1800 (Koenig, 2000).

When medical cures were rare at the start of the twentieth century, compassionate religious orders of nuns provided the only respectable hospital care. They served the indigent, especially children, the very ill, and the dying (Carson, 1989). Religious orders and charitable organizations of the day offered humanitarian acts focused more on support and palliative
measures (Puchalski & Ferrell, 2010). The concern for fellow man came from people whose

calling manifested itself in service to the whole person, physically, psychologically, socially and

spiritually (Chapman, 2009).

Biomedical science focused on cures for specific physical problems. When biomedical

science and physical care alone were unable to alleviate pain and suffering, people turned to

spiritual resources (Puchalski & Ferrell, 2012). Some people suffered from spiritual pain which
could not be fixed in the same way as physical pain. Health and spirituality were disassociated
even in the field of psychology. These topics avoided spiritual and religious mainstream
discussions. The origin follows the development of modern day psychology as a natural science
dominated by Freud, who challenged religious authority as the source of truth (Puchalski &
Ferrell, 2012). Jung and Adler rejected these assumptions, studying instead consciousness, which
ultimately was linked to spirituality. Many then adopted spirituality and religion as a means of
making sense of the world and maintaining well-being. In the 1960s, research on religion and
mental health began providing data that supported this notion. While controversy remains,
Puchalksi and Ferrell (2012) call for “integrating psychosocial and spiritual dimensions in

psychology” (p.14), which is still needed for patient care today.

Over the twentieth century, US hospitals grew in number to provide for the expanding

population. These improvements, paired with improved sanitation and public health measures
(Carson, 1989), made enormous differences in reducing illness and death. During this time, life
expectancy dramatically improved, from an average of 47.3 years of age in 1900 to 76.8 in 2000
(US Census Bureau, 2012). As hospitals grew in number, the percentage of religious-sponsored
hospital and health systems declined (Utley, 2002). Of the 5,754 hospitals in the US (American
Hospital Association, 2010), twelve percent, or 629, are Catholic hospitals (Catholic Health
Another eight percent are sponsored by other faiths, totaling 20 percent non-secular, religiously based hospitals overall. Despite this change, spirituality remains a concern for all hospitals, not just religiously based hospitals (Utley, 2001).

Modern hospitals in this millennium do not always provide loving care or the kind of relational care humans crave (Chapman, 2006). The technological advances of the last century that changed the focus toward physical cures, although not necessarily bad, caused healthcare providers to lose focus on their reason for being (Chapman, 2009). Starting with the act of replacing people’s clothing with humiliating gowns and wheeling them through hallways, hospitals treat patients without dignity. Hospital jobs are viewed as bureaucratic and assembly-line in nature. Technology and drugs are still used to fix people, often as a replacement for providing loving touch (Chapman, 2006; Puchalski & Ferrell, 2010). Business methods and profits focus on expanding market share in lieu of providing resources to staff at the front line (Chapman, 2006).

A return to patient-focused care began at the turn of the millennium. The Institute of Medicine (IOM) proclaimed in its landmark report in 2000 that healthcare is broken in the United States and needs a fundamental change. Leading physicians in the country critically evaluated the provision of healthcare services in hospital settings, igniting a new wave of thought regarding what constitutes quality care from a patient’s perspective. According to Dr. Don Berwick, former chair of the IOM and former administrator of the Centers for Medicare and Medicaid Services (CMS), the United States healthcare system is fragmented, not patient-centered, unreliable, inefficient, and promotes wasteful spending (Government Health IT, 2011). After a stint in a leadership role with CMS that was truncated for political reasons, Berwick
maintained that “despite the best efforts of the workforce, we built healthcare wrong for modern times” (para. 2).

The provision of spiritual care is once again receiving considerable attention (Gunderman & Wilson, 2008; Koenig, 2007; Williams et al., 2011). Given that spirituality has become a central issue for patients at the end of their lives, we have witnessed a growing interest in hospice and palliative care that has, in turn, contributed to a reinfusion of spiritual practices into care (Puchalski et al., 2004; Astrow et al., 2001; King & Bushwick, 1994). Joint Commission accredits most of the nation’s hospitals, and as of 2000 required hospitals to administer a spiritual assessment for patients to assure the delivery of high-quality care.

There is growing recognition that patients want holistic medicine that encompasses the mind, body and spirit (Koenig, 2005; Williams et al., 2011) as a means of healing, whether or not a cure can be found. Hodge and Wolosin (2012) conducted a study to determine the relationship between addressing spiritual needs and overall perceptions of satisfaction with care among 4,112 older adults in geographically diverse hospitals. Their results indicated a positive correlation between levels of patient satisfaction and the degree to which patients’ spiritual needs were addressed. Attending to patients’ spiritual needs also predicted higher levels of overall satisfaction.

The Affordable Care Act (2010) placed emphasis on patient satisfaction by requiring hospitals to survey their patients. Overall outcome measures from patient satisfaction surveys for individual hospitals are available and transparent to the public for the first time (CMS, 2012). Reform measures are intended in part to improve the value of services for patients covered under the federal Medicare insurance program by improving health outcomes and reducing costs. Financial incentives are in place for hospitals that receive higher satisfaction scores by their
patients. Such incentives are available, too, for those hospitals that achieve higher clinical quality outcomes measures for their patients for specific kinds of care, such as cardiac surgery, stroke care, emergency care for acute myocardial infarctions, etc. Individual hospital performance in these areas is posted on the internet for all patients and consumers to view and compare.

Measuring patient satisfaction occurs via a standardized survey sent to all Medicare and Medicaid patients after discharge from acute hospitals. The required survey, called Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), asks patients 27 questions about their hospital experience, including their satisfaction with such matters as level of communication with doctors and nurses, pain management, medications, cleanliness, food, and returning home. Patients are also asked whether they recommend the hospital. One question inquires whether the hospital met patients’ mental and emotional needs. The standardized survey and implementation protocol produce data that allow objective and meaningful comparisons of hospitals by consumers.

Private vendors provide alternative patient survey instruments to the HCAHPS. The survey is sent to all patients, not just Medicare or Medicaid patients. While the standardized HCAHPS survey does not directly ask patients whether a hospital met their spiritual needs, many hospitals use a more sensitive survey tool that does (Press Ganey, 2003). Press Ganey, in existence since 1985, is one of a few private firms widely recognized in the healthcare industry for providing patient satisfaction surveillance for participating hospitals nationwide. In addition to the required HCAHPS survey questions, Press Ganey includes a question in their survey that asks patients whether a hospital met their spiritual and emotional needs. Their data shows a high correlation between the degree to which staff address emotional/spiritual needs and overall patient satisfaction (Graber, 2009, p. 517). Press Ganey (2003) found that patients do not
distinguish between an “emotional need” and a “spiritual need.” The 2001 national inpatient data, compiled over many years, indicates a relationship between patient satisfaction with spiritual and emotional care and hospital profitability.

A statistically small but meaningful difference in patient satisfaction exists between religious and non-religious acute care hospitals, according to Press Ganey (2003) research. Religious hospitals show a small favorable edge over non-religious hospitals in this regard. Some focus group and anecdotal evidence suggests that patients who select religiously affiliated hospitals expect a higher degree of spiritual and emotional care, and hold staff to a higher standard. Additionally, Press Ganey hypothesized that religiously affiliated hospitals are more predisposed to having dedicated pastoral care departments and resources.

Ronstrom (2011) believed both non-secular and secular hospitals must recognize spirituality as universal and essential. This is even more important in an environment dealing with healthcare reform measures. Regardless of affiliation status, many authors (Carson, 1989; Chapman, 2009; Frampton et al., 2003; Watson, 2005) agreed that more can be done across all hospitals to recapture spirituality as an important element in the healing process.

**Holistic Care**

Western and Eastern medicine traditions that seemed at odds in the twentieth century have found at least some mutual ground today. *Holistic care* is a term that refers to meeting the needs of the whole person, including mind, body *and* spirit (Frampton et al., 2003; Koloroutis, 2004; Watson, 2005; Young & Koopson, 2011). It is differentiated from traditional Western medicine’s prioritizing of physical, social, and psychological issues, going beyond these to embrace the spiritual needs of the human experience. The American Holistic Medical Association, founded in 1978, reflected growing concerns by a number of health care professionals who believed in a balance of Eastern and Western medical approaches. This
includes combining physical, environmental, mental, emotional, social and spiritual aspects of health and wellness (AHMA, 2009).

Strategies that support holistic care emanate from individual belief systems found in every culture (Young & Koopson, 2011). These belief systems proceed from individuals’ spiritual, religious, and cultural heritage, and influence how they view their world and, in turn, how they elect to manage health and illness. Young and Koopson (2011) describe three major categories of belief systems: scientific or biomedical, magicoreligious, and holistic. Biomedical systems in traditional Western medicine consider disease to be caused by physiological disturbances (Puchalski & Ferell, 2010; Young & Koopson, 2011). Such an outlook is based on the belief that health and illness are physical and that humans can control biochemical processes. Treatment involves isolating the problem and repairing it by placing the person in a hospital and administering medication or surgery. Magicoreligious systems hold that supernatural forces determine fate and influence health with disease. They contend that illness is punishment for weakness, retribution, behaviors or evil deeds. Examples include the Christian Science religion, and the belief systems of certain African and Caribbean cultures (Young & Koopson, 2011). Holistic systems, including certain Chinese and Native American traditions, are based on the belief that the forces of nature should be kept in natural balance or harmony. The underlying premise of holistic systems is that natural laws govern all things and that disequilibrium and disharmony cause illness. Followers use home and community resources, defaulting to hospitals only if all else fails (Young & Koopson, 2011).

Engebretson, Headley and Luckmann (in Young & Koopson, 2011) describe four healthcare belief systems: biomedical, popular healthcare, folk sector/traditional medical, and alternative. Biomedical healthcare systems seen in America are represented by self-reliant
individuals who seek care from scientifically trained doctors and nurses. Popular healthcare systems are most common and exist in all cultures. People with this belief choose self-treatment, using personal and social networks such as friends or support groups as sources of information. Folk sector or traditional medical systems place their health in the hands of folk healers, such as shamans, curanderos, herbalists, acupresssurists, and acupuncturists. These healers enjoy high status within their cultures, and are considered to have special healing powers that arise from traditional cultural history. These beliefs dissipated as Western medicine grew.

Evidence-based information exists supporting the integration of medicine in mainstream Western healthcare. Integrative, alternative, or complementary medicines are terms used to describe holistic techniques stemming from Eastern medical belief systems (Samueli Institute, 2015; Young & Koopson, 2011). Until recent years, the West rejected these approaches primarily because it perceived them as outcome-based rather than evidence-based (Chapman, 2009). Chapman (2009) suggests that enlightened organizations properly apply these therapies together with traditional medical treatments. The Samueli Institute (2015), a non-profit research organization, validates research on the safety, effectiveness and integration of healing-oriented practices and environments. Evidence-based research attempts to integrate knowledge into mainstream health care for such things as natural products, nutrition and lifestyle, mind-body practices, complementary and traditional approaches such as acupuncture, manipulation, yoga and the placebo (meaning) effect.

In conclusion, there is considerable evidence linking spirituality, religion and medicine from both Western and Eastern perspectives over the last century. As patients voice their desire to have both care and cures, healthcare organizations are responding in a more holistic and
integrated fashion. Below I articulate additional evidence that has emerged during the twenty-first century, as healthcare organizations have attempted to enhance their cultures.

Organizations Including Spirituality

This third section reviews spirituality as part of organizational cultures historically, and examines three specific models that exemplify caring cultures that involve spirituality as a significant component of the healing process. The historical evolution of spirituality in the workplace in general helps us to understand the great divide that occurred between the spiritual nature of work and home life. I then review how the thread of spiritual life evolved in a hospital context. Subsequently, I define and discuss three models of spiritual cultures. These models are: Samueli, Planetree, and Radical Loving Care. In illumining the role of the leader in these cultures—as well as important characteristics for establishing the cultures, along with key characteristics of each model—we will see how staff can provide humanistic care focused on relationships. In so doing, they can meet patients’ needs.

Spirituality in the Workplace

Thompson (2000) refers to the process of adult development as “growing up” as a grown-up. He believes that the meaning and purpose people once found at the confluence of their personal and professional lives can occur in today’s world. In order to understand the workplace experience, he recounts the historical evolution of our concepts of work, beginning with medieval Europe and continuing up to the attitudes we hold today. In agrarian societies, where “life was work and work was life” (p. 16), the human tendency to separate good from bad and sacred events, places and activities from their secular counterparts, created a dichotomy of secular and non-secular worlds. Monks lived in a favored world that commoners could partake in only by invitation to mass or sacraments. The Protestant Reformation brought about by Martin Luther challenged this thinking and proposed that every type of work, including common men’s
work, could serve God. John Calvin extended this idea by suggesting that man could be redeemed through God’s grace, without a priest’s interceding, but only if the individual earned it. Thompson (2000) refers to the era as “the great divorce,” where faithfulness in work as the path to salvation gave way to the perception that success in work was a mark of salvation. A period of “enlightenment” redefined the Protestant work ethic, liberating the common man from organized religion and disconnecting the purpose of work from religious or spiritual significance.

Rugged individualism and the beginning of commercial enterprise became apparent as the Industrial Age arose. The work experience, which played out mostly in the context of home by farmers, merchants, and craftsmen, began to change as people traveled distances to work in factories. The physical separation of work life from other aspects of life alienated individuals from the process and meaning of work. In 1956, Daniel Bell (in Thompson, 2000) declared that our culture had accepted the premise that work can have no intrinsic value, and work thus became a means of gaining a “standard of living.” Thompson (2000) believes the overemphasis on individualism, paired with the failure of business institutions today, has led to the loss of a sense of community. The church, in particular the Catholic Church and its theologians, remained silent on the subject of work while spiritual connectedness in the workplace lost ground. The failure of theology to connect with working people today is a result of the church’s attempts to model itself after commercial culture, as well as its tendency to fit the idea of “work” into the tenets of traditional church dogma (Thompson, 2000). With few philosophers and theologians looking beneath the surface, most of what has been written about work in recent years has viewed the subject through economic, sociological, or psychological lenses, using a scientific method.
Over the past several decades, the culture of workplaces had been described by researchers and managers as the norms and practices that organizations prescribe for handling people, or as the values and credo that organizations espouse (Schein, 2010, p. 13). Current behavioral studies seeking to understand worker motivation also point to common values as a source of purpose and meaning (Craigie, 2010; Schein, 2010; Thompson, 2000). However, values alone are incomplete without considering the complexities of individuals’ need for meaning and purpose.

More recently, a few experienced business/faith-based leaders not directly associated with the church have used terms such as service, stewardship, and calling to describe work and business in a more meaningful and exalted manner (Thompson, 2000). Such terms resonate with leaders seeking to align their outer lives with inner faith. A paradigm shift to embrace the congruence between personal and professional life is emerging. This shift calls for leaders who seek to heal the rift between the personal and professional, between faith and work; leaders who, in their vision of work as a holistic unity invested with spiritual conviction, can provide the energy for cultural change.

Leadership is the original source of the beliefs and values that get organizations moving as they deal with internal and external problems (Schein, 2010). Leaders act as forces for change rather than victims of change, and rather than manipulating people, they help people to find meaning for themselves. Leaders orient people to the meaning, purpose and vision of the organization (Craigie, 2010; Thompson, 2000; Schein, 2010). Leaders can influence and “organize” meaning for the members of their organizations, by personifying the vision in all aspects of their professional lives.
Most important however, is the process by which the fundamental assumptions and shared values in a culture are questioned and changed. Fundamental and non-incremental change occurs when an individual’s core values are aligned with those of the organization’s leadership (Dehler and Welsh, in Thompson, 2000; Craigie, 2010; Schein, 2010). Transforming organizational culture requires alignment primarily at the level of a subordinate’s spiritual realm (Thompson, 2000). This kind of alignment is apparent when employees are intrinsically motivated by the leader’s vision to infuse work with spirituality and meaning, and can be discerned in employee behaviors that produce enhanced performance. This heightened performance continually reinforces and re-energizes an organization’s mission. Schein (2010) notes the need for alignment of inherent subcultures within organizations in order for leadership to be effective. Most importantly, the leader who focuses attention on the vision operates on the emotional and spiritual resources of the organization, its values, and its aspirations (Bennis and Nanus in Thompson, 2000; Craigie, 2010), and ultimately he or she inspires others to share in the same.

According to Geh (2014), organizational spirituality as a field is still in a nascent stage of its development. The growing interest in workplace spirituality, both in the popular press and in academic research, may be due to a heightened interest in exploring the meaning of our own lives; how the work we engage in is an integral part of our self-concept and thus central to our existence. The work environment dominates our time, and this often contributes to a sense of desperation and a thwarting of spiritual growth (King & Nicol, 1999). Workers suffer from a perceived loss of meaning and purpose in an environment of heightened change. This, in turn, contributes to a sense of spiritual desolation. The management of an organization helps make the individual experience positive and strengthens the structure of the organization. Management’s
ability to understand the process of individual spiritual growth within the context of the organization has mutual benefits. King and Nicol (1999) point to Carl Jung’s theory of “individuation,” wherein an individual must be cognizant of their whole personality, “the Self,” to gain awareness of their higher purposes and potential capabilities. By re-thinking organizational variables that affect workplace performance, leaders may impact an individual’s ability to feel inspired. Continual assessment is a prerequisite to sustainable learning in organizations that are both “made” and “found” (Geh, 2014).

The centrality of the workplace provides an opportunity for meeting both economic and spiritual needs (Fairholm, 1996; Schein, 2010). Workplace values breed the most useful social contributions in society. Fairholm (1996) points to research confirming that mature leaders and workers are seeking more than economic rewards at work. They seek to satisfy inner needs for spiritual identity and satisfaction. Kantrowitz’s (in Fairholm, 1996) survey of managers in the workplace indicates that 85% of respondents found a significant connection between their leader’s disposition to spirituality and the impact he or she has on their work. Without taking away from religious perspectives, a leader’s focus on workplace spirituality can improve both individual satisfaction and the organization at large. Fairholm (1996) concedes that spirituality made manifest is the essence of leadership.

Leadership that aspires toward a spiritual relationship between leader and workers is founded on morality, stewardship, and community (Craigie, 2010; Fairholm, 1996; Thompson, 2000; Schein, 2010). Spiritual leaders are moral leaders who prefer not to compromise core values. They view organizations as places where stewardship of resources is essential and is entrusted to them for a temporary period of time. Stewardship is based on self-directed free moral choice and self-governance. This differs from leading organizations for reasons of
personal ownership, passion, or control. Leaders value service to community and are able to create cooperative, action-oriented communities from a sense of spirituality. Leadership based on a spiritual relationship between steward and worker is characterized by the leaders’ shared values, as well as their ability and willingness to engage others in reaching their personal and group goals. Plurality or parallelism of intellectual and spiritual worlds is possible in the workplace through empowerment, assigning meaning, and people-centered business practices that are integrated with a guiding spiritual theory.

Milliman and colleagues (1999) found that spiritual values can be integrated into organizations. They studied spirituality and community in a values-based model at Southwest Airlines (SWA), a successful secular organization. With a strong emphasis on community, teamwork, serving others, and acting in the best interest of the company, employees feel that they are part of a family who takes care of one another as well as its customers. Members of the organization share attributes of teamwork, a sense of being part of a common cause, and empowerment. These observations are consistent with the conclusion that Collins and Porras (in Milliman, 1999) advance: that people want to have something to believe in, to have meaningful work, and to feel like they can contribute to an organizational mission in a way that makes a difference for people. SWA’s core values emphasize skills, humor, enthusiasm, and fun. The major reason SWA offers for its success is its human resource management practices, which are designed to provide conditions that energize and inspire people. Prospective employees are tested for certain behaviors before being hired. Employee selection places the highest importance on attitudes and values rather than on technical skills. Other operational strategies reflect the organization’s core values with the intent of generating strong employee, customer, and business results.
Organizational culture is constructed by the environment that surrounds and influences learned group behaviors (Schein, 2010). Culture is what a group learns over time to solve the challenges of surviving in the external environment, as well as internal integration challenges. The process is simultaneously emotional and behavioral. At its deepest cognitive level it results in groups who share feelings, emotions, attitudes, espoused values, and behaviors.

Scholars contest the definition of culture. Some argue that some organizations possess cultures rather than being, themselves, cultures (Bolman & Deal, 2003). Patterns of shared basic assumptions develop as a culture adapts and integrates new members (Schein, 2010). New members are taught “the correct way” to perceive, think, and feel in relation to organizational challenges and dilemmas. More simply put, Deal and Kennedy (in Bolman & Deal, 2003) describe culture as “the way we do things around here.” Patterning and integration (Schein, 2010) results in shared assumptions that evolve. New members are taught and perpetuate group behavior rather than deviate from it.

Cultures begin to take shape through founders’ and leaders’ actions (Schein, 2010; Thompson, 2000). Organizational cultures with similar external environments and technologies, and with founders of similar origins, may operate in different ways over many years. Organizational success leads to growth over time, requiring organizations to differentiate themselves from others. A critical function of leadership is to recognize the cultural consequences of the differentiation process and to strive toward the desired cultural outcome.

**Spirituality in Hospital Cultures**

Viable healthcare systems are supported by hospital cultures which embrace patients beyond the physical aspects of care, including the whole person: body, mind and spirit (Carson, 1989; Chapman, 2009; Koloroutis, 2004; Frampton et al., 2003; Institute of Medicine, 2000; Watson, 2005). Regardless of reform, reorganization or merger, healthcare leaders have a
fundamental responsibility to sustain cultures that provide humane care for patients in a way that is also financially viable (Chapman, 2009) and improves the public’s trust (Atchison, 2004; Chapman, 2009; Dye, 2000; Dye & Garman, 2006; Institute of Medicine, 2000). Organizational culture is central to the productivity and performance of healthcare organizations, and is influenced by spirituality (Craigie, 2010). Hospital leadership can adopt a multitude of approaches to foster a culture with a caring clinical and spiritual environment (Craigie, 2010; Thompson, 2000). Creating and sustaining the environment is more than a program or project (Craigie, 2010; Graber, 2009; Schein, 2010; Thompson, 2000); it requires a radical approach firmly entrenched in the consciousness of the organizational stakeholders in order to withstand time.

There is a plethora of research on the lack of caring and empathy in hospitals, a phenomenon linked to a corporate mentality focused on high-level technology, efficiency, productivity and profit (Graber, 2009). These concepts are not necessarily bad, however there may be a tendency to supplant or eliminate humanistic, compassionate care—and this suggests patients may perceive that they are being neglected, ignored or disrespected (Chapman, 2006; Graber, 2009). Recent years have witnessed a trend toward detachment and more formal relationships between staff and patient; a host of recently-coined industry terms reflect a movement toward counteracting this pattern: “Patient-centered care” and “relationship-centered care,” for example, are designations aimed at redirecting thinking toward humanism and patient relations (Chapman, 2006).

While hospitals assert a commitment to empathy and patient dignity, as described in their mission and vision statements, it becomes a challenge to support staff efforts to achieve this in the general environment. Changes are needed at both a micro level by individual care givers and
at a macro level by the organization’s leaders, to ensure that compassionate care is part of an organization’s culture (Chapman, 2006, 2009; Graber, 2009). Leaders at every level must serve as role models, and can take practical remedial steps to remold their organization and shape its culture. This includes such things as identifying the characteristics of key staff and clinicians to hire and develop.

Creating positive spirituality in healthcare requires that three interdependent domains within an organization be in harmony: the clinical, personal, and cultural (Craigie, 2010). Nine interventional strategies under the three domains provide guidance. The clinical domain includes ways in which patients’ spiritual needs may be supported in various life situations such as transitions, chronic or terminal illnesses, or lifestyle changes. Connecting with patients clinically means selecting areas of inquiry to understand what matters to them, creating collaborative spiritual care conversations about where the patient wants to go, and being attuned to themes of transcendence and valued directions. The personal domain includes caregivers’ cultivating their own character, staying connected to their own purpose, and staying grounded in intention and presence. A culture of empowerment and affirmation that brings out the best in patients and staff is essential.

Healthcare workers who are hesitant about spirituality are generally concerned about the time it may take to provide spiritual care, invalidation (inability help someone in their suffering), and/or lack of skills. These fears can be acknowledged and overcome in a culture of positive spirituality, especially one whose leaders embody spirituality in their professional and personal lives. Craigie (2010) defines positive spirituality not as curing spiritual suffering, but rather as identifying and encouraging the patient’s spiritual values and resources and bringing those to bear on a journey toward health, coping, dignity, and wellness (p. 11). Spirituality is seen as
“embodiment” rather than as a specialty. Caregivers who embody spirituality meet the needs of patients and others through intentionality and their presence (Craigie, 2010).

Organizations have “souls” or cultures with certain qualities that play a significant role in the process of healing (Craigie, 2010). These cultures include staff who: have a shared understanding of mission, values, respect and empowerment; function as a community that supports one another, deals with conflict in healthy ways, and has fun; and possess leaders who provide inspiring models of personal integrity that brings out the best in others. There is a noticeable difference among organizations. Those with more positive spirituality do better than others with respect to employee retention and satisfaction, patient satisfaction, performance improvement and process measures, and health care outcomes (Craigie, 2010, p. 312). The culture is central to spirituality. The three interlocking pieces of cultural, personal, and clinical arenas are necessary for spiritual care to be complete.

There are several exemplary organizations attempting to change the nature of care delivery by providing humanistic care focused on relationships with patients (Graber, 2009). Below, I review a number of successful pioneers of humanistic hospital cultures that use a wide variety of transformative initiatives. These include the Samueli Institute, Planetree, and Chapman’s Radical Loving Care.

**Samueli Institute**

The Samueli Institute (2011) is a pioneering organization that developed a total patient experience approach that emphasizes the spiritual, physical, emotional, behavioral and environmental aspects of healing. In 2002 Samueli coined the term ‘optimal healing environment’ (OHE), which refers to a philosophy of care for hospital/healthcare systems that integrate healing-oriented concepts. In 2006 and again in 2007, Samueli conducted surveys of hospitals across the country to better understand the nature and prevalence of initiatives that
contribute to OHE. The 2007 survey drew responses from 748 hospitals, a 12 percent response rate. The survey’s questions addressed the seven different components of the Samueli OHE framework: developing healing intention; experiencing personal wholeness; cultivating healing relationships; practicing healthy lifestyles; applying collaborative medicine; creating healing organizations; and building healing spaces. The survey found that hospitals of all dimensions across the nation are implementing all seven OHE components, with over half implementing four or more components; almost a quarter of hospitals implemented all or almost all seven components (Samueli, 2007, p. 23). According to the authors, the high frequency of adoption suggests that all hospitals and health care systems may want to implement OHE components that support, stimulate, and optimize healing. They suggested, moreover, that health care reform financial incentives may entice professionals to consider OHE strategies to achieve the rewards.

An OHE framework has evolved over the last decade (Samueli, 2015). The social, psychological, spiritual, physical and behavioral components of an environment can affect the inherent healing capacities of those within an organization. The framework includes four domains: internal, interpersonal, behavioral and external. Major components of the framework include clear constructs for each domain.

The internal domain is focused on an individual’s personal development and healing of self. It is the conscious and intentional effort by individuals to develop awareness, expectation, and belief in improvement and well-being. Personal wholeness is the harmonious cohesion of the mind, body and spirit. These skills can be fostered over time, reinforcing wellness and recovery.

The interpersonal domain is characterized by healing relationships with others and the organization. It requires cultivating relationships and social supports with others who value teamwork and service. These relationships with peers, families, and friends evolve into an
organizational culture of holistic healing. Healing relationships are intentional and reciprocal. They are nurtured by personal and professional interactions to develop a sense of belonging, well-being, coherence and healing between and among people. The healing presence is founded on love, compassion, self-awareness, and inter-connectivity. Adopting these kinds of behaviors forms a healing culture. The culture is supported by the organizations’ mission, vision and values, along with a strategic plan carried out by leaders who advance team-based, patient-centered care. The healing organization is regularly evaluated, reinforcing its values.

The behavioral domain involves what we do for others and ourselves to maintain health. It requires practicing healthy lifestyles and applying integrative healthcare strategies. Lifelong healthy behaviors such as healthy food choices, regular exercise, relaxation, and self-care practices are emphasized. Personal integration of these behaviors creates a sense of balance, wholeness, and wellness that can improve well-being and prevent, treat or possibly cure disease. Team-based person-centered care with active engagement of family and social supports is important. It includes integrative medicine and complementary therapies blended with conventional medicine to treat the whole person.

The last domain, the external, focuses on physical healing spaces designed to optimize healing and improve the quality of care. Healthy outcomes and positive experiences for patients and staff are achieved using evidence-based design features to reduce stress and have a calming effect. The physical features foster both wellness and healing, and include: specific architectural design elements that promote patient safety and good clinical practices, soothing color choices and lighting, and access to nature, music, and art. Ultimately, ecological sustainability focuses on reducing the carbon footprint. Energy-efficient buildings that reduce the use of resources and chemicals are implemented for a healing planet.
The four domains overlap and no one stands alone. The synergy among each of them surrounds a person, optimizing individuals’ energy so that they may heal and become a nurturing presence for others.

**Planetree**

In recent years, research has confirmed the value of architecture in shaping organizational culture or “the way one works” (Hamilton, Orr, & Raboin, 2008), and in improving the quality and safety of care provided to a patient (Ulrich, Zimring, Zhu, DuBose, Seo, et al., 2008). Although a specific kind of architecture or design alone does not define healing environments for patients (Frampton et al., 2005; Hamilton, Orr, & Raboin, 2008; Ulrich et al., 2008), it does influence the culture of care, such as those created using Planetree philosophies and design.

A meta-analysis of current literature by Ulrich et al. (2008) indicates that well-designed physical settings help to heal the whole person. Evidence-based research on the physical environment’s impact on patient healing and satisfaction, staff efficiency and effectiveness, and organizational culture is reviewed in depth by The Center for Health Design (2013). Planetree-designed facilities are included in this research.

The Planetree philosophy created by Angela Thieriot (Frampton et al., 2005) was one of the first models to use the physical environment to enhance care. Planetree strategies changed thinking about typical sterile-looking, technology-focused hospitals. They are designed to fulfill patients’ desires for more personal and humanitarian care in a homelike and family-centric environment that feels safer and less intimidating. Patients’ needs are incorporated into the culture and design of the hospitals’ physical space to reflect their desires for respect, kindness, privacy, information, autonomy, choices, and inclusion in healthcare decisions.

In concert with its care philosophies, Plantetree has created essential physical environments in which families and friends can offer support to their loved ones in the patient
room. Alternative, separate sleep rooms and nurturing spaces for families are often available. Meditation rooms, chapels or other spaces for rituals and symbols, as well as healing gardens, are provided to embrace spirituality. They may also provide options for complementary and alternative medicines, including human touch and massage. These relax patients while creating connections with caregivers.

Healing arts in patient rooms and throughout Planetree campuses provide patients with positive distractions. Patients are redirected to think about something other than being ill. The campuses afford patients views of nature that aid the healing process and reduce the time patients spend in the hospital (Ulrich, 1985). The general organization of supplies, materials, and adjoining spaces can aid staff efficiency and effectiveness.

In 2007 a Planetree Designation Program was launched. Planetree independently and collaboratively conducts research on healthcare quality, and also provides research and consultation to partners in academic, practice, and policy forums (Planetree, 2013). Healthcare organizations following this philosophy will model and educate healthcare stakeholders on the meaning and implications of patient-centered excellence.

**Radical Loving Care**

All healthcare workers, including leaders, should form fundamental relationships and commitments with each patient to create a culture of caring (Chapman, 2006, 2009). This extends to the relationships healthcare workers forge with one another and themselves. Healthcare workers grounded in intentional acts of love create a culture that distinguishes caregiving from a more transactional and mechanistic customer service approach that is demeaning (Chapman, 2009, p. 15).

A “culture of care philosophy” created and implemented by Chapman (2006; 2009) salvaged three troubled hospitals. Acting on his personal beliefs, Chapman asserts that healing
occurs through a culture of caregivers who provide loving service or “radical loving care” for all patients, especially the unlovable. In his model, the culture of caring is built upon universal humanitarian beliefs found in all religions: to affirm the human need for love and care, and to heal and serve others above oneself. Chapman’s objective is to affirm the notion of charitable work in hospitals as sacred rather than religious.

The practice of providing loving care is an enlightened way of thinking about human relationships. It gives people meaning (Chapman, 2009, p. xvii). Caregiving is humanitarian, sacred work that ministers to the needs of others. It is based on the idea that every encounter with another is grounded in loving intentions. Healthcare providers slipped out of balance over time due to the forces of technology and profits. The process of loving care was lost. Cynicism arose from professionals focused on treating a disease rather than a person. Chapman (2009) suggests that healthcare providers ought not to abandon good operating procedures and technology. Loving care must find its proper place as the foundation of charitable work. Care and respect must be woven into all business propositions. Care for patients must be provided with kindness and compassion.

Many authors use the term love in connection with spirituality (Chapman, 2006, 2009; Diering, 2004; Jaffe & Erlich, 1997; Sanford, 1998; Watson, 2005). Without love for others or love for God or a Higher Power, spirituality would not exist (Sumalsy, 1997, p. 13). Fromm (1956) posits that all people have a desire to be separate individuals and simultaneously need to be in union with others. Watson (2005) affirms Fromm’s idea of being as one, describing it as “a moment in time when we connect with our deep inner humanity, we are in the right relationship with ourselves and our world, and consider ourselves whole, holy and at peace” (p. 80).
Love is more than a relationship to a person or an object. It is part of our character, and constitutes the way in which we relate to the world at large (Fromm, 1956). Genuine love is an expression of productiveness and implies care, respect, responsibility, and knowledge of self and others (p. 55). Like spirituality, the practice of loving gives people meaning and is an enlightened way of thinking about human relationships (Chapman, 2009; Watson, 2005). People need each other in loving and caring ways, but these needs are often overlooked (Watson, 2005). Watson (2005) equates caring with love, and describes it as “the most universal, the most tremendous, and the most mysterious of cosmic forces comprising the primal and universal psychic energy” (p. 67). We become more caring and loving by starting with ourselves. We can then respect others with love, gentleness, and dignity.

One must love oneself in order to love others (Chapman, 2006, 2009; Fromm, 1956; Watson, 2005). In the act of giving oneself to another while fully knowing them, the giver discovers one’s own self (Fromm, 1956). People who love themselves are more apt to find pleasure in giving, which Fromm (1956) considers the ultimate form of real love. Conjunctive love, related to self-love, suggests that, as objects of our feelings and attitudes, we cannot be divided. Respect for one’s own uniqueness and integrity therefore cannot be separated from understanding, respect, or love for another individual.

Because each individual’s situation and needs differ, the art of loving requires practice. This is essential to the provision of loving care for patients (Chapman, 2006, 2009; Watson, 2005). Individuals must practice presence in all encounters, loving self equally with others (Carson, 1989; Chapman, 2006, 2009; Puchalski & Ferrell, 2010; Watson, 2005). Encounters are not a function of time, but rather the quality of the loving presence that arises from one’s way of being (Chapman, 2006, p. 127). Individuals who are present are aware of how they affect others,
accept a needed change in behavior, and integrate changes into new patterns of thought and action. Individuals can achieve presence through meditation and/or prayer; pausing to prepare thoughts before entering a patient room; studying the arts; breathing techniques; eye contact; testing their own mental model of others; listening gracefully; apologizing; forgiving; and caring for self first.

Love is an important healer for both professionals and patients (Chapman, 2006; Diering, 2004, Watson, 2005). The professional practice of giving and receiving love between caregiver and patients creates a workplace where better care is provided. Staff and patients are happier, and staff experience higher job satisfaction (Chapman, 2006; Diering, 2004). Healthcare professionals must educate their minds and hearts alike, as well as assess their own capacity to love. If love is dormant it cannot flourish or be shared with patients. If this is so, they may not be in the right profession (Chapman, 2009).

Leadership is responsible for failing to convert the culture from houses of technology to homes of healing (Chapman, 2009, p. 42). A 2006 survey (p. xxii) of hospital executives’ greatest worries showed financial challenges ranked first (67 percent), quality ranked fifth (23 percent) and patient safety sixth (20 percent). Chapman concludes that loving care is part of most hospital mission statements, yet believes leaders give little attention to it. Graber (2009) defends hospital leaders, noting they are challenged to devote the same level of energy and attention to ensuring compassionate care for their patients that they do to all other hospital initiatives.

The single most vital ingredient in a cultural change toward loving care is CEO commitment (Chapman, 2009, p.11). It requires maintaining focus on the mission, serving those in need. It takes a minimum of two years to implement. The model runs deeper than mere customer service programs. Love-based leadership is exemplified by service and the cultivation
of love rather than the exercise of power or creation of fear. In this model, relationships are cultivated with all people, not just patients. Four key encounters that need to be nurtured include caregiver to patient (the primary encounter); caregiver to caregiver; leader to caregiver; and caregiver to self.

Tools to create a balance between essential business functions (quality, finance, skills, and technology) and loving care (compassion, kindness, respect, truthfulness) include: listening and using positive language; balancing time spent doing, understanding and being; changing patterns of self-behavior; hiring and counseling staff toward good performance; tracking where people are at and how they are performing; and providing ongoing encouragement (Chapman, 2009). Cultural change can be orchestrated by a vision-steering committee with several subcommittees focused on key elements such as: hiring and orientation; quality of work life; retention; crucial conversations; leader rounding; appropriate meeting agendas; loving language; and creating pilot projects to test changes.

**Responsibilities for Providing Spiritual Care**

In this last section, I review the roles and responsibilities of staff in providing spiritual care. Moreover, I detail the responsibilities of non-direct caregivers such as CEOs and other leaders, as well as those of direct caregivers. Finally, I discuss the importance of caregivers’ own spiritual needs, as well as professional development and training.

The healthcare setting provides a framework for professionals to help patients deal with spiritual stress. Holistic care goes beyond mere professional training; it makes the duties of caregivers into a calling (Chapman, 2006, 2009; Puchalski, 2010). Spirituality enables caregivers to be open to the mystery of the work while growing personally in spiritual wisdom.
and knowledge (Puchalski & Ferrell, 2010, p. xx). This, in turn, may help patients under stress to move in a braver direction.

The loving, trusting relationship between the patient and caregiver is essential to healing. Staff members play essential roles in creating a culture that includes spiritual care (Carson, 2005; Chapman, 2006, 2009; Craigie, 2010; Koloroutis, 2004; Watson, 2003). Most healthcare professionals are trained within the limits of science (Puchalski & Ferrrell, 2010). They tend to be focused on treating the disease rather than the person (Chapman, 2009). They are not trained in developing boundless relationships based on trust (Puchalski & Ferrell, 2010).

Personal readiness for offering spiritual care is another consideration among many, contributing to the challenge of understanding how each of the many different professionals might best serve patients’ spiritual needs (Craigie, 2010; Puchalski & Ferrell, 2010).

CEOs and Leaders

Healthcare is by its nature a high-stress vocation. Leaders must deal with negative public sentiment, conflict with physicians, discontented employees and dissatisfied patients (Atchison, 2004; Dye, 2000; Dye & Garman, 2006). Healthcare leaders are blamed for the last three decades of capitalistic modern medicine, which have changed the focus from people to profits (Atchison, 2004). Healthcare leaders are doubtful of their ability to rebuild the public’s trust and guide their organizations through changes (Dye, 2000). Leaders must look within to improve their own performance and strengthen their healthcare organizations (Atchison, 2004; Dye, 2000; Dye & Garman, 2006; Schein, 2010).

The commitment of the CEO is the single most important element in creating a culture of caring in a healthcare setting (Chapman, 2009). The leader in any organization serves as its moral compass, earning the trust of the people, empowering them to be the best they can be, and modeling the behaviors themselves (Atchison, 2004; Chapman, 2009; Covey, 2009; Dye, 2000;
Dye & Garman, 2006; Greenleaf, 2011; Hunter, 2004; Schein, 2010). The CEO sets the stage for all leaders who must foster healthy relationships with physicians, staff and others (Chapman, 2009; Dye, 2000; Dye & Garman, 2006; Puchalski & Ferrell, 2010).

In a positive, creative culture of caring, leaders nurture staff members, helping each person find his or her own voice (Chapman, 2009; Greenleaf, 2011; Puchalski & Ferrell, 2010). Leaders must be aware their own values and spiritual nature. Such an awareness is essential to identifying where and how to strengthen or develop these attributes in others (Chapman, 2009; Covey, 2009; Dye & Garman, 2006; Greenleaf, 2011; Hunter, 1998; 2004; Puchalski & Ferrell, 2010; Thompson, 2000).

Leadership is both inherited and learned (Dye, 2000). Leaders grow as they become more conscious of value systems. Values and skills are so interrelated that one cannot exist without the other (Covey, 2009; Dye, 2000; Greenleaf, 2011). Values to be cultivated include respect, stewardship, ethics, integrity, interpersonal connection, initiative to make change, commitment, and intelligence. To build teams, leaders must also value cooperation, sharing, cohesiveness and collaboration, trust and conflict management (Covey, 2009).

Servant leadership is transformational in nature and is intended to produce positive change in society (Greenleaf, 2003, 2011). A servant’s heart is important not only for the CEO, but to all leaders within healthcare organizations (Chapman, 2009). Exceptional leaders possess attributes and values that develop and nurture spiritual needs which, over time, have the potential to improve the organization as a whole (Chapman, 2006, 2009; Greenleaf, 2003, 2011; Hunter, 1998, 2004).

Greenleaf (Spears, 2004) began an influential servant-leadership movement in the 1970s toward encouraging trust, foresight, listening, collaboration, the ethical use of power, and
empowerment, with particular focus on the development of others. The movement coined the phrase “servant leader” to emphasize the fact that a person in a leadership position must first make a conscious choice to serve others, followed by a resolution to be the leader (Greenleaf Center for Servant Leadership, 2011). On the opposite end of the spectrum, those desiring to be leaders may initially be driven more by power and money than a genuine inclination toward service. The leader-first and the servant-first are two extreme types. Between them lies the continuum of the infinite variety that is human nature.

Servant leaders share power, seeing to it that the highest priority needs of other people, including those of their staff and the community, are met (Greenleaf, 2003; Hunter, 2004; Covey, 1990, 1992, 2004). Those being served must grow, and while served, must themselves become servants (Greenleaf, 2003). Servant leaders integrate spirituality into their work as well as their personal lives (Hunter, 2004). Successful leaders possess personal commitment, have passion and positive attitudes, explore their own and others’ potential, are persistent, practice being present, and pray or meditate (Frankel, 1963).

Principle-centered leadership encompasses the whole-person: mind, body, heart, and spirit (Covey, 1990, 1992, 2004). The same basic four dimensions of the whole person apply in both Western and Eastern philosophies and religions, including: the physical/economic, the mental, the social/emotional, and the spiritual. They represent the four basic needs of all people: to live (survival), to love (relationships), to learn (growth and development) and to leave a legacy (meaning and contribution) (Covey, 2004).

Leadership qualities, similar to those of volitional love, manifest themselves as leaders extend themselves for the sake of others (Hunter, 2004). When practicing the behaviors of love and extending themselves to others, leaders develop new positive habits.
To affect the entire culture, leaders must also have the ability to identify others in the organization with these same capabilities and help them grow as leaders (Chapman, 2006; Schein, 2010). Such an assessment of the organization’s level of awareness, and readiness to accept this way of being, occurs by a process of appreciative inquiry (Craigie, 2010, p. 77), that is, engaging staff in meaningful ways and allowing them to express a new vision in their own voices.

Transcendental leaders have an important impact on organizations (Beckwith, 2010; Biberman & Whitty, 1997; Fry, 2003; Gardiner, 2006; Lui, 2007). The presence of transcendental leadership in workplace spirituality may create adaptive as well as successful organizations (Beckwith, 2010). Transcendental leadership can be viewed as a spiritual-relational process (Biberman & Whitty, 1997) that draws on values, attitudes, and behaviors such as altruistic love, hope, and faith to intrinsically motivate followers (Fry, 2003; Gardner, 2006). Transcendental leadership is, then, both a follower-centered and leader-centered process that reflects a congruence of values (Fry, 2003). In prioritizing service above self (Gardner, 2006), as well as the sense of well-being resulting from care and concern for oneself and others, leaders can empower their followers to accomplish their own objectives and lead independently. The followers experience a sense of a calling and interconnection with the leader, resulting in positive outcomes for the organization. These leaders have more inclusive, nurturing, trusting, and meaningful interactions with their followers (Gardiner, 2006). Such an environment helps both leader and follower meet their fundamental spiritual survival needs (Lui, 2007, p. 4). Self-identified transcendental leaders believe that they impact their organizations through personal spiritual development (Beckwith, 2010). They apply their personal experience and knowledge to
relationships between themselves and their followers. Their followers, in turn, emulate the same intrinsic values.

Success in healthcare is achieved when the leader builds a culture focused on human capital (Atchison, 2004). Followers respond to leaders who reward compassion and understand the high-stress demands of healthcare. Creating an organization of self-managed employees who clearly understand their role in achieving change is the ultimate goal of leaders (Atchison, 2004; Covey, 1990; Schein, 2010). Trust, or the lack thereof, is the root cause of failure in these relationships (Atchison, 2004). Leaders build trust by interacting with employees, modeling the organization’s mission, vision and values, and communicating clear messages about its past, present and future (Covey, 1990; Schein, 2010). This helps followers embrace the frustration and apprehension that comes with significant change.

Followers are motivated and adapt to change on an individual basis through some combination of the following four interests (Atchison, 2004): recognition for their work such as service awards; power from the satisfaction of competing and “winning”; accomplishment found in being engaged in productive ventures and doing the job correctly; and affiliation with coworkers in creating a family-like feeling of respect and care. In the end, a culture focused on people will produce successful healthcare organizations known for high employee and physician commitment, patient satisfaction, quality, market share and profits (Atchison, 2004).

Taking care of others requires taking care of oneself (Boyatzis & McKee, 2005; Craigie, 2010; Schein, 2010; Thompson, 2000). High-stress environments have demanding physiological and psychological effects that can diminish even the greatest of visionary and passionate leaders (Boyatzis & McKee, 2005). The challenges of organizations undergoing continual change cause leaders to sacrifice much-needed time for renewal and recovery. People under stress tend to cut
themselves off from others and from life at large. Resonant leaders, who generally have the ability to manage their own and others’ emotions, may suffer from relentless schedules and destructive behaviors. Little recovery time, coupled with loneliness at the top, can cause leaders to burn out.

Spiritual care represents a commitment to one’s values and can be restorative, inspiring and uplifting for leaders (Covey, 1989; Craigie, 2010). Being self-aware, staying in balance, and choosing principles to live by create an upward spiral of growth, change, and continuous improvement. Spirituality that leads to inner peace can be nurtured in various ways, including meditation, prayer, immersion in nature, or listening to music (Covey, 1989; Puchalski & Ferrell, 2010). Mental development occurs through formal education, study, training, reading, organizing, and planning. The social/emotional dimensions of spiritual care manifested in one’s relationship with others center on interpersonal leadership skills, empathy, and creative cooperation (Covey, 1989).

Caregivers also suffer from burnout in systems whose chief virtue is efficiency (Carson, 1989; Puchalski & Ferrell, 2010). Bazan (1999) notes that those physicians who are spiritually depleted and out of balance are unable to meet their own or their patients’ spiritual needs. A chronic cycle of sacrifice and renewal can cause leaders to descend into acrimonious behavior and a feeling of victimhood. By contrast, leaders can achieve resonance in their personal relationships, teams, organizations, and communities by remaining in tune with their personal needs and necessity for self-renewal (Atchison, 2004; Boyatzis & McKee, 2005; Covey, 1989; Craigie, 2010; Schein, 2010; Thompson, 2000).

Direct Caregivers

Experts agree that spiritual matters are central to people who are seriously ill. They want spiritual care from their physicians and other healthcare professionals (Chapman, 2009; Koenig,
Providing spiritual care for patients is both an individual and collective responsibility that calls for interdisciplinary teamwork. It requires the establishment of a strong care model—articulated in a mission statement—that stresses honoring patients’ dignity and providing them with compassionate care acts, as well as helping to maintain core ideals (Puchalski & Ferrell, 2010). Clarifying the model of care and individual roles for team members increases their awareness of patients’ spiritual distress and inspires action, similar to responding to pain and medical needs.

Team members are each responsible for attending to the dimensions of the whole patient, including his or her physical, psychological, emotional, spiritual, religious and existential needs (Puchalski & Ferrell, 2010). Team competencies include: treating one another with respect, dignity and compassion, listening and learning from others, and being responsible. Healthcare professionals should practice these behaviors with their patients as well as their colleagues (Chapman, 2009; Koloroutis, 2004; Puchalski & Ferrell, 2003).

Interdisciplinary team meetings provide a forum in which to share strategies for alleviating suffering. While all team members have some level of responsibility for patients’ spiritual support, the main professionals with the most implied or actual responsibilities are the nurse or chaplain (Carson, 1989; Puchalski & Ferrell, 2010; Watson, 2005). While this may be so, several types of professionals are capable of conducting a spiritual assessment and providing spiritual care (Young & Koopsen, 2011). In addition to the hospital professionals, the team can include other spiritual advisors and experts of non-Western orientation, e.g., shamans, medicine men, or spiritual guides (Young & Koopsen, 2010, p. 151). Family members and others from a patient’s religious group who provide primary support may be included as well.
Puchalski and McSkimming (2006) cite studies to suggest that in hospitals which provide team-based integrated spiritual interventions, the caregivers were more able to provide compassionate care for patients that also met their own spiritual aspirations. The integrated process includes spiritual screening done primarily by nurses on admission, spiritual history, assessment, and an interdisciplinary treatment plan developed with a chaplain expert. The healthcare professional’s sense of transcendence, meaning, purpose, call to service, and connectedness to others, are important components of the framework for transformation that occurs among colleagues and with patients.

Few national interdisciplinary training programs exist (Puchalski & Ferrell, 2010). While doctors, nurses, social workers, pastoral care personnel, and psychologists receive training, their roles in the healthcare setting may be vague and vary widely. This variation may result in a patient’s and family’s spiritual needs being unreliably or inconsistently addressed. Additional training to address spiritual needs during end of life palliative care is available through The National Consensus Project (2009) and National Comprehensive Care Network (2008).

Patients have certain expectations of professionals. Professionals provide care through professional training, meeting standards of care, and through their own experiences. The following section highlights the professionals who serve patients’ spiritual needs.

**physicians.**

Patients want their physician to address their spiritual needs (Ehmann, 1999; Koenig, 2002; McCord, 2004; Puchalski & Ferrell, 2010), yet physicians are inadequately prepared for this responsibility by their medical school training (Bazan, 1999; Koenig, 2002; Koenig, Hooten, Lindsay-Calkins, & Meador, 2010), have other constraints, or are reluctant to fulfill it (Bazan, 1999; Koenig, 2002).
Various research studies show that between 41 and 95 percent of patients want physicians to address spiritual issues while administering care (Puchalski & Ferrell, 2010). In one example, Ehmann, Ott, Short, Ciampa, and Hansen-Flaschen (1999) surveyed 177 pulmonary outpatients about their spiritual or religious beliefs. Half of the patients who did not feel spirituality was important still wanted their needs addressed. Of the 51 percent who self-described as religious, 90 percent believed prayer could expedite or promote their recovery from illness. Although most patients in this study would have liked their physician to inquire about spirituality under certain circumstances, only 15 percent recalled that they had ever done so. Patients perceive physicians who attend to their own sacredness are more compassionate.

Medical schools should raise awareness of spirituality, assisting physicians in developing the skills necessary to enhance their spirituality (Bazan, 1999). Training has focused on technological developments and diagnostic skills, which were valued as essential sources of power, rather than the spiritual, human side of medicine (Bazan, 1999, p. 19). In 1992, only one medical school reported teaching courses on spirituality (Puchalski & Ferrell, 2010, p. 55). By 2010, 90 percent of US medical schools had curricula that included spirituality and health, although such curricula varied greatly in scope. 78 percent reported spirituality content within required courses. Only seven percent reported having a required course dedicated solely to spirituality and health (Koenig, Hooten, Lindsay-Calkins, & Meador, 2010).

One study—among physicians and psychiatrists who considered themselves highly spiritual or worked with critically ill patients, and conveyed a higher degree of personally acquired spiritual knowledge—did not associate discussions of spiritual care with their medical school training. Instead, these professionals related to patients from their own religious traditions (Rasinski, Kalad, Yoon, & Curlin, 2011).
Fewer than one-third of physicians inquire about the patient’s religious denomination, and fewer than one in ten routinely take a spiritual history (Koenig, 2002). Physicians may be reluctant to address spiritual concerns due to lack of time, the absence of a clear definition of spirituality (Bazan, 1999; Koenig, 2002), concerns about proselytizing, or trepidations about doing harm by triggering an existential crisis in the patient (Puchalski & Ferrell, 2010). Assessing patients’ spiritual needs then falls to the nurse or the chaplain on the healthcare team.

In an industry where the chief virtue is efficiency, available time to serve patients spiritual needs is of concern (Chapman, 2006; Puchalski & Ferrell, 2010). Physician visits with patients are minimized to just a few minutes in order to meet productivity goals (Puchalski & Ferrell, 2010). This economic rivalry between patients and professional caregivers makes it difficult for either party to feel a sense of dignity. This suggests a need to personalize healthcare and to “rebirth” it as a spiritual enterprise (Puchalski & Ferrell, 2010, p. 167).

Physicians who become spiritually depleted may be unable to meet either their own or their patients’ spiritual needs (Bazan, 1999). Work-life balance and spiritual alignment are therefore needed. Physicians can develop spiritual dimensions “to bring their own humaneness and inner spirit to the practice of medicine” (Bazan, 1999, p. 148), thereby becoming better practitioners.

*nurses.*

Nurses serve as key leaders in the clinical setting. They spend more time with patients than any other professional on the team, with the potential exception of nursing assistants who perform at the direction of a qualified nurse (Koloritis, 2004; Mitchell, Bennett, & Manfrin-Ledet, 2006). The registered nurse (RN) who has responsibility, authority and accountability for the provision of nursing care determines what care must be provided and delegates
responsibilities to others as appropriate. The nurse articulates expectations and standards, and provides encouragement and coordination to support team member contributions.

Nurses have a code of ethics that addresses the whole person and generally includes meeting the patients’ spiritual well-being. The Code of Ethics for professional nurses (ANA, 2001) includes a provision (1.3) indicating that nurses are responsible to care for the whole person, thereby enabling the patient “to live with as much physical, psychological, social, and spiritual well-being as possible.”

The Joint Commission (2011) defines who provides spiritual supports for patients. Its guidelines include specific responsibilities for nurses and pastoral care professionals. These caregivers are instructed to conduct spiritual assessments. The guidelines do not, however, exclude other members of the healthcare team from offering support. Different degrees of responsibility and engagement with the patient occur during the caregiving process; however, it is generally the nurse who spends the most time with the patient and therefore is most exposed to the evolving nature of spiritual distress (Carson, 1989, p. 158).

Multiple conceptual frameworks are used in the nursing profession to focus on the special healing relationships between patients and nurses (Watson, 2005). The scientific approach to medical care includes “humanities concepts of caring and love that apply to all health professionals” (Watson, 2005, p. 2). Watson’s Model of Human Care is guided by scientific knowledge, methods, and predictions that provide a values-based context for caring with a primary focus on the interpersonal relationship between the patient and nurse. Medical and nursing professionals are challenged personally and professionally to ponder a deeper sense of spirituality applied to healing and life purpose.
The spiritual dimension of nursing practice, including the process of diagnosing patients, is important for people of all ages, beliefs, and traditions and in a variety of settings (Carson, 1989). Determining patients’ spiritual needs may begin with adequate assessment or interviews as a means to elicit more than simply the patients’ religious preferences (Carson, 1989; Puchalski & Ferrell, 2010). It is common for nurses to believe they have assessed the patients’ spiritual needs when in reality they have only uncovered membership in organized religion. Patients who are active in organized religion may not be attuned to their spiritual nature. Further assessment may be required (Carson, 1989, Puchalski & Ferrell, 2010; Young & Koopsen, 2010).

A number of spiritual assessment tools exist to assist in determining patients’ religious and spiritual beliefs, participation, and practices (Young & Koopsen, 2010, p. 157). Carson recommends specific spiritual questions for assessing patients in four areas: their concept of God; their source of hope and strength; the personal importance of their own specific religious practices; and their ideas about the relationship between their spirituality and their state of health. To heal the whole person, assessments require the use of an integrated biopsychosocial-spiritual model that obtains the patient’s spiritual context, whether it be religion, nature, relationships, or values (Puchalski & Ferrell, 2010). More effective tools used to obtain a shared meaning between patients and caregivers “are open-ended, individualized, and process-oriented” (Hodge, 2001, p. 204). Various assessment tools also evaluate a patient’s inner strength, interconnectedness, and transcendence.

Assessment can be more difficult if the patient’s beliefs are different from the beliefs of the caregivers. The caregiver’s ability to listen and willingness to address any personal spiritual barriers may lead to spiritual growth and better care for the patient. According to Watson (2005), the patient can only change himself from the inside out, and a nurse facilitates the change
through a consciousness conveyed during interactions between the nurse and the patient and family.

Mitchell, Bennett and Manfrin-Ledet (2006) posit that although nurses are required to assess patients, a gap exists between the theoretical understanding of spirituality and the practice of providing spiritual care. Assessing a patient requires that the caregiver have a deep spiritual awareness of self in order to consciously connect with and understand the patient’s unique situation (Kumpala, 2011; Watson, 2005). The nurse/caregiver’s ability to assess the patient is related to their sense of personal spiritual well-being and knowledge of their own beliefs, values, and biases (Young & Koopsen, 2010, p. 152).

Some nurses may have difficulties discussing sensitive spiritual issues with their patients and may be uncomfortable with this practice (Carson, 1989; Molzahn & Shields, 2008). Some of the concerns that nurses harbor include: not being able to distinguish clearly the difference between spirituality and religion; not having the right words; having inadequate education and training; focusing on technology and techniques versus dealing with difficult issues; believing that other professionals on the team are responsible for offering spiritual care, such as the chaplain; fear of offending others; a lack of confidence in their own spiritual lives; a lack of understanding of others’ beliefs in a multicultural society; and a lack of time (Carson, 1989; Molzahn & Shields; 2008; Watson, 2005). These trepidations point toward a need to remove barriers through education, training and support.

*chaplains.*

Many healthcare professionals can assist in meeting the religious and spiritual needs of patients; however, the responsibility is often deferred to hospital chaplains (Buryska, et al., 2008; Frampton et al., 2005; Press Ganey, 2010; Puchalski & Ferrell, 2010). When specific
interventions for spiritual care are needed, trained specialists in spiritual care, pastoral counseling, theology, and psychology may be called upon (Young & Koopsen, 2010, p. 44). Pastoral care chaplains are professionally trained spiritual advisors who play an important role in dealing directly with the patient and family. The chaplain may serve alone or with other spiritual advisors, such as the patient’s own clergy (Frampton et al., 2005; Puchalski & Ferrell, 2010), parish nurse, or folk healer (Young & Koopsen, 2010). Chaplains assist professionals and non-professionals who spend much more time at the patient’s bedside (Frampton et al., 2005).

Historically, when science separated care for the body from attention to the mind and spirit a century ago, and clergy believed science to be antireligious, pastoral care emerged as a profession (Frampton et al., 2005). Pastoral care staff members (chaplains) are professionals trained to provide guidance to patients of all faiths and beliefs, as well as non-believers in organized religion. Professional chaplains are trained to honor and value all individuals and respect all faith traditions and beliefs. They are specifically trained to mobilize spiritual resources in an effort to assist patients and the staff who support them (Puchalski & Ferrell, 2010). Chaplains may be volunteers who are trained, or may be professionally trained and employed by their respective hospital(s).

Chaplains receive interfaith professional training and board certification by obtaining 1,600 hours of clinical pastoral education (Puchalski & Ferrell, 2010, p. 159). Chaplains learn to apply theological perspectives to various patient situations. They are trained in an interdisciplinary process to gain a deeper awareness of themselves and those to whom they minister. Community religious professionals may also serve an important role in supporting patients and families, even though they may lack professional training as chaplains in an interdisciplinary setting.
Chaplains may obtain professional certifications from a number of sources (Young & Koopsen, 2010). The Joint Commission (2011) has specific requirements for chaplaincy services. Taylor (2002) notes four roles for chaplains, including: conducting spiritual assessments, helping with religious coping strategies, supporting other professional staff with their own spiritual needs, and serving as a community liaison to other religious and spiritual supports.

Chaplains only see about 20 percent of hospitalized patients (Young & Koopsen, 2010, p. 44). A study of 535 patients at two Mayo-affiliated hospitals in Rochester, MN addressed patients’ expectations of the hospital chaplain (Buryska, et al., 2008). Most were aware of the availability of chaplains, and 62 percent would have liked a chaplain visit every few days. Of the 53 percent who received visits, 86 percent reported this visit as important to them. The main reason was “to be reminded of God’s care and presence” (p. 58) with ritual, prayer, and pastoral support that they also highly valued. The study concludes that these visits and interventions are of great import to patients, and suggest additional opportunities for improving patient care, education, and research.

social workers.

Social workers assist with relationships among patients, families and caregivers. They help patients deal with changes in their lives as a result of illness (Puchalski & Ferrell, 2010; Young & Koopsen, 2010). Moreover, they assist patients in seeing opportunities, and serve as the healthcare system’s change agents in obtaining spiritual supports (Young & Koopsen, 2010).

Mindful of cultural, ethnic and religious diversity, social workers advocate on behalf of patients and assist them with self-determination in a socially responsible way. The National Association of Social Workers Code of Ethics (2008) indicates that social workers are responsible for advocating for individuals, and are regarded as ombudsmen tasked with calling
for more spiritual resources. Their core values emphasize human relationships, dignity, and the worth of the person.

Growing interest exists in social workers’ role assisting patients’ spiritual needs. Several studies have shown that social workers lack the necessary training to address these issues in a culturally competent manner (Hodge, 2002). Social workers do not function as pastors or spiritual directors who offer advice about spiritual practices, beliefs, or behaviors; rather, they assist patients in overcoming obstacles (Hodge, 2002). Social workers may now obtain credentials in hospice and palliative care (Puchalski & Ferrell, 2010). The Society for Spirituality and Social Work (2014), founded in 1990, provides a forum in which to foster education and innovation among social workers. It also serves to promote research, theory development, teaching, and the dissemination of best practices in the field (para. 2).

Hospital social workers may be assigned responsibility for completing a spiritual assessment of patients, yet they may lack adequate assessment tools (Young & Koopsen, 2010). As collaborators they are also responsible for a safe return of patients to their communities. They connect patients and families with community resources, thereby helping them organize their support system, which may include spiritual supports.

*non-direct/other allied health professionals.*

Other team members also play important support roles. Psychologists and other mental health providers assess the spiritual and existential concerns of patients (Puchalski & Ferrell, 2010). Physician Assistants may provide spiritual care according to their Code of Ethics (2008). Their code urges that they meet the holistic needs of patients, including spiritual and religious needs. Puchalski and Ferrell (2010) indicate that different types of professionals may serve as members of transdisciplinary teams that serve patients’ spiritual and other needs. These teams
may also include physical, occupational, and respiratory therapists, pharmacists, home health aides, nurse assistants, and others (p. 39).

Individuals who are not employed by the hospital may also play an important role in meeting patients’ spiritual needs. Clergy may serve as team members; however, they may have varying levels of training in clinical pastoral care and mental health issues. They may work with clients’ therapists to understand the client and resources available throughout the client’s spiritual journey (Young & Koopsen, 2011). Other individuals from the community—including parish nurses, spiritual mentors, folk healers, and family and friends—may also provide vital support to clients in a time of need. They may offer prayer, reading, signing, comforting thoughts, rituals, intimacy, or simply convey empathy (Young & Koopsen, 2011, p. 49).

**Spiritual Interventions for Patients**

Many spiritual interventions are available for team members to assist patients in meeting spiritual needs. These may include presence, touch, listening, empathy, vulnerability, humility, commitment, prayer, use of religious literature, religious artifacts (Carson, 1989; Watson, 2005; Young & Koopsen, 2010), or spiritual inquiry about what is important to the patient (Craigie, 2010). Craigie (2010) indicates there is substantial empirical literature that testifies to the fact that intention and presence with patients aids in healing. Entering patients’ rooms in a prayerful or thoughtful state may conduce to emotional states of love, peace, compassion, and tranquility. Intentionally listening and being open may create an honoring and safe space in which patients can be forthcoming about their lives, their fears, and their values (Craigie, 2010, p.169).

According to Craigie (2010), there is no algorithm for presence; it is a matter of being open to intuition. Young and Koopsen (2011) describe the importance of rituals in healing the spirit. Rituals help people connect inwardly and outwardly with others and with nature, and in so doing
remember, honor, and change (Young and Koopsen, 2011, p. 83). Prayer is the most common form of ritual for both religious and non-religious people. Prayer is acknowledged by modern medicine as a source of healing. Meditating, applying guided imagery, showing gratitude, spending time in nature, appreciating art, and storytelling are examples of rituals or activities that may help patients heal. The National Center for Complementary and Alternative Medicine (Samueli Institute, 2015) promotes music therapy, art therapy, dance and movement therapy, and animal-assisted therapy as adjunctive options for consideration that facilitate healing. Allowing space for expressive activities with appropriate environmental aesthetics helps patients understand and interpret humanity on a scale that exceeds themselves (Chapman, 2009; Frampton et al., 2005; Puchalski & Ferrell, 2010). Supporting these activities will help cultivate what can be intimate and transformational relationships between and among clinicians and patients.

Care team members and clinicians on the team cannot allow their own values and beliefs—which may be different from those of the patient—to interfere with their capacity to deliver good care unless it violates their own ethical standards (Carson, 1989). Professionals must foster the virtue of fundamental acceptance of the ill person, who may display a range of distracting behaviors, especially amid the distress of life-threatening illness. The challenge for clinicians is not to allow the drama that suffering patients or family members may exhibit to distract them from being present for their patients’ pain.

There is strong agreement that being present and listening to patients helps convey compassion and dignity for the transcendence of spirituality (Carson, 1989; Chapman, 2009; Puchalski & Ferrell, 2010; Watson, 2005). Techniques are centered on relationship-building with patients at their time of need, listening to them, and providing introspection. Grounding yourself
in healing intention and presence is essential (Craigie, 2010). Being clear about your own intentions helps you to be present for others. Being fully “present” physically and emotionally when meeting a patient is also important. The practice of presence may include such things as: taking a few moments of silence to get centered just outside a patient’s room before entering the room, or doing the same between visits with patients; praying; being intentional and appreciating patients; or, journaling to gather your inner thoughts in advance.

**Spiritual Self Development**

The best work of healthcare professionals may not be about something they do, but instead something they are, something they become and something they bring into relationships (Puchalski & Ferrell, 2010, p. xx). Healthcare professionals can benefit from taking responsible action in order to increase their own awareness of spirituality. Exploring one’s own beliefs can bring mutual benefits for both professionals and their patients (Bazan, 1999; Carson, 1989; Chapman, 2006; Koloritis, 2004; Molzahn & Shields, 2008; Puchalski & Ferrell, 2010; Puchalski & McSkimming, 2006; Watson, 2005; Young & Koopsen, 2011).

Professionals who seek to strike a balance among mind, body and spirit are accessible and most effective in caring for others (Craigie, 2010; Watson, 2005). Healthcare professionals acting from their own set of beliefs can transform their relationships with patients as well as increase their own resiliency in the face of stress. Authenticity and integrity come as a result of exploring one’s own beliefs and answering difficult questions that patients and families also struggle with (Kaeton, 1989).

Professionals need to attend to their own spiritual needs. They need to cultivate a spiritual practice as part of their professional development (Bazan, 1999; Carson, 1989; Chapman, 2009; Craigie, 2010; Koloroutis, 2004; Puchalski & Ferrell, 2010; Watson, 2005). While spirituality is
intuitive to some professionals, it is likewise important that they acquire the knowledge and skills they need to provide competent spiritual care. Professionals cannot do for others what they cannot do for themselves (Neil McKenna in Puchalski & Ferrell, 2010, p. 171). Caregivers should reflect on the following: what provides them with meaning; what their personal values and beliefs are; what the meaning of their own religion is; how they themselves would react to a life-threatening illness; and what spiritual resources they bring to their practice (Watson, 2005). Cultivating these skills may cause profound change from within.

Professionals may cultivate their own spirituality through a variety of practices unique to their own personalities (Puchalski & Ferrell, 2010). They may also find value in taking time to participate in an organized religion, or in practicing non-religious exercises such as reading, journaling, visualization, yoga, poetry, or connecting with colleagues to form discussion groups and share texts. Craigie (2010) divides these into devotional practices, energy practices, and mini-meditation practices. Reflection is an important part of one’s development into an authentic, whole person, and will open one to transformation by the healing experience of patients (Puchalski & Ferrell, 2010). Reflective preparation promotes a sense of transcendence, call to service, and connection to others. Spiritual questions and existential struggles in the professional’s life can cause bidirectional transformation of both the professional and the patient. Seeking out a chaplain or other spiritual counselor for spiritual support may add value to the relationship or experience.

Professionals may also find therapeutic value in sharing (with consent) patient stories that celebrate the lives of their patients and add value to their work (Diering, 2004; Remen, 2000). Recognizing the blessings in what we already know via shared stories helps professions to claim their own wisdom (Remen, 2000). Patient vignettes reveal ways of receiving, becoming, finding...
strength, or taking refuge. Spreading patient stories or “story catching” (Covey, 2009) is also a way for individuals to help share an organization’s values, transmit its mission, and maintain vibrancy.

While spiritual care in nursing is positively correlated to personal well-being, it went unstudied a long time among occupational therapists. One study of 310 occupational therapists (Morris, 2007) concluded that therapists with higher self-reported spiritual well-being had significantly more favorable attitudes toward the use of spiritual practices with their patients than their counterparts with lower spiritual well-being. Individual comfort with spirituality moderated the relationship.

Meeting patients’ spiritual needs is a shared responsibility of many. Distinguishing each team member’s role is important. Individual professionals need to care for themselves in order to care for their patients. The same is true of leaders’ responsibility to care for their staff and thus enable them to be successful in caring for patients.

**Spirituality Training in Healthcare and the Workforce**

As religious sponsors of Catholic health systems relinquished leadership positions in the latter part of the twentieth century, spiritual training to maintain the culture surfaced as a concern. New positions for religious leaders in particular were created to maintain integration of Catholic identity within the mission (Cullen, Richardt, & Hume, 1997; Richardt & Magers, 1997). In 1989, preparation for the change began when The Daughters of Charity National Health System-East Central Region (DCNHE-EC) explored their 10 hospitals to determine their underlying spiritual nature (Richardt & Magers, 1997). Guided by their research, they differentiated between the concepts of religion and spirituality, as well as between human
development and human formation. They noted that Western cultures prioritized the functional dimension of human development over its transcendent dimension. They articulated the phenomenon of human formation as “beholding the Mystery of life without controlling or manipulating it” (p. 34). With these principles in mind, new Vice Presidents of Mission Services were charged with integrating spirituality and spiritual formation training in their workplaces.

Mentoring programs for increasing the numbers of lay leaders in religious hospitals eventually arose. By 1997, The Daughters of Charity of St. Vincent de Paul developed a leadership training program on various topics such as ethics, spirituality, charism, and the relationship to the church (Hume, Richardt, & Applegate, 2003). The program advocated that various strategies be used in the workplace, such as retreats, pilgrimages, renewal practices, and committee assignments. A physical spirituality center was subsequently built for caregiving professionals, volunteers, and benefactors to provide additional training to facilitate spiritual development.

At about the same time, Bazan and Dwyer (1998) called for Catholic institutions to respond to their managers, physicians, and employees, whom they believed were experiencing deep pain about their meaning and purpose. A call to action suggested that healthcare organizations can, through their structures and culture, create environments that promote spiritual work (p. 24).

Other notable Catholic healthcare systems such as Ascension Health, with 72 hospitals in 20 states (Rose, Thomas, Tersigni, Sexton, & Pryor, 2006), and smaller systems such as Wheaton Franciscan, with eight hospitals in Wisconsin (McGuire & Rocole, 2005), developed succession plans with leadership frameworks designed to indoctrinate the organizational spiritual culture. Likewise, Hospital Sisters Health System (HSHS), with thirteen hospitals in both
Wisconsin and Illinois, defined mission integration accountability. HSHS (2003) requires their institutions to reflect Franciscan heritage and service, Catholic identity, commitment to the community, and stewardship. Staff is educated in these guiding principles as the healing ministry’s primary approach to serving those in need.

Secular institutions also began recognizing spirituality in the workplace. As the workplace becomes more complex and chaotic, more people seek a deeper sense of meaning in it (Thompson, 2000). Using the lenses of depth psychology, adult development theory, and spirituality, Thompson (2000) described a historical separation of our personal lives from our career lives. More recently, shifting attitudes toward spirituality recognize its importance in both our places of work and our personal lives. Organizational leaders who hold the maturation of the inner spirit in high regard have an opportunity to move individuals and organizations toward more congruent lives.

Marceau (2005) compares Catholic workplaces to secular institutions. He suggests that spirituality at work has become a fad in the secular workplace, declaring that secular organizations attempt to be non-offensive and take an inclusive and universal approach. Marceau believes their interest is in helping their employees find balance between their personal beliefs and the company’s bottom line financially, which differs from a Catholic approach. Catholic organizations focus on the ministry of Jesus Christ and portray His healing ministry as the basis of training, which is crucial to the organizational culture.

Some secular healthcare leaders describe the spiritual nature of their culture using terms that avoid the use of the word “spirituality.” They may be uncomfortable with terms like “spirit,” “soul” and “inspiration” (Simmons, 2002). Instead, they may opt to use phrasing such as “higher ground leadership… to reawakening spirits and values” (p. 2) in order to help people find
fulfillment in their jobs and personal lives. Ultimately, the intended result is to reduce turnover and improve the organization’s financial condition.

Training people in spirituality was at one time not thought to be possible, nor did secular organizations even consider undertaking it (W. D. Thompson, 2000). More than a cultural phenomenon, spirituality is another way to view work. Similar to personal lives, work lives require being in touch with our own spirit and helping others do the same. A dispirited workplace manifests itself in low morale, high turnover, burnout, stress-related illness, and rising absenteeism (W. D. Thompson, 2000, para. 3). Understanding how spirituality relates to labor is important. For example, training for supervisory skills, such as learning how to deal with difficult people or coaching them on a career path, is analogous to providing spirituality training, only under a different name. The training can help supervisors as well as employees discover their own identities, purposes and values, paralleling spiritual self-discovery.

A variety of strategies are used to train staff in non-secular healthcare organizations (Center To Be, 2014; Hospital Sisters Health System, 2003; Craigie, 1998; 2015; McGuire & Rocole, 2005; Rose et al., 2006). Peer support and collaboration by staff are fundamental to realizing the spiritual potential of staff themselves and patients and families. Multiple strategies are employed, such as orientation, forums, workgroups, renewal strategies, internal and external training, retreats, pilgrimages, and pursuit of advanced degrees.

Spirituality in the healthcare workplace can be cultivated through training tailored to three different dimensions that influence one another: patients and families, the workers, and the general organization (Craigie, 1998). Healthcare organizations develop staffs’ clinical skills so they, in turn, can help patients and families find meaning and cultivate their own gifts. The workers must have balance and purpose in their own lives, and cultivate self-awareness. The
organization, for its part, must create norms with beliefs and values that promote the spiritual well-being of individual workers and teams that support one another. These three concepts are interdependent, not deployed separately. Patients cannot receive good spiritual care unless staff is spiritually grounded and supported in a healthy work environment where spiritual mindfulness is everyone’s job.

Incorporating spirituality in the workplace includes a number of processes (Craigie, 2010). Spirituality must first be clearly defined and distinguished from chaplaincy and religion to avoid misconceptions and encourage spiritual dialogue. Affirming individuals’ behaviors, gifts, and beliefs rather than deficits is essential, and asserts the unique spiritual nature of each person. Group programs have value; however, embracing spirituality is a unique experience for each individual.

A leader’s important role of modeling spirituality personally and professionally entails embodying the mission, vision, and core values of the organization in a manner that reflects spirituality (Craigie, 2010). More specifically, leaders identify parameters and means of measuring spirituality and well-being, such as in job descriptions, performance appraisals and recruitment strategies. They can promote spirituality through forums, storytelling, education, and development activities for staff who could also become facilitators. All staff and physicians are included and share responsibility.

Specific training programs designed for either non-secular or secular hospitals interested in developing a culture of spirituality exist today. Reinvesting Spirituality and Ethics in Our Networks (RISEN) is an applied spirituality training program designed to assist healthcare workers in developing their own spiritual nature and growth (Center To Be, 2014). The program raises personal consciousness of the power of the human spirit for health and healing. It assists
participants in integrating spirituality into their own personal and professional growth, as well as creating a culture of spirituality in the workplace. Two phases of RISEN include mentor training for those capable of and interested in mentoring others, and spiritual health training. Mentors are taught to use Myers-Briggs personality diagnostic tools for themselves and others. The second phase includes classroom presentations on the educational-spiritual dimension of human health and a three-month practicum along with mentor support. Participants gain insight into their spiritual potential and develop professional skills to diagnose spiritual needs and provide treatment for patients and others in need.

**Informative Studies**

In the following section I review four relevant dissertations that supplement the general literature. In addition to considering the related literature to date, I look at relevant theoretical frameworks or potential ways to look at data, which emerged in the form of dissertations I found by searching the same databases with the same search terms I noted above, with one exception. In order to gain a broader perspective on the roles of staff, I excluded studies of pastoral care professionals whose exclusive role in a hospital setting is to provide spiritual care directly, and physicians who are often not employed as staff. While nurses were not the only aim of the search, their primary role is to develop and execute a plan of care for patients. I found several dissertations on the role of nurses in the provision of spirituality for patients in hospitals. Other than one study of occupational therapists, I found no studies that included other professionals or non-professional direct caregivers such as nurse aides, or non-direct caregivers such as registration or other administrative staff.
I found four relevant qualitative research studies of healthcare leaders and spirituality that inform this study. Although I was seeking a broad sample including executive leaders, I found dissertations that included nursing leaders only. The primary purpose of these dissertations was to understand the role of registered nurses or nurse leaders responsible in the provision of spiritual or holistic care for hospitalized patients (Chotkevys, 2009; Jenkins, 2008; Kumpala, 2011; Nelson, 2008). They encompass registered nurses and nurse leaders in a variety of settings, including community hospitals both religiously affiliated and non-religiously affiliated, and nurses trained in faith-based religious arts institutions. The methodological approaches included two studies based on grounded theory: one using phenomenological theory, and one qualitative descriptive case study. All used various interview methods. Chotkevys (2009) conducted interviews of 25 registered nurses working in a Midwestern religion-affiliated hospital inpatient or outpatient setting, and responsible for providing spiritual care for patients. Jenkins (2008) interviewed 10 nurse leaders from four hospitals in California. These leaders were responsible for providing holistic care with emphasis on the often-overlooked spiritual component. Kumpala (2009) interviewed 12 registered nurse alumni of a faith-based liberal arts institution in a variety of clinical practice settings. Nelson (2008) interviewed eight nurses at four levels of leadership from four faith-based community hospitals in California.

Chotkevys’ (2009) purpose was to determine which strategies healthcare leaders could use to help nurses overcome barriers to providing spiritual care. Using a grounded theory approach, she asked 25 nurses in a religiously affiliated organization to describe spiritual care and how they provide it; to explain whether they experienced what Watson (2006) calls a caring moment; to describe barriers they encountered when trying to provide spiritual care; and to describe strategies healthcare leaders might provide to help overcome barriers while rendering
spiritual care to patients. The researcher found that in Watson’s theory of transpersonal caring, a caring moment actually occurred when nurses experienced a mutual point in time in connection with a patient. The core theme found from among 15 nurses was that their comfort zones vary in size. The study posited a spiritual temperament theory which recognizes genetic and environmental factors that influence the nurses’ ability to provide spiritual care. Recommendations from the study include providing spiritual health care training for nurses, and encouraging nursing leaders in both universities and health care organizations to model spiritual care.

Jenkins’ (2008) grounded theory study was conducted to identify the role of nursing leaders in the provision of spiritual care for hospitalized patients in non-faith-based community hospitals. Ten nursing leaders—including four directors, four managers, and two supervisors from four hospitals responsible for providing holistic care on their medical-surgical unit—were purposely selected for this study. They were asked about their role and expectations for providing spiritual care; what internal and external factors influenced their role in providing spiritual care; and to explain perceived role conflicts and other factors influencing the provision of spiritual care. Role theory guided research questions, and the questions themselves engendered two conceptual models with six internal and five external factors impacting effectiveness. The majority of participants interviewed perceived spiritual care as religious, pastoral visits as the primary intervention, and comfort measures as the primary benefit to patients (Jenkins, 2008, p. 75). Most perceived no spiritual influence from their job description or supervisor, nor were they aware of regulatory guidelines related to spiritual care. The majority reported feeling uncomfortable providing spiritual care themselves, but believed their staff was doing so. Most had no previous education on spiritual care for patients, but believed staff
participated in hospital in-services. Subsequently, the researcher concludes that these nurse leaders lacked adequate preparation for this role.

Kumpala’s (2011) phenomenological study used mixed methods and sequential interviews of 12 registered nurse alumni of a faith-based liberal arts institution to learn how nurses form their own patterns for practicing spiritual care. The purpose was to understand what influences nurses’ conceptualization of spirituality and how these factors are internalized and operationalized to form their patterns for the practice of spiritual care. While developmental theory provided the framework for this phenomenological research, social cognitive theory and Modeling and Role Modeling theory were also correlated to some of the findings. Linking knowledge to their own practice of spiritual care and their own beliefs, the nurses cited several factors that influenced the development of their practice patterns, such as role models, their first experience providing spiritual care, support they received from their work environment, personal religious practices, culture, their use of spiritual assessment tools, and holistic interventions. Several patterns of spiritual care emerged. They included: trusting intuition, sensing, and connecting through caring and comforting; surveying and offering spiritual support; and affirming or accommodating patient affiliation with religious/spiritual practices (p. v). Findings suggest that these nurses incorporated holistic care concepts from dialogue, and applied innovation or alternative pedagogies derived from their nursing education, and that nurses who grow from personal faith development integrate and shape patterns in the provision of care.

Nelson (2008) used a case study approach, interviewing eight nurse leaders at four different leadership levels, i.e. executive, director, unit manager, and charge nurse, each with a different sphere of influence, from four faith-based community hospitals. The qualitative descriptive case study sought to define spiritual leadership through the eyes of nursing leaders in
a faith-based healthcare organization, and to provide additional understanding of how practicing this type of leadership fosters shared meaning with employees to create a sense of community. The particular faith-based organization was chosen based on its “emphasis on holistic inclusion of spirituality in the embodiment of the hospital” (p. 9). Noted were the institution’s reputation, mission and likelihood for the practice of spiritual leadership, freedom of spiritual expression, and the presence of the religious community serving with hospital staff in support roles such as the Mission Council and the Spiritual Care department. A network technique among nurse colleagues was used to identify nurse leaders seen as spiritual, and corroborated by components of spiritual leadership identified in literature. After collecting, organizing, and analyzing the data, a definition for a spiritual leader emerged: “A person who created sacred vision, worked with others to provide meaningful community, helped fellow coworkers find meaning and purpose in work, and was values-centered” (p.183). The researcher posits spiritual leadership as having the potential to revolutionize the nursing environment, promote retention, increase productivity, enhance meaning and purpose in work for nurses, provide a positive atmosphere and improve working conditions.

These four studies differ in organization, methodology and intent. Three of the four studies are conducted with religiously sponsored organizations (Chotkevys, 2009; Kumpala, 2011; Nelson, 2008). Regardless of sponsorship, they serve as evidence that there is an ongoing challenge to define and refine roles and responsibilities for professional staff, in particular nurses and nursing leaders responsible for the provision of spiritual care. One of the four studies indicates that the pastoral care department was seen as responsible for meeting patients’ spiritual needs (Jenkens, 2008). Two of the four studies indicate the need for leadership to have better knowledge and education (Jenkins, 2008; Nelson, 2008) while all four cite the need for more
education overall (Chotkevys, 2009; Jenkins, 2008; Kumpala, 2011; Nelson, 2008). All four studies also indicate that personal comfort and one’s own beliefs play an important role in the provision of spiritual care for patients (Chotkevys, 2009; Jenkins, 2008; Kumpala, 2011; Nelson, 2008).

**Summary of Topical Literature**

This study of hospital system staff experience in meeting patients’ spiritual needs is intended to look more inclusively at a broader range of caregivers engaged in this practice. I anticipate that, by attaining a more comprehensive understanding of the knowledge, motivations, and challenges of staff at all levels attempting to meet patients’ spiritual needs, hospitals can better position themselves to fulfill their patients spiritually—doubtless a vital part of the healing process.

A survey of the literature revealed a substantial amount of research about the experience of direct caregivers who are traditionally clinical hospital system staff providing spiritual care. Notwithstanding the abundance of studies that encompass direct caregivers (nurses, physicians, chaplains, and to some extent social workers), I identified a number of gaps in the process of providing care, as well as other gaps. At the same time, many members of a hospital/health staff were not represented in the literature at all.

With the exception of CEOs, no studies were found that included other indirect caregivers such as non-nursing directors, managers, supervisors, marketers, central registration staff, or others in the delivery of spiritual care. Puchalski & Ferrell (2010) reference other possible direct care staff that may be considered, including psychologists, mental health providers, physical, occupational, and speech therapists, home health aides, nurse assistants and others. Except for one study involving occupational therapists (Morris, 2007), I found no studies
of these staff members that attend to the delivery of spiritual care. Numerous studies referenced supplemental spiritual advisors, such as the patients’ own clergy (Frampton et al., 2005; Puchalski & Ferrell, 2010), parish nurses, and folk healers (Young & Koopsen, 2010). Additionally, many authors reference the important role of family members in delivering spiritual care, although I located no research on their specific roles.

The team models described by many researchers—including Puchalski and Ferrell (2010), Watson (2005), and Young and Koopsen (2011)—fail to expound on the potential roles of other vital non-direct caregivers as key team members. The absence of, or minimal reference to, these caregivers leaves significant gaps in the research—gaps to do with the roles and responsibilities of staff members who represent a healthcare or hospital system in meeting their patients’ spiritual needs. Further research on the broadened concept of interdisciplinary team member roles and responsibilities is needed.

Although there is confusion over who should address these spiritual needs, there is plentiful evidence that patients want this care (Koenig, 2007, 2012). Two studies by Ehman, Ott, Short, Ciampa, & Jansen-Flaschen, (1999) and Williams (et al., 2011) explore the question of who, exactly, receives spiritual care versus who doesn’t—and speculates on the factors that determine this. The literature often alludes to poor organizational processes used to identify and assess patients and provide care.

Two of the three pioneering models of care for serving the whole person, Samueli (2011), and Planetree (Frampton et al., 2005), have committed to research efforts to contribute empirical evidence about holistic approaches to care. While Chapman (2006, 2009) provides a theoretically based practical model, Radical Loving Care is outcomes-based, designed to demonstrate the perceived benefits of a particular culture. Chapman (2006) and Diering (2004) suggest higher job
satisfaction among professionals who work in a “loving” culture. Further research on this subject may be useful.

Two studies confirm patients’ increased interest in spirituality associated with quantifiable patient satisfaction data (Hodge & Wolosin, 2012; Press Ganey, 2012). The associations are positive, yet more research could provide valuable contributions to knowledge on this matter, particularly as it relates to this study.

While Koenig’s (2012) meta-analysis of spirituality in healthcare shows enormous growth in the numbers of related research studies recently, I support his continued advocacy of better understanding of the relationship between religion and spirituality, and of deepened comprehension of the psychological, social, and behavioral forces behind them.

Spiritual training and development for integration and congruency with missions has roots in non-secular institutions (Cullen, Richardt, & Hume, 1997; Richardt & Magers, 1997; Hume Richardt, & Applegate, 2003). Marceau (2005) points out differences between secular and non-secular workplaces, however, training of a similar nature is identifiable in both types of institutions (Craigie, 1998, 2010; Thompson, C. M., 2000). While spiritual training and development is suggested for all staff (Center To Be, 2014; Craigie, 1998, 2015; McGuire & Rocole et al., 2006), Craigie (1998, 2015) emphasizes an integrated, three-dimensional approach for effectiveness: patients and families, staff, and the organizational supports, driven in large measure by the infrastructure and moral support rendered by the leader(s) of the organization.

The four informative studies reviewed differ in organization, methodology and intent. Three of the four studies included religiously sponsored organizations (Chotkevys, 2009; Kumpala, 2011; Nelson, 2008). Regardless of sponsorship, they all provide evidence that there is an ongoing challenge to define and refine roles and responsibilities for professional staff, in particular nurses.
and nursing leaders responsible for the provision of spiritual care. The pastoral care department was seen as responsible for meeting patients’ spiritual needs in one study (Jenkens, 2008). Two studies indicate the need for leadership to have better knowledge and education (Jenkins, 2008; Nelson, 2008). All four cite the need for more education overall, and suggest that personal comfort and one’s own beliefs play an important role in the provision of spiritual care for patients (Chotkevys, 2009; Jenkins, 2008; Kumpala, 2011; Nelson, 2008).

Analytical Theories

I propose five theories that are compatible with the phenomenological approach. These include: Kohlberg’s Theory of Moral Development; Thompson’s Congruent Life Theory; Fisher and Torbert’s Theory of Work and Development; Fowler’s Theory of Faith Development; and Schein’s Theory of Organizational Culture. I chose the first four theories (Kohlberg, Thompson, Fisher and Torbert, and Fowler) because they share a common thread of adult developmental theory focused on individual growth, maturation, and behavior personally and/or professionally in work lives. The fifth theory (Schein) was selected for its views of the collective behavior of many individuals in an organization. All theories chosen have the potential to inform how the experiences of hospital system leaders contribute to their capacity to meet patients’ spiritual needs.

Kohlberg’s Theory of Moral Development

As adult development theories evolved, the notion of moral maturity introduced by Lawrence Kohlberg (1981) evolved with it. Building upon the work of well-known child and adolescent psychologist Jean Piaget, Kohlberg recognized that psychological and emotional maturity did not end at childhood. His conceptual framework of human growth and development in adulthood focuses on differences in moral reasoning ability rather than on behaviors.
Kohlberg (1981) espouses a basic social science truth: that as adults we make different decisions even when we have the same moral values. Moral values derived from social justice can be thought of as a set of moral principles upon which people operate. Values represent justice with equal respect for all people. Although they may be regarded as arbitrary and relative to individual experiences and preferences, the virtues or moral values possessed by individuals grow and develop in stages over their lifespan. While the relationship between moral judgment and moral values is not fully defined, Kohlberg and Hersh (1977) clarify that moral judgment is a necessary but not sufficient condition for moral action. The researchers hypothesize that behavior informed by mature moral judgment is influenced by a level of moral development. The theory follows sequential stages of lifespan development, evolving from a cognitive approach focused on differences in moral reasoning. In all cultures of the world, the same steps toward moral maturity are found. Even when consistent moral principles are present, different social environments produce different beliefs. The differences in basic beliefs and values are based on the level of maturity an individual brings to moral and social issues and concepts.

The stages of development relate to moral reasoning that individuals adopt. Kohlberg (1981) constructed three levels of cognitive development, with each containing two stages: pre-conventional, conventional, and post-conventional (Table 1). Kohlberg’s levels of development are as follows:

**Pre-conventional level.** This *impulsive* level begins with two stages. Stage one is known as the as “punishment and obedience oriented” stage, where the young child seeks gratification of basic needs while avoiding personal harm. This egocentric period of life focuses on meeting personal needs and is relatively devoid of concern for others (Kohlberg, 1981). Stage two, the “instrumental relativist orientation,” emerges between the ages of seven to twelve with the
recognition of others by the individual. Sharing, equity and fairness are now important (Kohlberg, 1981).

Conventional level. The conventional level, with two stages (three and four), is characterized as the recognition of the value of family and other institutions and the desire to conform as well as support social order (Kohlberg, 1981). Also known as the conformist level, the “interpersonal concordance orientation” at stage three occurs when behaviors are judged and the desire to “be nice” becomes evident. At stage four, “social maintaining orientation,” social order is guided by rules while respect for authority develops. A fuller consciousness of others and of the value of relationships begin to develop. The idea that a good society provides benefits for all people comes to light.

Post-conventional level. At this level, also described as the principled level, the two stages include: the recognition and definition of moral values; and principles by individuals, apart from those of society which are valued independently (Kohlberg, 1981). At stage five, the “social contract orientation,” individuals become capable of reflection and examination of their own values relative to those of society. Individuals at this stage have the capacity for “generativity,” or becoming an autonomous moral entity capable of a meaningful life of self-sufficiency. Stage six, the “universal ethical principle orientation”—a higher level of consciousness achieved by few—is characterized by principles of justice, reciprocity, dignity, and human rights (Kohlberg, 1981). Stage six is an almost unattainable state of being reached by a rare few individuals, including such well-known figures as Gandhi, Mother Theresa, and Martin Luther King, Jr. The qualifications include a radical commitment to peace, justice and love, and a “selfless passion for a transformed world…in accordance with intentionality both divine and transcendent” (Fowler, 1981, p. 201).
Table 2.1. Kohlberg’s Stages of Moral Development

<table>
<thead>
<tr>
<th>Kohlberg’s Moral Development</th>
<th>Pre-conventional</th>
<th>Conventional</th>
<th>Post-conventional</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Punishment/Obedience</td>
<td>3 Interpersonal Concordance</td>
<td>5 Social Contract</td>
<td></td>
</tr>
<tr>
<td>2 Instrumental Relativist</td>
<td>4 Societal Maintenance</td>
<td>6 Universal Ethical Principle</td>
<td></td>
</tr>
</tbody>
</table>

Kohlberg (1981) predicts that individuals move through stages of development only after their prevailing worldview becomes inadequate to manage their lives’ challenges. Individuals become attracted to the next level of development as they move toward it. They cannot comprehend the reasoning of any person more than one stage beyond their own. Movement to higher stages of moral development occurs by a process called “individuation” or self-evaluation, which includes internalizing good knowledge acquired through outside experience while jettisoning the bad. Disequilibrium drives the inner-directed desire for serious reflection about one’s self and place in the world. The successful individual puts aside all egocentric preoccupations, gaining the freedom to be directed by a higher power and the potential for the reconstruction of her worldview.

Although Kohlberg (1981) states that movement through developmental levels is sequential and invariant, Thompson (2000) argues sequential movement is not predictable and that all individuals are subject to regressions, depending on life situations and traumas that can arrest their development or accelerate it. For him, developmental levels serve as frames of reference as our worldview expands.

At the highest level of moral development, post-conventional, individuals are autonomous, principled, and have developed an awareness of personal values and opinions relative to those of society. The transcendent experience is available to all, regardless of religion,
but cannot be forced upon others (Kohler, 1981; Thompson, 2000). It is a level of development accessible only to those who are open to the experience.

**Thompson’s Congruent Life Theory**

Using Kohlberg’s (1981) moral development theory as a lens, C. Michael Thompson (2000) examines the moral development of adults in the context of leaders growing in maturity and in spirituality in the work environment. Thompson (2000) theorizes that individuals who seek to find meaning and purpose congruently in work and their personal lives do so through concentric circles of meaning. Individuals move from job culture to career culture, and ultimately arrive at a transcendent meaning of work and vocation. Using Kohlberg’s theory of moral development as a framework for personal growth, Thompson (2000) begins with the individual’s *inner-personal* traits at “pre-conventional” low levels of adult development in relation to serving his personal needs. Moving upward, individuals develop *interpersonal abilities* in an organization that correlate with the “conventional” middle level. Ultimately, individuals acquire *organizational* skills at the “post-conventional,” highest level of development. At the highest level, the fully mature leader in a state of transcendence possesses all three attributes (Table 2.2.). *Note.* Table from Thompson (2000, p. 137).

**Table 2.2. Thompson’s Congruency Theory**

<table>
<thead>
<tr>
<th>Congruency Theory</th>
<th>Pre-conventional</th>
<th>Conventional</th>
<th>Post-conventional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>Inner-Personal Traits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal Abilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Beginning at the “pre-conventional” low levels of adult development, individuals who possess inner-personal traits are not likely to be in management roles (Thompson, 2000). This is because individuals at this stage focus primarily on themselves, gratifying personal needs and avoiding personal harm. Those who become capable of assessing and occasionally meeting the needs of others do so primarily as a means of obtaining something for themselves in a quid pro quo relationship. At this level there is a very small but disturbing number (five percent) of business managers who, although pleasant, are adept at using power and coercion in their leadership style. With self-serving behavior, they are typically unaware of their effect on others.

The inner orientation of the congruent leader is intrinsically religious and defined by positive personality traits, characteristics, and behaviors (Thompson, 2000). Consistent devotion over time to spiritual traditions of the inner life deepens and accelerates personal growth. Thompson (2000) attributes the work of Kohlberg and Fowler, and Eastern and Western traditions of world religions, to the belief that the highest level of development is accessible only to those who are open to the transcendent experience and to living lives consistent with universal truths. This process of individuation, linked to spiritual growth, has implications for business and other organizations.

The many inner-personal qualities associated with a deep inner life include: flexibility to tolerating stress, uncertainty and surprise without burning out or becoming paralyzed; big-picture thinking with great abstraction of thought and ability to reframe or re-conceptualize problems; polarity, paradox, and equanimity for dealing with dichotomies and the ability to find balance in life; introspection and self-awareness to truthfully self-assess and change within; faith and hope not only for ourselves, but for others, our organizations, and society; sense of self and selflessness with the ability to stand against societies peer pressure, yet a capacity to set aside
strong identities to grow toward God; learning while accepting failure, accepting that deep learning follows in the wake of loss or failure; creativity and openness to intuition and inspiration; humor; energy; vision; and true integrity with courage to act upon expectations congruent with God’s will.

As inter-personal skills develop, individuals in the workforce advance to the “conventional” middle or conformist level. Individuals at these levels are more acutely conscious of others and their expectations in the workplace (Thompson, 2000). The emphasis on rules, laws, and obligations becomes evident while organizational skills develop, and the values of the larger society begin to be internalized. Kohlberg (1981) projected that approximately 80% of Americans stay at or below this level. Cook-Grueter (1990) is less optimistic, reporting a study of 2000 subjects showing that 91% of participants ranging in age from eleven to eighty-four scored at level four or lower. The lack of progression to the highest level is most important, as is what prompts individuals to move to a higher level. It is the role of the inner life that makes the difference (Kohler, 1981; Thompson, 2000).

The inter-personal qualities of high-level leaders at Kohler’s conventional level are built on a foundation of inner-personal traits (Thompson, 2000). These relational skills are manifested in many ways, including: empathy, by seeking to understand before being understood with exceptional listening and hearing others; vulnerability, by being open to being influenced; tolerance and acceptance of difference between people, even if not understood or embraced; communicating purpose through metaphors and symbols that influence ways of thinking; power used consultatively and constructively for purposes of furthering the needs of others; love by caring for others without recompense; Suffering, service, and sacrifice, as they are inseparable companions to love.
At the highest level of post-conventional level development, leaders affect organizational culture (Thompson, 2003). The highest-level leader possesses attributes at the inner-personal level, inter-personal level and organizational level. The management literature on leadership and professional development parallels that which exists on spiritual living. At this level, the leaders’ fundamental assumptions and core values are shared by almost all people in the culture. Leaders organize meaning and personify the vision in all aspects of their lives, providing meaning for others without manipulating them. Individualism and relatedness are balanced. Democratization with employee empowerment occurs, rather than command and control leadership. Excellence is pursued over efficiency. The spiritual organization embraces all of the above. Those who do ascend to the highest “post-conventional” level of organizational skill embrace the inner life, experiencing an enormous leap in their frame of reference and worldviews. Research over many years has shown that individuals at this level possess good managerial and leadership skills (Thompson, 2000). Displaying a notable increase in, and capacity for, self-reflection and critical self-examination of his or her values and those of society, these individuals are more aware of themselves, their prejudices, and the different perspectives of others. They have higher-level conceptual skills and can effectively manage the complexities of the work environment. At this level, individuals are less duty-oriented in the workplace, and become more autonomous moral entities interested in a meaningful life for themselves and others. They align themselves with a purpose and possess a strong spiritual life by cultivating the presence of a higher power.

Thompson (2000) expresses concern that society and institutions do not provide incentives for individuals to advance beyond their vested interests. He encourages individuals to expose themselves to more mature moral thinking, which will allow them to individuate and become the people they aspire to be.
Fisher and Torbert Theory of Work and Development

Thompson (2000) refers to research by Fisher, Torbert, and other associates who researched and refined work-related traits and characteristics at each developmental stage. Torbert and Fisher (1995) provide a lens for understanding the spiritual development of leaders in the workplace, integrated with Thompson’s congruent life theory.

In a study of 4,510 profiles of managers, consultants and MBA students conducted by Susann Cook Grueter (in Fisher, Rooke, & Torbert, 2003), key meaning-making frames were found to reveal various levels of development that coincide with Thompson’s congruency theory and Kohlberg’s developmental levels. Fisher and Torbert (1995) profile leaders in the following manner (Table 3):

*Table 2.3. Fisher & Torbert’s Developmental Model of Work and Leadership*

<table>
<thead>
<tr>
<th></th>
<th>Pre-conventional</th>
<th>Conventional</th>
<th>Post-conventional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fisher &amp; Torbert's Work and Leadership</td>
<td>1 Impulsive</td>
<td>3 Diplomat</td>
<td>5 Achiever</td>
</tr>
<tr>
<td></td>
<td>2 Opportunist</td>
<td>4 Technician</td>
<td>6 Strategist</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7 Alchemist</td>
</tr>
</tbody>
</table>

At the pre-conventional level—stage one—*impulsive* people are interested in fulfilling their personal needs directly or through others. They may be charming and pleasant or may be coercive, while focusing on the short-term. They reject negative feedback, and avoid self-criticism by rationalizing their failures. They see work as a necessary evil. No leaders are found in this group (Fisher & Torbert, 1995). Stage two *opportunist* encompass only three percent of leaders (Fisher, Rooke, & Torbert, 2003) who are described as over-simplistic, concrete and rationalistic. They generally deal with financial matters, production, and efficiency. Opportunists are narrow-minded, hegemonic, use power to manipulate, and lay blame on others when things
go wrong. For them the workplace is governed by a *quid pro quo* logic, where everything is done for something in return.

At the “conventional” level stage three, the *diplomat*, advances to create a self-image based on the approval of a particular core group. Interpersonal skills evolve for harmony and social approval. Two studies (Torbert, 1987; Fisher & Torbert, 1995) show that 24 percent of first-line supervisors fall into this group, along with nine percent of junior managers and only five percent of senior managers. For these people, the workplace objectives are conformity and avoidance of conflict. By avoiding negative feedback, diplomats are blind to opinions and issues that may linger beneath the surface. The next stage includes *technicians*, with a larger frame of reference than the small group. Technicians define themselves adamantly with skills and areas of expertise where they excel, allowing them to stand out from others. There are more technicians among supervisors and managers than any other type. They are disdainful of authority or bureaucracy; however, they are obedient to supervisors. They generally feel there is only one answer to any problem and they are often not team players. Technicians foster stressful cultures filled with unproductive competition. They can be competent in their own performance, but may encounter difficulty when supervising others, especially for the first time. Technicians may need assistance identifying personal behaviors that need to change before they are able to move to the next level.

At the “post-conventional” level stage five, *achievers* are able to recognize and allow for contingencies in the workplace. Achievers have a longer-range view of goals and achieving results in the workplace. Those with well-developed interpersonal skills have a deep sense of responsibility and may go to significant lengths to avoid hurting others. They are conscientious, show initiative, foster creativity, and accept personal feedback as a means of helping others
toward goals. Very few first-line supervisors reach this level, however 40% of managers and executives do (Fisher & Torbert, 1995). Achievers see the world as objective and rational, rather than as individualized and subjective. Their response to negative feedback is dual in nature: they accept it if blame is assigned to them or if corrective action advances their goals, or reject it if it threatens their construction of the world. No more than 10% of senior leaders, and even fewer from lower levels of leadership, ever move beyond this stage. A few, however, do advance to the strategist level of moral development (Fisher, Rooke, & Torbert, 2003). Managers reach this stage as a natural progression from experiences in their own lives, and as a consequence of their appreciation for the disparate points of views of those around them. They are aware of their deficiencies and able to get past them. As strategists become more open, they collaborate and empower others in the organization to develop critical skills for the future. These leaders are goal-oriented, and are distinguished by their knack for reacting flexibly and fluently in rapidly changing environments by framing and re-conceptualizing issues (Fisher & Torbert, 1995).

Thompson (2000) suggests that strategists gain the capacity to transcend conflict by replacing their need for achievement with a desire to serve a higher good. Strategists have the capacity to reframe the organization’s mission, strategy and structure, taking others with them on the journey (Fisher & Torbert, 1995). Moving beyond their own ambitions and achievements, they find more transcendent meanings in work. Values and principles, in either religious or philosophical terms, occupy the center of their lives, rather than solipsism. For them the notion of a transcendent force is accompanied by the development of their inner selves and an awareness of spiritual life as an ultimate reality. The alignment with a transcendent purpose, and the cultivation of its presence in the reality we inhabit, is the essence of a strong spiritual life.
Leaders who aspire to achieve these ideals are capable of transforming their organizations 
cultures.

Torbert and associates (2004) developed yet another level, which is unattainable except 
by a rare few individuals who have transformative capabilities for broad worldly social 
processes: the *alchemist*. Those leaders who are becoming alchemists continually inquire about 
the most difficult political and social issues of the outside world. They value justice and act in 
ways that exhibit their appreciation for both the light and dark side of matters, seeking tensions 
and opportunities to blend them. They expose themselves to, and share in, suffering, 
participating in historical and spiritual transformations and in creating foundational communities 
of inquiry. The founders of the Jesuits, Gandhi, and the Buddha are eminent examples of 
alchemists.

**Fowler’s Theory of Faith Development**

James Fowler created his theory of faith development to illuminate various pathways by 
which individuals make sense of and relate to the highest level of spiritual being, to reach what 
he termed “the ultimate environment” (Fowler, 1981; Parker, 2010). Fowler (1981) approaches 
faith not necessarily as religion or religious beliefs, but instead as a person’s way of making 
sense of life. Fowler’s faith development theory provides a conceptual model for how 
individuals’ spirituality helps them develop meaning in their lives, and can be used to add 
insights to the spiritual experience of leaders and their organizations.

Fowler’s theory recognizes the relational, cognitive and affective aspects of faith, and can 
be applied both within and outside of organized religion (Balswick et al., 2005 as cited in 
Kumpala, 2011). His distinction between faith and religion mirrors contemporary interpretations 
of faith as inclusive of all human beings rather than limited to a religious construct (Parker, 
2009). Fowler (2004) distinguishes between faith as a quest for a relationship with the
transcendent and faith that manifests itself as a specific belief or a religion. His approach is characterized by a phenomenological account of what faith does, with a conceptual model of what faith is. This social relations theory views faith as an aspect of human growth and transformation that cultivates trust and loyalty. Fowler conceptualizes the interplay of faith and identity as a “fiduciary or covenantal structure,” a trinity pattern between oneself, others and love. The mutual trust and loyalty that ensue from such a model create shared centers of value and power that form the individual’s faith system.

Fowler’s (2004) faith development theory is seen as a more dynamic universal activity grounded in certain cognitive development structures that occur in stages. These structures make it more discernible and distinguish it from the content of faith. Faith is understood, then, not as a set of beliefs, but as a way of making meaning. The multileveled description contains various patterns by which humans make sense of, and commit to, transcendent values and reality as they progress through life. Building upon the psychosocial theories of Erickson, the cognitive-structural psychologies of Piaget, and Kohlberg’s moral development theory, Fowler’s robust theory includes seven developmental stages. The tacit structure of faith underlying each of the stages of adult development demonstrates how individuals process social interactions. The stages consider individuals’ locus of authority, social awareness, worldviews, logic, moral reasoning, perspective-taking, and symbolism (Fowler, 1981; Fowler, 2004). While the stages are congruent with those of other developmental theorists, the blending of models also contributes to some problems in measuring each stage operationally (Parker, 2010).

The seven stages of faith development that occur over the lifespan include: primal faith, intuitive-projective faith, mythic-literal faith, synthetic-conventional faith, individuative-reflective faith, conjunctive faith, and universalizing faith (Fowler, 1981; 2004).
Stage 1, *primal faith*, or undifferentiated faith, occurs from infancy through age two, prior to language acquisition, where infants imitate and attach themselves to others and form foundational trust. In the early stages of faith development, “seeds of trust, courage, hope, and love are fused” (Fowler, 1981, p. 121). Children experience faith as a connection between themselves and their primary caregiver. They have the potential for faith but lack the ability to act on that potential.

Stage 2, *intuitive-projective faith*, from toddler to early childhood, begins with language development and progresses to the emergence of moral emotions and the awakening of standards (Fowler, 1981). Faith, for individuals at this stage, is not a thought-out set of ideas, but instead a set of impressions that are largely gained from the significant adults in their lives. A child can be “powerfully and permanently influenced” (Fowler, 1981, p. 133) by the examples, emotions, stories and behaviors of primally related adults. In this way, children become involved with the rituals of their religious community by experiencing them and learning from those around them.

Stage 3, *mythic-literal faith*, from middle childhood (ages three to seven) and beyond, begins with Piaget’s concrete operational thinking as the child begins consciously shaping and interpreting his or her experiences and meanings (Fowler & Dell, 2010). Marked by a “fluidity of thought pattern” (Fowler, 1981), this beginning stage of self-awareness is marked by egocentricity and the birth of imagination. A grasp of cause and effect logic emerges, along with the ability to differentiate their own perspectives from those of others, yet the child, adolescent or adult has not yet formed an internal guiding process. Cosmic patterns of the universe, fairness, impulse, feelings, and concrete symbols and concepts dominate this early stage of meaning-making and ideas of faith.
Stage 4, *synthetic-conventional faith*, from adolescence and beyond, is recognized by the individual’s extension of his or her own worldview beyond family (Fowler, 1981), and the emergence of interpersonal perspectives based on the judgment of others. The individual forges a capacity for abstract thinking, reflection, and meaning-making, while crystallizing values and beliefs and, simultaneously, conforming to the personalities and religious beliefs of others (Fowler & Dell, 2004).

Stage 5, *individuative-reflective faith*, from late adolescence through adulthood, is marked by the emergence of personal responsibility for one’s commitments, lifestyle, beliefs, and attitudes (Fowler, 1981, p. 182). Independent judgment with critical thinking skills emerge at this stage, leading to an individual’s reexamination of previously held beliefs regarding the creeds, symbols and faith traditions of self and others (Fowler & Dell, 2004). The individual questions her self-worth and identity. The individual may choose either to accept or reject tenets of traditional faith that, previously, she had internalized without reflection, taking responsibility for her personal beliefs and lifestyle.

Stage 6, *conjunctive faith*, occurs, if at all, during the mid-life stage of adulthood, and characterizes reflective thinkers capable of balancing the tensions of multiple perspectives and paradoxes through a reflective process. Open to contradictions and able to recognize the truths of “the other,” individuals at this stage seek unification and justice “freed from the confines of tribe, class, religious community or nation” (Fowler, 1981, p. 198). Faith transcends rational categories, including the unconscious (Parker, 2010). There is an appreciation of multivariate symbols and recognition of past discrepancies and social influences that provide newly acute insights. Such people are individuated, yet have an increased awareness of their being dependent
on, and simultaneously in solidarity with, friends and strangers as they build relationships (Fowler & Dell, 2004).

**Stage 7, universalizing faith,** occurs in the very few who reach a mature level of unconditional love and the capacity to embrace all people regardless of variables, ideology, and/or religious tradition. This ultimate state of faith is the manifestation of God’s goodness and love with peace for all humanity (Fowler & Del, 2004). Parker (2010) describes this state as “idealistic descriptions of faith terminus” for those who transform culture, but have their lives cut short because they may be seen as subversive.

Fowler’s (1981) faith development theory provides a framework with which to understand faith orientations apart from an individual’s specific faith. Relative to healthcare leaders understanding of their own spirituality, and that which is provided to patients in their organizations, it provides a framework for correlation and interpretation of findings.

A comparison of the prior four theories shows the parallel developmental of models using Kohlberg’s three levels, pre-conventional, conventional, and post-conventional. The table (Table 2.4) that follows, which I have generated, shows these four developmental models along with the character traits that—according to Kohlberg’s Theory—accompany each developmental phase. The table (Table 2.5) immediately after it—likewise an original table—displays the phases of an individual’s life, along with the psychological and behavior traits he comes to assume in each phase according to Kohlberg, Fowler, Thompson, and Fisher and Torbert.

**Table 2.4. Parallel Developmental Models with Kohlberg’s Theory**

<table>
<thead>
<tr>
<th>Kohlberg’s Moral Development</th>
<th>Pre-conventional</th>
<th>Conventional</th>
<th>Post-conventional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Punishment/Obedience</td>
<td>1 Primal</td>
<td>3 Interpersonal Concordance</td>
<td>5 Social Contract</td>
</tr>
<tr>
<td>Instrumental Relativest</td>
<td>2</td>
<td>4 Societal Maintenance</td>
<td>6 Universal Ethical Principle</td>
</tr>
<tr>
<td>Fowler’s</td>
<td>1 Primal</td>
<td>4 Synthetic-</td>
<td>6 Conjunctive</td>
</tr>
<tr>
<td>Faith Development</td>
<td>Thompson’s Congruency</td>
<td>Conventional</td>
<td>Fisher &amp; Torbert Work and Leadership</td>
</tr>
<tr>
<td>-------------------</td>
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<td>--------------------------------------</td>
</tr>
<tr>
<td>2 Mythic-Literal</td>
<td>Inner-Personal</td>
<td>5 Individuative-Reflective</td>
<td>1 Impulsive</td>
</tr>
<tr>
<td>3 Intuitive-Projective</td>
<td>Interpersonal</td>
<td></td>
<td>2 Opportunist</td>
</tr>
<tr>
<td>4 Synthetic-Conventional</td>
<td>Inner personal</td>
<td></td>
<td>3 Diplomat</td>
</tr>
<tr>
<td>5 Individuative-Reflective</td>
<td>Interpersonal</td>
<td></td>
<td>4 Technician</td>
</tr>
<tr>
<td>6 Strategist</td>
<td>Organizational</td>
<td></td>
<td>5 Achiever</td>
</tr>
<tr>
<td>7 Universalizing</td>
<td>Organizational</td>
<td></td>
<td>6 Strategist</td>
</tr>
<tr>
<td>7 Alchemist</td>
<td>Organizational</td>
<td></td>
<td>7 Alchemist</td>
</tr>
</tbody>
</table>

**Table 2.5: Stages of Human Development**

<table>
<thead>
<tr>
<th>Ages</th>
<th>Kohlberg</th>
<th>Fowler</th>
<th>Thompson</th>
<th>Fisher &amp; Torbert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy (0 – 1 1/2)</td>
<td></td>
<td>1. Primal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Childhood (2 – 6)</td>
<td>Pre-conventional Level</td>
<td>2. Intuitive-projective</td>
<td>4. Synthetic-conventional</td>
<td>A. Impulsive</td>
</tr>
<tr>
<td></td>
<td>1. Heteronomous Morality</td>
<td></td>
<td>Inner personal</td>
<td>B. Opportunist</td>
</tr>
<tr>
<td></td>
<td>2. Instrumental Exchange</td>
<td></td>
<td></td>
<td>C. Diplomat</td>
</tr>
<tr>
<td>Childhood (7 – 12)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescence (13 – 21)</td>
<td>Conventional Level</td>
<td>5. Individuative-reflective</td>
<td>Inter personal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Mutual Interpersonal Relations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young Adulthood (21 – 35)</td>
<td>4. Social System and Conscience</td>
<td></td>
<td></td>
<td>Inter personal</td>
</tr>
<tr>
<td>Adulthood (35 – 60)</td>
<td>Post-conventional Principled Level</td>
<td>6. Conjunctive</td>
<td>Organizational</td>
<td>D. Technician</td>
</tr>
<tr>
<td></td>
<td>5. Social Contract, Individual Rights</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maturity (60 – )</td>
<td>6. Universal Ethical Principles</td>
<td>7. Universalizing</td>
<td>Organizational</td>
<td>F. Strategist</td>
</tr>
</tbody>
</table>

**Schein’s Theory of Organizational Culture**

Schein’s theory of organizational culture provides a lens from which to view the role of leaders in healthcare. Organizational culture is constructed by the environment that surrounds and influences learned group behaviors (Schein, 2010). Culture is what a group learns over time to solve the challenges of surviving in the external environment, as well as internal integration.
challenges. The process is simultaneously emotional and behavioral. At its deepest cognitive level it results in groups who share feelings, emotions, attitudes, espoused values, and behaviors. Schein’s work provides a theoretical and practical approach to understanding the leaders’ experience of meeting patients’ needs within their organizations.

Schein (2010) defines culture as “patterns of shared basic assumptions as the culture adapts and integrates and where new members are taught the correct way to perceive, think, and feel in relation to problems” (p. 18). As both a product and a process, culture relies on prior organizational members’ knowledge and experience, and is constantly renewed as new people join the group and become the keepers. Culture evolves by patterning and integration. There may be inhibitions that prevent evolution, such as turnover in leadership, changes in technology, or changes in tasks or mission (Schein, 2010). Shared assumptions develop and are taught to new members who perpetuate them. Contributing past experiences and introducing new elements over time may modify the culture’s group-based stability. However, members generally attempt to be accepted rather than deviate from group behaviors and patterns.

In the early stages of organizational development, leadership and the organization are most deeply intertwined with leaders who impose their own values. In a test of Schein’s model, Hogan & Coote (2014) describe the intrinsic worth of values. They see them acting as social principles or philosophies that guide behavior in a way that creates a broad framework for organizational routines and practices. The values held and communicated by senior management, in particular, establish expected behaviors that become embedded in the organization. By emphasizing these closely held values and expecting certain behaviors, managers build organizations that have a powerful influence on employee behavior. The values then manifest
themselves in the artifacts of the organization by way of rituals, stories, language, and innovations (Schein, 2010).

Cultures begin through founders’ and leaders’ actions (Schein, 2010). Organizational success leads to growth over time, requiring organizations to differentiate themselves from others. A critical function of leadership is to recognize the cultural consequences of the differentiation process and to strive toward the desired cultural outcome. As successful organizations mature and grow, founders will age or die and will be replaced. An organization’s values may be eroded if not adhered to by the new leader or the organization may become more diverse. At organizational midlife, defined as the stage at which founder/owners have relinquished control to another generation of leaders, succession to a new leader can present challenges. At midlife, the most important elements of culture have become embedded in major processes, and in the structure of the organization. With a change of top leadership, cultural issues and values may be forced into the open for reconsideration. An important stage in transition is the re-establishing of what the organizational culture is and what it is doing for the organization, regardless of how it came to be (Schein, 2010, p. 281).

Organizations have levels of complexity not visible in small groups. However, all organizations start as small groups that continue to grow. Although we sense that culture is static, it is in fact a very dynamic construct that is shaped and reshaped to a greater or lesser extent by the behaviors of the members within it (Schein, 2010). Culture will vary in strength, stability, emotional intensity, and time. As organizations age they can diversify by functions, divisions, geography and other factors. Large “macro-cultures” appear to be more orderly and change less if they have a lengthy existence. Understanding culture formation in small groups or
subcultures, and observing how the latter interplay within an organization, helps one understand the organization at large.

Subcultures may be based on rank, level, or status. Occupational subcultures are also evident in organizations (Schein, 2010). They are divided by differences in training, roles, responsibilities, and the identities they form in their practice. Their basic beliefs, values and assumptions vary by virtue of the fundamentally different kinds of work they do. A blend of values and assumptions may be associated within each of these occupations. Occupational cultures may also be striated by virtue of the three generic levels of subcultures, operator, engineer/designer, or executive function. Inherently, all subcultures are necessary to the effectiveness of an organization, but can also conflict with one another. A critical function of leadership is to bridge relations between occupational subcultures (Schein, 2010).

Every organization has three generic subcultures (Schein, 2010): the operator or the staff who produces and sells the products and services; the engineering/design subculture that represents staff, who has the knowledge to operate the technology underlying the work; and the executive subculture, which includes top managers who in all organizations share similar environments and concerns. For an organization to be effective, the subcultures must be in alignment with each other (Schein, 2010).

How leaders embed their values and assumptions in an effort to transmit culture in organizations is important. The primary means of embedding these values and beliefs include: what they pay attention to and reward, how they allocate resources, role modeling/teaching/coaching, and the human resource functions. Secondary strategies such as storytelling, rituals, and other factors embedded in the artifacts are more difficult to control, however they serve to reinforce primary methods. Leaders need to become learners and culture
managers to be successful, especially in the modern global environment. Schein (2010) postulates three levels of culture formation. Table 2.6, which I have generated myself, displays these three levels, along with their corresponding degrees of visibility.

Table 2.6. Layers of Organizational Culture

Most visible

Least visible

At the surface level of an organization, the culture includes *artifacts*, or all things you can see, hear, and feel in the environment (Schein, 2010). The most obvious artifacts include physical products such as architecture, symbols, language, technology, artistic creations, clothing or dress codes, forms of addressing others, emotional expressions, shared stories, published values and mission statements, ceremonies, and rituals.

A group’s climate is a product of deep underlying assumptions that manifest themselves in the group’s culture as observable artifacts. Observable behaviors and structural elements such as organizational charts provide images and metaphors with significant meaning. While easy to observe, these symbols are important and ambiguous to decipher. Insights can be obtained through inquiry regarding group values, norms and rules.

The second level represents the *espoused beliefs and values* reflected by learning activities, group decision-making, and problem-solving approaches (Schein, 2010). The beliefs and values of early leaders are validated by group members in order to successfully resolve
group problems. These successful endeavors eventually become transformed into the shared values creating norms, and ultimately, shared assumptions that are validated by the group.

If the beliefs and values that provide meaning and comfort to the group are not congruent with performance, the behaviors will not be apparent. What is actually done rather than what is said is a more accurate view of the underlying assumptions. If the beliefs and values are not part of the ideology and philosophy, they “are only rationalizations or aspiration for the future” (Schein, 2010, p. 27). Alternatively, validating the philosophies can provide a powerful core mission and source of identity (Schuder, 2014). The espoused beliefs or values may be abstract or contradictory, thereby requiring a deeper level of understanding of patterns of behavior that predict the basic underlying assumptions.

When the basic underlying assumptions have become so ingrained in group behaviors, there is little variation among individual performance (Schein, 2010). These guiding theories are reinforced by repeated success, and are non-confrontable and non-negotiable, thereby making them very difficult to change. They dictate how group members think, feel and act.

The process of changing, and of learning something new, requires that one alter one’s cognitive perceptions, along with what Argyris (in Schein, 2010) calls a “double-loop learning theory” or “frame breaking.” Destabilization motivated by change creates anxiety among group members, which leads to avoidance, distortion, denial, and other behaviors that give the culture its ultimate power. The human mind needs cognitive stability. Overcoming changes in cultural differences that disrupt self-esteem occurs when the “different” common assumptions are recognized and honored. The discernment process leads to the creation of a third assumption that is incorporated into the new identity and behaviors of individuals and groups, resulting in new cultural norms.
Although comprehending organizational culture requires an assessment of all three levels, including identifying artifacts at the surface and observing espoused beliefs and values, the essence of understanding lies in the basic underlying assumptions (Schein, 2010). Leaders are charged with understanding the functionality of organizations at all levels. They must commit to group processes that unleash anxieties that occur in the change process and ultimately help the individual and the group to find a new sense of stability and meaning.

**Summary of Analytical Theories**

The five analytical theories stand alone, yet merge at several levels. Four theorists consider adult development as a means of understanding the moral and faith development of individuals in their personal (Fowler, 1981; Kohlberg, 1981) and work lives (Thompson, 2010; Torbert & Fisher, 1995). An additional theory from Schein (2010) encompasses the development of all the individuals to form a single culture in an organization.

A comparison of the four developmental theories shows parallel developmental characteristics and traits using Kohlberg’s (1981) theory as the basis with three levels, pre-conventional, conventional, and post-conventional. Each developmental phase represents the personal growth of an individual’s moral and faith characteristics over a lifespan or the potential for it, along with the psychological and behavior traits he or she may come to assume. Moving from a low or primal level of self development toward the highest level of moral and faith development, a conscious effort to nurture individual growth is made to achieve maturity in personal (Fowler, 1981; Kohlberg, 1981) and work (Thompson, 2000; Tobert & Fisher, 1995) realms. The mature individual at the highest level moral development is a reflective thinker able to examine their personal values in relation to those of society (Kohlberg, 1981). At this stage, the individual has unconditional love and the capacity to embrace all people regardless of
variables. Their high-level moral values represent justice, reciprocity, dignity and the human rights of others. The individual has a high level inner orientation and understands faith as a way of making meaning and balance the tensions of multiple perspectives and paradoxes (Fowler, 1981; Thompson, 2010).

A fifth theory by Schein’s (2010) is based upon the top leader, whose mission and highly developed values are embodied by, and integrated into the entire organization to form a culture. The leader’s deeply-held values and assumptions serve as social principles or philosophies that guide the behaviors of individuals in the organization, creating a broad framework for organizational routines and practices. Intentionally aligning internal processes and structures, or “the way of doing things,” considering artifacts in the physical environment, and fostering the development of individual members of the organization causes the culture to move toward the highest level of development where members find meaning and purpose.

Summary

In the second chapter I reviewed the literature regarding: the meaning of spirituality for patients; spirituality and healing in healthcare delivery; organizations that include spirituality as a way of providing care, and; professional responsibilities for providing spiritual care. Several strengths and gaps in knowledge were noted. I also reviewed five relevant analytical theories and four informative phenomenological studies related to providing spiritual care for patients to help identify the best methodological approach for this study. In the next chapter, I will describe the methodology selected and used to research the experience of healthcare leaders in meeting patients’ spiritual needs.

CHAPTER THREE: METHODOLOGY
Introduction

This study seeks to find the meaning and lived experience of multidisciplinary leaders of healthcare system staff as they endeavor to meet patients’ spiritual needs. It follows a qualitative approach that examines the experience of cohorts of people. This approach typically uses small samples rather than the large-scale samples used in quantitative studies. A quantitative approach is not appropriate for this research because questions that might be used in statistical-inquiry procedures are not known at this time.

The qualitative research tradition is recognized as a valid scientific methodology (Bogdan & Biklen, 2003; Creswell, 2007; Maxwell, 2005; Moustakis, 1994). Qualitative studies’ inductive and interactive approach, with its focus on specific situations or people, works well with research including the lived experience. It explores individual experiences that occur interactively. The interpretive and context-specific orientation of phenomenology centers on the verbal and visual expression of participants. Resulting theories are considered transferable rather than (externally) generalizable (Maxwell, 2005) and buttress the credibility of my study. For these reasons, my aim in using qualitative research is to describe and interpret the experiences of my participants rather than to generalize based on a sample of the population (Creswell, 2007; Moustakis, 1994). Phenomenology is used as the qualitative research approach.

Phenomenology

In empirical phenomenological research, the participants return to the original experience to obtain a comprehensive original description that provides the basis for “a reflective structural analysis portraying the essence of the experience” (Moustakis, 1994, p. 15). I used this approach in an attempt to understand the meaning of events and interactions of ordinary people, in this case healthcare leaders who received particular healthcare spirituality training (RISEN), and the
way they construct meaning. While a case study approach might be considered, it would fail to recognize the multifaceted experiences of individual participants. The vast majority of participants in this study possess a wealth of experience as leaders in a variety of healthcare settings, both secular and non-secular, over the course of time. The focus of this study involves the experiences of leaders who had a relatively common experience at a specific point in their careers, yet takes into consideration the cumulative effect of their work experiences in other settings.

My investigation began with the formulation of the problem and related questions that were clear and understandable to the participants. I engaged them in dialogue, asking them to return to their healthcare and leadership experiences in order to provide a narrative with vivid descriptions of what they saw, heard, felt, and did in the context of the events as they unfolded. Once I had obtained these comprehensive, original descriptions, I reflected on what they said, analyzing the data to gain an understanding of the meaningful concrete relations contained within the context of each situation (Moustakis, 1994).

I approached the data I collected from participants openly and without prepossession, allowing the events, people, and actions to enter into my mind as though seeing them for the first time (Moustakis, 1994). Moustakis (p. 22) refers to this as “the Epoche process…free of preconceptions, beliefs, and knowledge of the phenomenon from prior experience and professional studies,” coming to know things as they appear to the participants.

I interpreted the socially constructed experiences that constituted reality for each participant, first by intensively scrutinizing the data, known as “transcendental phenomenological reduction” (Moustakis, 1994, p. 91). As the researcher, I looked at the data as an external object and internalized it through inward reflection to form a relationship with it. I
bracketed the data to describe it with reference to its textural qualities, i.e. range, size, emotions, etc., serving as the mediator and evaluating the occurrence of each. I focused on horizontally arranging every statement with equal value, and approached the data with imaginative variation using polarities and reversals from divergent perspectives (Moustakis, 1994). I identified possible meanings, then triangulated the data and clustered it into horizons and themes with a coherent textural description of the phenomenon. I synthesized, configured and constructed meaning based on how it was created (Moustakis, 1994) and determined the essence to vividly illustrate how the participants made meaning of the lived experience phenomenon (Maxwell, 2005).

**Recruitment/Selection of Participants**

I used a snowball sample of 22 current and former leaders who are both direct care and non-direct care staff from multiple levels at one secular hospital/health system, and two hospitals within one non-secular health system. Participants had received healthcare-related spiritual education/training within the last ten years. The not-for-profit health systems with hospitals similar in size (approximately 300 beds) each have a mission, vision and values that emphasize holistic care including the mind, body, and spirit. They serve in predominantly Catholic communities of similar size (approximately 66,000 to 104,000 populations) in the same state. All hospitals had been recognized for their very high levels of patient satisfaction compared to their peers using the same standardized patient satisfaction research instrument, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). This standardized survey instrument and data collection methodology has been in use since 2006 to measure patients' perspectives on hospital care.
The leadership of both organizations has demonstrated a commitment to creating a culture of spirituality by virtue of offering their staff the opportunity to participate, at the hospitals’ expense, in an educational program called Reinvesting Spirituality and Ethics in Our Networks (RISEN). This program is aimed at personal and professional growth and integrating spirituality for health and well-being in the workplace. The hospitals each provide the intensive training at no cost to interested staff members, who voluntarily participate in the training. Initial training requires a minimum of six full work days, spread out over time, followed by several months of working under an assigned mentor during paid work time.

The sample population included 22 individual hospital/health system leaders for both direct and non-direct caregivers at three levels of the organizations, which were involved in the RISEN educational program aimed at enhancing spirituality in healthcare. The snowball sample of individuals interviewed includes: senior leaders (executive, chief, vice president or similar title); mid-level leaders (directors, managers, supervisors or similar title); and frontline leaders ( coordinators, charge nurses, lead or similar title) for both direct and non-direct care departments in each of the secular and non-secular hospitals/health systems.

In the snowball sampling I contacted leaders involved in each of the two organizations to obtain a list of prospective participants who met the criteria, seeking to saturate the span of leadership roles including (but not limited to) titles such as executive, vice president, director, manager, supervisor, coordinator, charge or lead, with both direct and non-direct patient care responsibilities. The participants include predominately white, Anglo-Saxons with a mix of seven males and 15 females approximately ages 35 to 65. No patient interviews took place. No confidential or private data from any source or any patient record was used.
Table 3.1. Cross Section Sample of Leaders Interviewed

<table>
<thead>
<tr>
<th>LEADERS</th>
<th>DIRECT Clinical, Chaplaincy</th>
<th>NON-DIRECT Administrative, Non Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Senior</strong> (10) System &amp; Hospital Executives, Chiefs, Vice Presidents</td>
<td>2 Secular (Vicky, Ben)</td>
<td>2 Secular (Quinn, John)</td>
</tr>
<tr>
<td></td>
<td>3 Non-secular (Louise, Farrah, Ellen)</td>
<td>3 Non-secular (Randy, Darla, Steve)</td>
</tr>
<tr>
<td><strong>Middle</strong> (7) Hospital Directors, Managers, Supervisors</td>
<td>2 Secular (Candy, Alberta)</td>
<td>1 Secular (Tony)</td>
</tr>
<tr>
<td></td>
<td>2 Non-secular (Nancy, Patti)</td>
<td>2 Non-secular (Marge, Gail)</td>
</tr>
<tr>
<td><strong>Frontline</strong> (5) Coordinators, Charge Nurses, Leads</td>
<td>3 Secular (Olivia, Iona, Wanda)</td>
<td>1 Secular (Ursala)</td>
</tr>
<tr>
<td></td>
<td>0 Non-secular</td>
<td>1 Non-secular (Henry)</td>
</tr>
<tr>
<td><strong>22 TOTAL INTERVIEWS</strong></td>
<td><strong>12 DIRECT</strong></td>
<td><strong>10 NON-DIRECT</strong></td>
</tr>
</tbody>
</table>

I sent a letter and identical email in advance (Appendix A), inviting each participant to a 60- to 90-minute individual interview with me at a convenient date, time, and location of their choice. One week later I followed up with an email and/or phone call to each participant to confirm their acceptance or denial, and to fix the date, time and location for the interview. If I did not receive a response, I made another attempt to reach them a week later. Those who did not respond by the third attempt, or simply declined, were excluded from the study.

I met with each of the interested participants individually to conduct the interview in confidence at their desired location, such as their office, a conference room, their home, or a public meeting space such as a library or coffee shop with private space. When I met the participant to conduct the interview, I completed an intake form (Appendix B). I also asked for permission to follow up with email and/or a phone call at a later date if needed to obtain clarification or garner additional information to complete the data.

At the interviews I asked for permission to record using an audio device. I obtained an informed consent (see Appendix C) prior to data collection to minimize the risk of probing for
personal or sensitive information during the interviews. I informed participants at the onset of the interviews that if they became uncomfortable or unwilling to reveal their story or experience, they were free not to answer any questions and to withdraw from the study at any time. If they chose to withdraw from the study during the interview, I would have ended the interview and eliminated the recording. This did not occur. However, if they had withdrawn after the interview and prior to submission for participant checks, I would have eliminated their interview data. If they had chosen to withdraw after participant checks, I would have de-identified the interview data and used the transcripts. In some instances I suggested that the participant offer other potential interviewees who met the research criteria. I then asked a series of interview questions (see Appendix D).

When the interviews were completed, I sent them to a transcriptionist. The transcriptionist then sent completed verbatim copies of the interviews to me directly. I, in turn, sent a verbatim copy to the participant to verify the accuracy of the transcription. They were free to edit the copy to reflect their intended meaning. The corrected data was used for the sole purposes of this study.

Voluntary Nature of the Study

Participation in this study was voluntary. Individual decisions regarding whether or not to participate did not affect participants’ present or current relations with The University of St. Thomas or any other organization with which they are professionally affiliated. Participants were free to withdraw at any time up to and until coding and analyses of completed transcripts. None did so. Each participant was given a pseudonym to protect their identity. I did my best to ensure that there was no way to identify individual participant data.
Data Collection

Twenty-two participant interviews conducted by the researcher served as the primary method of data collection. The data collected was bracketed, horizontalized, synthesized, and clustered into relevant themes. Coding categories were developed and refined on an ongoing basis, guided by the study’s conceptual framework. These data were triangulated against one another with a comprehensive review of relevant literature for interpretation and drawing conclusions.

Confidentiality

In keeping with the mission and mandate of the University of St. Thomas Institutional Review Board (IRB) and the mission of the hospital systems, I safeguarded the dignity, rights and privacy of all human participants involved in this research project using the highest professional and ethical standards for human participation. I obtained authorization from the IRB prior to commencing the study and reminded participants of the Health Insurance Portability and Accountability Act (HIPAA), which sets the standard for protecting sensitive patient data and protected health information.

I coded the names of all participants to secure the information. I assigned pseudonyms to all participants, locations and practice settings. To protect confidentiality, I used only anecdotal information acquired about patients through research participant accounts or staff accounts anonymously recorded in journals, stories or similar forms. I used no patient records. Any anecdotal stories involving patients were portrayed using pseudo-names. I disclosed no actual identities.

Audio-recordings and transcripts of the audio-recordings are available only to me, the researcher, and my dissertation advisor. They are kept in a locked cabinet in my home to which
only I have access and are digitally filed in my home in a password (known only to me) protected computer. Written notes available solely to me and my advisor are stored in a locked cabinet in my home. Psuedonyms are used for any of the notes or published material. The transcriber I use to transcribe the audio recordings signed a confidentiality agreement (Appendix E). The transcriber returned the audio recordings and all transcription digital files to me for storage in my password-protected computer and in the locked cabinet in my home.

In addition to me as principal investigator, my advisor, Dr. Thomas Fish has access to the data and records. Audio recordings and transcripts will be destroyed within one year of the dissertation’s acceptance.

**Ethical Considerations**

There are no vulnerable adults or children involved in this study. No patients were interviewed and no medical records were accessed. There was minimal risk to staff who self-reported his or her own knowledge, experiences and beliefs about spirituality. With inductive qualitative research questions and open-ended methodology, participants were able to determine the extent of self-reporting and to share their informed opinions and personal experiences with me as the researcher. Inductive, open-ended questions proved risky only if participants chose to disclose sensitive information. Interview questions were not self-disclosing in nature (Bogden & Biklan, 2003). I honored and respected participant responses and provided an interview atmosphere that facilitated participant expression openly and provided a milieu for sharing (Charmaz, 2006).

**Assumptions, Rationale, and Significance**

In the interest of fully disclosing my role in this research, I had previously worked at both of the hospital/health systems that participated in this research. At the secular hospital/health
system, I was personally engaged as the coordinator of an educational spirituality pilot study and I also participated in the RISEN program. Prior to accepting this role, I had worked for the health system for two years as the chief executive officer at one of system hospitals. At the non-secular hospital/health system, I was a regional director and participated in Franciscan formation education. I personally know many of the prospective participants. I attempted to keep any biases out of the study that may have resulted from these personal relationships.

In this research I made three primary assumptions. First, I perceived that due to their religious affiliations, non-secular hospitals/health systems prioritize and promote spirituality as a value in their organizations to achieve holistic care. Second, I perceived that hospital/health system leaders believe that meeting patients’ spirituality needs is predominantly a clinical function to be delegated to direct caregivers. Third, I perceived that staff have difficulty differentiating between spirituality and religion, and have concerns about how they themselves can identify and/or support the spiritual needs of hospitalized patients.

The reason I perceived that non-secular hospitals/health systems prioritize and promote spirituality as a value is because of my personal experience comparing secular organizations to the Catholic organization I worked in. There, I found that the religious-based organization seemed more likely to maintain a cultural framework and, consequently, was more apt to educate staff about spiritual beliefs.

I also perceived that most hospital/health system leaders believe, as I once did, that meeting patients’ spiritual needs is predominantly a function of direct clinical caregivers, especially nurses and pastoral care staff, by virtue of their required training. Conversely, because I had not received any spiritual training in my formal healthcare leadership education, I perceived something that leaders do not often understand: that leaders and other non-direct
caregivers wield an influence over whether, and how, patients receive spiritual care as part of the healing process.

The rationale for and significance of this study emanated from the desire to provide a holistic approach to healing, including meeting patients’ spiritual needs. I attempted to uncover the experience of all health system leaders, including those who led both direct and non-direct caregivers, along with all of their interactions. This study will provide helpful information and insights about the experience and opinions of trained leaders—insights meant for both direct and non-direct caregivers at all levels of a secular and a non-secular hospital and health system.

**Interviews**

This exploratory qualitative research design used a one-event, 60-90 minute face-to-face interview between the study respondent and me. Follow-up occurred by email, phone call or face-to-face to gain clarity of data, nuances, accuracy or contextual understanding of what the participant meant in their response. I conducted twenty-two in-depth interviews with current and former leaders who participated in RISEN training while at the secular or non-secular hospital/health system.

I initially interviewed two participants in a pretest. I gave each participant a copy of a consent form, indicating that in signing it, they agreed to the use of their interview in confidence as part of the study. I allowed them to withdraw from the interview at any point if they chose, or to do so after review of the transcribed copy of their interview. I described the purpose of the research and refreshed the participant’s recollection of the project.

I used inductive qualitative research questions (Appendix D) with open-ended methodology, such that participants determined the extent of self-reporting for sharing their informed impressions and life experiences with me as a researcher. The interview questions were
framed with a positive orientation toward participants, allowing them to follow their own lead (McCracken, 1988).

I informed the participant that he or she may receive a follow-up phone call(s) for further clarification of their responses. Once I completed the final follow-up with each participant, I sent them a transcribed copy of the interview for their review and/or modification. After receiving the final, edited copy of their transcription, I thanked each of them for their contribution to medical knowledge and terminated the researcher/participant relationship for the study.

**Data Analysis**

Each interview was transcribed by a professional transcriptionist who signed a written confidentiality of data agreement in advance (Appendix E). Transcribed data was forwarded to participants to review their responses for clarity, via the participants’ preferred email addresses. I reviewed the data and followed up directly with participants by phone or email for further clarification when needed.

After conducting preliminary data analysis, I reflected upon the themes that emerged. Once emerging themes and issues were identified and responses checked across participants, I identified similar category types as organizational categories, substantive categories, and theoretical categories (Maxwell, 2005).

I reviewed my notes, analysis, and coding of all data, including discrepant data, to avoid validity threats (Maxwell, 2005). I used my notes and memos to incorporate participant observations as cues for triangulation. I conducted follow-up interviews with participants via email or phone to gain clarity of data, nuances, accuracy or contextual understanding of what the participant meant in their response, and to confirm triangulation.
I ensured the reliability of coding using categorization strategies and coding responses from open coding (identifying, naming, categorizing and describing phenomena found in the text), axial coding (disaggregation of core themes), and selective coding (core variables of the data) (Creswell, 2007). I wrote notes and memos to capture insights and coding connections among the data. I fractured and rearranged data to identify broad themes and issues (Charmaz, 2006) with the aid of NVivo software. I checked individual responses against the interview questions before coding, using NVivo Software. I searched for discrepant evidence in the coding process and other appropriate strategies at different stages as the study progressed. I organized data for saturation and triangulation between phases of data collection (Charmaz, 2006).

Validity

Validating this research included triangulating data from various sources, correlating methods and theory, searching for discrepant evidence, and comparing findings with related literature. Sources of data include verbatim transcription of interviews, notes and observations I made during and immediately after the interviews, emails, notes, and correspondence with participants. The interviews derive their validity from a series of open-ended questions, concordance of methodologies, and utilization of theoretical constructs to explain the data (Creswell, 2007; Maxwell, 2005). To avoid inferences from any one verbatim interview description, data was triangulated with other interviews and/or other data sources noted.

The methods for triangulation to test internal validity were adjusted when similar themes or stories were raised by more than one participant. Data saturation was tested across multiple methods and was supported by an explanation of how it was achieved, and substantiated with clear evidence of its occurrence (Maxwell, 2005).
Study Limitations

Internal generalizability within the sample studied, rather than external generalizability, may be a limitation to inferring broader applications of the findings (Creswell, 2007). This study in two hospital/health systems should be replicable in other similar hospitals, regardless of affiliation, size, location, and specialty. There should, however, be no reason why the results would not apply more generally, having “face generalizability” (Maxwell, 2005, p. 115). While titles within organizations may reflect similar but not identical roles, the comparison of three different levels of leaders for both direct and non-direct departments is replicable. Another limitation is the likely difference in the period of time that passed between the actual participation in an educational experience and the interview, within the past ten years. This time gap may also have a bearing on the recall of participants. Since a number of the participants were involved in various educational experiences with me, we set aside our personal relationships to the fullest extent possible when we recounted events, in order to achieve an unbiased perspective.

Summary

In chapter three I reviewed the methodology used for this phenomenological study. I reviewed: the process for the recruitment and selection of participants; the voluntary nature of the study; the methods for data collection; the confidentiality requirements of the study; ethical considerations; the assumptions, rationale and significance of the study; the process of interviewing participants; the process of data analysis; the validity of the study, and; the limitations of the study. In chapter four I will review the findings of the research.

CHAPTER FOUR: FINDINGS
Introduction

The purpose of this study is to explore the experience of health system leaders in meeting patients’ spiritual needs. I believe that better knowledge gained from this will help healthcare system leaders to understand their role in leading their hospitals’ staff and physicians’ efforts at meeting patients’ spiritual needs. In this chapter, I present findings obtained from in-depth interviews of a sample of 22 leaders across various levels of two healthcare organizations, one secular and one non-secular. I call these leaders “participants” throughout the remainder of this study.

An overall finding was that healthcare leaders play a significant role in meeting patients’ spiritual needs. They influence the values of the organization and the development of a culture where spirituality can flourish. Four themes emerged within this finding: First, top leaders reveal and embody spirituality, which defines the culture. Four subthemes arose within this first theme. These include the observation that “marker events” defined or redefined both organizations’ values; that personal spiritual development has specific attributes; that observable moral characteristics are identified; and that the alignment and structure for leadership are important.

The second theme indicates that participants hold themselves and others accountable to defined values and behaviors and hire/retain staffs whose values are congruent with those of the leader. Within this larger, second theme, I discerned three subthemes: accountability for standards of behavior for services, structured feedback, and adherence to hiring/termination practices.

The third theme is that the capacity to meet patients’ spiritual needs is contingent on actions by direct and indirect caregivers alike, and is strongly associated with “presence.” Two subthemes arise from this theme. They include: that the training experience helped some
participants to differentiate between religion and spirituality, and that top leaders have a significant influence on training, which requires a commitment of resources for individual and broad cultural development.

The fourth theme is that both secular and non-secular participants believe that intentionally invested resources in the spiritual development of individuals positively impacted the organization’s culture. Two subthemes include: that the RISEN (ReInvesting Spirituality and Ethics in our Networks) program helped participants to grow personally and professionally and helped to differentiate between religion and spirituality; and that top leaders commit to a learning culture and individual empowerment for spiritually congruent work lives.

**Top Leaders Reveal and Embody Spirituality, Which Defines the Culture**

The first major theme I identified was that *top leaders* reveal and embody spirituality which defines the culture. Four subthemes that emerge within this one include: “marker events” defined or redefined organizations; personal spiritual development has three specific attributes; five observable moral characteristics are identified; and alignment and structure of leadership is intentional.

The first subtheme, to do with marker events, occurred in both the secular and non-secular hospitals/health system. These events reveal top leaders’ spiritual values. In the second subtheme, personal spiritual development, participants described three attributes including implicit beliefs, the inward nature of spirituality, and the need to replenish their spiritual reserves. In the third subtheme, observable moral characteristics, five key moral values are identified. In the last subtheme, alignment and structure, leaders align with values at the top of their respective organizations by intentionally structuring them.
Participants in both health systems believe that top leaders represent the mission of the organization and its spiritual values in a way that embodies spirituality, while all other leaders align with them. Founders who established the original mission and values of each organization are represented today by heirs who lead them through tumultuous midlife marker events to reaffirm the mission and values. The latter, in turn, ultimately also reaffirm the top leader’s role. Leaders at all levels emulate the top leader, developing their inner-personal spiritual beliefs and exhibiting moral characteristics that others observe. The alignment and structure of leaders in the organizations is an important leadership function for consistency of values at all levels of leadership.

**Marker Events**

A midlife “marker event” that occurred during the 1990’s in each organization defined or redefined their values and cultures. According to Schein (2010) an “originating event” by founders of the organization or a sudden “marker event” that occurs sometime in midlife, requires a common response from the members of the organization. The originator or leader of the organization calls together a group that shares a common experience, and forms or reforms the values that define the culture. Defining and then embedding the organization’s values into the culture is the top leader’s primary function (Schein, 2010). A midlife “marker event” occurred in each organization and is discussed below.

**secular.**

The secular community hospital originated for purposes of serving the poor, aged, sick, and dying early in the twentieth century. It evolved over time and suddenly experienced a crisis in the latter part of the twentieth century that challenged the core values of the organization and threatened its mission. The CEO leader at that time was faced with what Schein (2010) identifies as an organization encountering midlife changes and a “marker event” or dilemma that
negatively affected the organization. The CEOs response to the marker event that transpired ultimately established a new set of values that markedly altered this organization’s culture, defining it afresh during his tenure as its top leader.

The secular CEO leader described the circumstances of the marker event that plagued his organization. An ethical dilemma arose surrounding the need to find a common position on the controversial subject of rendering abortions at his secular hospital. “If I had to cite challenges to the organizational ethic, probably the most dramatic, and it remains the most dramatic for us as a society, it is the abortion issue.” Although this was a secular hospital, the issue became particularly divisive among physicians and staff in a Catholic-dominated community. Obstetrical physicians wanted to provide abortion services locally rather than transferring their patients to another hospital for such procedures. The CEO gathered angry nurses and other members of the organization to address their concerns:

I had to go in front of a group of nurses from our obstetrical unit, and these were people who were against the idea. [I said] There is no certainty about this issue. You are not right and somebody else isn’t wrong. Please be tolerant of one another…these are the reasons that we felt we need to serve our patients in this way.

After appeals for tolerance, the CEO called for and led a retreat among fifty of the organization’s leaders. The leaders stayed up all night wrestling with the issue and developing a set of values for the organization. They “owned” the results presented in the morning, according to the CEO. The retreat ended favorably, resulting in a concise and clearly articulated set of values that were presented and supported by most members of the organization at large. Senior leader Ellen and Steve confirmed the results. “We were grounded enough to work through an issue that just torments people and I think we proved that to our employees,” says the CEO.
Schein (2010) notes that cultural alignment requires humility on a leader’s part and skills in bringing together different subcultures, including layers of leadership, to create and maintain dialogues of respect and coordinated action. With humility the CEO credits the values of his organization to its members:

I don’t create values, though. I identify as a group, values, and then we say ‘what can we do to practice these values, to reinforce these values, to make sure that others understand that these are our values,’ but how do you identify? The core values that reflect the deep spiritual roots of the CEO and the organization continue today: respect and compassion for the individual, service, and excellence. A member of the senior team, Darla, reflects that the values “bubbled up organically.” The CEO delightedly reports that the simple values statement “stuck” and can be recited by most people at all levels of the organization today. The proposition statement rolls off the tongues of senior leader Ellen and staff as easily as saying their own names.

Members of the secular health system corroborate their leader’s story. “I like to say that the flavor of the sundae starts on top,” says Louise with a whimsical knowing grin that reflects her years of experience in both staff and leadership roles at both secular and non-secular hospitals. She and others believe that top leaders must “walk the talk.” Patti, who also happens to be a very traditional Catholic with deep religious convictions, shares a balanced perspective of her faith in the context of her business worldview. She believes the top-level executive is responsible for recognizing the value of spirituality. She stresses “the contribution it can make to patient care, patient outcomes, (and) potential market share—because you are making people happy, and you are making them well.” She stresses the importance of top leaders communicating spirituality as a cultural as well as a business priority.
In comparison, the *non-secular* hospital’s originating event began in the late nineteenth century, in response to similar significant social needs of the times, when hospitals were scarce: to provide care for the sick, poor, and dying. The responding nuns with deeply held values inspired by their patron saint became the leaders of the non-secular Catholic hospital and still carry out its mission today. A marker event occurred in the late twentieth century during the midlife of the organization, when lay leaders began replacing the religious leaders with few heirs apparent. While deference is given to the current non-secular CEO by Quinn—“Don’t get me wrong,” he remarks, “she [the lay CEO] is an amazing person”—strong attributions for the spiritual leadership remain with the very small number of religious heirs today. These rare, few committed sisters, and a few priests, still contribute today in meaningful ways to inspire the people and affect the culture through direct caregiving or as part of the health system governing board.

Non-secular leaders Vicky and Tony, among others, paint vivid pictures of spiritual leaders/role models walking the halls of their hospital in their religious regalia, inspiring colleagues by their very presence. Deeply moved by these individuals, who selflessly dedicate their lives to a healing ministry, the leaders and staff revere them for their altruism, dedication to direct patient care, and ongoing presence even at advanced ages and possessed of serious health issues of their own. These visible religious leaders motivate staff and the patients whom they serve with faith and hope, in a way that makes the staff feel secure in the charitable mission of the organization. Participants speak of how important their living example is to them personally, with Quinn stating the need for today’s leaders and staff to “embody Christ’s healing mission.”
Participants indicate that staff is nervous about the impending loss of very aged spiritual leaders who are not physically well, yet who carry on with their duties both for their love of the work and for the lack of replacements. The concerns run far and deep among non-secular participants. “A lot of people asked, ‘Why would I work [here] when Father and the Sisters are gone?’ Their presence had given their lives a lot of meaning” says Ben. Quinn credits the nuns for their foresight:

The sisters have done an exceptional job of, a long time ago, discerning and seeing the need to really create some way of passing this on and a lot of what they call ‘formation.’ They connected it …to servant leadership, to continuous performance improvement, to quality.

Ben agrees with Quinn, describing a “strategic sense” the nuns had, as well as their creation of several newer activities designed to reinforce the mission and values of the organization’s founder. These activities include appointing lay leaders to positions previously held only by nuns and calling them “mission integration” leaders. A certain standout physician was appointed to replace the recently retired nun responsible for implementing strategies to enhance the organization’s values. One of many new practices involves sending a cross section of leaders at different levels of the health system on a spiritual pilgrimage to the European convent and home of the patron saint. This firsthand experience of meeting the protégés of the founding leaders helped them to forge personal relationships, and deepened the bonds between them and the other leaders across the globe who carry out the mission on their behalf. Given the miniscule number of nuns in the religious order today, the healthcare mission would end if not for these lay leaders. The important link to the past is a “spiritual journey that profoundly affected a lot of people…and create(ed) loyalty,” to their organization according to Ben. Many
other mission integration strategies are in place, including an additional day of new employee orientation to emphasize spiritual values early in their employment relationship. Vicky played the appealing new orientation video featuring the Sisters at the US home convent and headquarters, talking about their heritage and the importance of the healing values that continue to drive the mission today. Vicky also described required “leadership rounding,” or meeting intentionally with employees and patients with specific focus on values and building relationships with others who share those values. Rounding is required at least eight times per month by each executive leader, and is reported to the hospital lay CEO. Other leaders at midlevel and frontline are required to round even more frequently in an attempt to deeply embed the values of the founders.

**Personal Spiritual Development**

The second subtheme that emerged is that participants have deep spiritual beliefs which they develop and nurture in their own unique ways. “It is a way of being,” says Iona, who adds that this manner of existence entails being grounded in a higher power. Participants see their spirituality as a relationship or connection with others and/or some greater purpose that relates to their inner selves and purposes in life. Three attributes that are significant to participants’ development and ongoing formation include: possessing implicit beliefs about spirituality, being attuned to the inward nature of their spirituality, and placing importance on replenishing spiritual reserves.

**Implicit Beliefs**

All 22 participants have their own deeply held spiritual beliefs. They universally responded without hesitation to the question of what spirituality means to them. Quinn and Vicky are senior leaders in the non-secular organization who sanction their belief in something “larger than self.” They describe their lifelong relationship with this higher power and how
important this sense of spirituality is in their lives. Participants Olivia, Iona, Ursala, and Ben, at various levels of leadership in both secular and non-secular organizations, are also well-grounded in their belief systems, and passionately embrace spirituality. They use lofty descriptions of the reservoir of spiritual power in whose proximity they live their lives; indeed, they are open to the idea of a “larger intelligence” or “mystery,” a “universe” or an “energy field” that they do not control, but which they are connected to in their lives.

Ursala stated that her spirituality was her driving force and came from “[her] soul….deep within.” She sees her own spirituality as part of “who we are and who we connect with in the world.” When the clinical colleagues in the department she supervised perpetuated a longstanding culture of negativity that she was unable to change, she became frustrated and angry. Rather than leave the organization in defeat, Ursala retained her conviction that healthcare workers need positivity, and therefore changed her own career path to a position where she could incite positivity in others. She moved from frontline direct-care leadership to an indirect care leadership position where she holds a sphere of influence assisting a great number of colleagues. She now finds joy in helping individuals develop their career potential and in helping them find their own meaning and purpose in life. Although he is not religious in nature, Steve sees himself as very spiritual. As a senior leader in a secular organization, he embraces the idea that he and others connect with a universal force.

Inward Nature

Seventeen participants describe their inward nature, or the “inner calling” of their own strongly held spiritual beliefs. Focusing on the inward nature of their leadership, five among them state that they are heavily influenced by their faith tradition. Tony described growing beyond the confines of his family’s expectations en route to finding his own identity. He describes a rule-bound family with deep roots that, while he valued them, also restrained his
individualism. In contrast to his own life, Tony’s wife grew up very independent. After he met her, Tony recollected, she helped him find his own “wings.” Demonstrating his ability to step back and create a “critical distancing” from his previous value system, Tony emerged with a new self-awareness. He further reflects on the fundamentalism in the Old Testament, contrasting this with his own need for original thought. Tony states that his spirituality “only comes to fruition [when] you uncover the layers of nurture that have occurred throughout your lifetime.”

Participants in the secular health system such as Louise find that their inner spirit drives them in all they do in life. She examined her inward nature and found her meaning and purpose in “relationships [that] are huge for me.” Her choice of serving as an oncology nurse for a large portion of her career is founded in connecting with dying patients on a deeply spiritual level. Other participants who know Louise describe how she inspires them with her spirit. Nancy finds “comfort in private work” and in her “normal daily life” through her inner spiritual beliefs.

Among the inwardly focused participants, the personal faith tradition of five participants provides the foundation for their belief system, and grew over time. Participants like Farrah and Henry described early adolescent and childhood experiences of growing up in faith traditions, following the patterns of their parents, who didn’t always attend church services yet insisted they did. Sometimes they attended various services with their friends out of “curiosity,” but not necessarily fired by faith. Although Tony and others were also affected by their families’ religious beliefs, they did not feel the need for organized religion, and they chose their own spiritual pathways as adults.

John was driven from within, even though he followed his family tradition. He reflects on his Christian heritage, how he found his faith identity when he was “a pre-teen and didn’t
understand theology [or] much of the Bible, but I knew one thing is that God loved me.” He was affected emotionally by faith experiences, particularly a bible camp he attended each summer:

I got “saved” again and again and responded to that preacher’s salvation message and the revival service. But what I realized later is I wasn’t getting saved again… Coming to Bible camp, focusing on God’s word, having some people talk about different stories in the Bible and having a personal retreat, it was an encounter with God. It was a mountain-top experience…that sustained me spiritually throughout the rest of the year, which were kind of ups and downs and struggles. I struggled in public school being a person of faith and having to nurture that spiritual side. I didn’t have the language quite to describe what was happening other than I felt renewed, restored, reminded of the things that I believed, and reminded too of how important it was for me to read my Bible. How important it was to pray on a regular basis.

John was deeply affected by the experience: “You give your heart to the Lord and you say a prayer. You dedicate your life to following Christ and so I at that young age I did that…it wasn’t emotion. It was like something spiritual that I encountered for the first time.” John recognizes that his Christian faith, formed very early in life, developed core beliefs that provided him a foundation for spirituality “that needs to be nurtured, need[s] to be thought about, and considered just as you would think about physical health and growth.” Although he is not Catholic, he happily works in a Catholic health system while maintaining his own religious traditions.

While they did not indicate that their own faith traditions played a role in their spiritual development, both Randy and Steve describe spirituality in terms that are more indicative of their secular experience. Randy defines spirituality as an “agreement with society” that he
associates with “morality and a broader view of the world than just yourself.” Steve says that people drawn to their community hospital mission are capable of “fulfilling an inner calling.” Their basic values and principles are consistent with those of others, who declare their religion as their foundation for spiritual beliefs even though they did not express a connection with religion or religious beliefs.

**Replenishing Spiritual Reserves**

Two thirds (17) of the participants describe the importance of routinely replenishing their inner spiritual reserves as part of their ongoing spiritual formation. They speak of an innate desire or personal motivation to find these attributes within themselves, to self-discern, to reflect inwardly and outwardly. Farrah and Louise go on walks alone or with friends to find energy and refreshment. This “alone time” is restorative and is also time where they can reflect on themselves or their families away from the pressures of work. Alberta takes time for meditation and quiet reflection each morning before she begins her day. She wraps herself in a blanket with a warm cup of tea to reflect on how she will positively manage her day ahead. Henry enthusiastically listens to recordings of a daily Bible review, a challenge he took on to cover the entire Bible over the course of a year. He generally does not share that information with others. It is his own private ritual to replenish his spiritual reserves. Tony looks forward to quiet time on his long commutes to and from work, which he has learned to embrace. Quinn faithfully attends an annual spiritual retreat with longtime friends who introduced the idea a decade ago. He relishes their time together and returns renewed and refreshed. He also routinely meets friends for Bible studies and fellowship to take care of his inner need for spiritual renewal. These leaders strive for balanced lives away from the intense pace of their emotion-laden healthcare jobs by using many distinctive strategies that suit their individual personalities: prayer, exercise, quiet time, family, and /or whatever means brings them that sense of inner peace.
Observable Moral Characteristics

The third subtheme to arise in the finding is that moral characteristics are observed and consistently demonstrated in behaviors by secular and non-secular leaders at all levels of leadership. Participants provide images of the most significant moral behaviors of the leaders they admire and emulate. These characteristics distinguish spiritual leaders who are highly valued individuals. The five key moral behaviors most often identified by participants include trust, presence, relationship-building, honesty, and mentoring or coaching.

Trust

More than half (13) of participants at all levels and from both organizations identify trust as an important moral characteristic. Senior leaders Steve and his senior colleague Randy assert that the implicit trust they place in their leadership teams to build their culture and provide them with sound advice is based on shared values and mutual respect. Steve encourages the leaders who report to him “to develop their own culture and to pull the organization with them,” out of the belief that the culture they create will be consistent with leadership values and therefore one and the same. Mid- and frontline-level leaders Candy and Ursala garner the trust of others by making it “safe” for their staff to share when they feel vulnerable. They serve as their confidants to others, especially in times of personal or professional crisis. Mid-level leader Gail reveals her own vulnerabilities, weaknesses and challenges to demonstrate her humaneness to those she leads. Gail believes this helps her to earn their trust. Iona, at the frontline, works hard to demonstrate her great love and respect for the rights and dignity of her team and those they serve. While it may be difficult to understand staff who have different styles and approaches than hers, “When they put their heart(s) on the table” she feels that she and others form deeper relationships with them. As a senior executive, Darla firmly believes that trusting relationships between and among all members are essential to building strong and healthy organizations. To
that end, she works hard on transparency and education so staffs believe and trust in the leadership of the health system.

**Presence**

Eleven participants cite *presence*, or the process of actively listening and taking time to show genuine interest in others, as an important moral characteristic. Of these eleven, five discuss listening but not fixing. Listening non-judgmentally is an important component of being present for others. It is a spiritual practice important to staff as well as patients. Direct caregivers Candy, Olivia, and Wanda practice presence with their direct care staffs primarily through active listening. In the daily work of meeting the emotional needs of patients, their own staffs are personally affected from time to time. Candy is genuinely engaged with her staff, whom she mentors and seems to befriend. She is more interested in sharing living examples of patient and staff challenges than she is in articulating theory or tactics. In one instance, a frustrated patient took his anger out on Candy’s staff member, who in turn became aggressive. While Candy thought she may need to discipline the staff person, rather than jump to conclusions she instead chose to listen as he projected his thoughts and feelings. In the end, she realized that his behavior, while not appropriate toward the patient, was based on a personal problem that required a very different response from her. The staff member was grateful to Candy as a compassionate, non-judgmental listener who was present for him and ultimately helped him when he truly needed it.

The skill of being present for others does not always come easily for leaders. Patti describes herself as a driver who once managed and loved the hectic, adrenaline-ridden pace of emergency departments. She is used to working under high-stress conditions with like-minded colleagues, including physician partners who can be far more challenging to manage in difficult situations than staff. This may be due to a number of reasons, including a physician’s status;
however, being patient and non-judgmental can be hard when physicians or others are uncooperative. Candy learned about her own personality style and those of others through RISEN training, and believes this helped her to be present and to become a better leader.

**Relationship Building**

Although many of the behaviors demonstrated could be considered in this realm, seven participants explicitly identify *relationship building* as an important moral value. Participants work hard at connecting with people and building relationships that bring them joy and satisfaction. Connecting with people that Louise “works with on the journey,” including the staff, patients, physicians and others, is incredibly important to her no matter what position she has held, from a staff to an executive role. She especially works at building trust and rapport around the meaning and purpose that others find in their lives. Enthusiastically greeting the maintenance person and genuinely introducing him “as one of the best guys in all the place” when I visited, Louise knows and respects everyone she works with. She goes on to tell me how she connects with the staff, how each one contributes in their own way to the mission. Three other participants who know and have worked with Louise express their great admiration for Louise and her personality.

Darla, another senior leader, stresses the importance of connecting with staff as well. Her focus is on transparency at an executive level. As a result of his transparency about the direction of the organization, staff experience less anxiety and can be positive about the future. Maintaining positive relations among staff is something she believes is very important in their culture.

Building relationships is important to Gail at the frontline. As both a nurse and an educator, she sees each of her staff members “first as a person and who they are, rather than for what they can do for you.” After a recent job change outside of hospitals to a predominantly
male-oriented healthcare manufacturing environment, she feels the difference in culture between this and the predominantly female-oriented hospital where Gail spent much of her career. In her new, male-dominated environment, Gail works even harder at building relationships than she did before, in an effort to fit better into the new culture. To this end, she seeks to know her new boss and others on a deeper and more personal level, in hopes that they reciprocate. She goes out of her way to acknowledge and support her boss following the loss of a loved one, for example. She offers educational advice and coaching when appropriate. By strengthening their personal relationships, she hopes to strengthen their professional relationships.

Relationship-building is a skill set that is generally requisite for persons in management and leadership roles. It brings different challenges at different levels of leadership, especially for leaders who work directly with staff. Candy, a mid-level, non-secular leader, builds relationships with her staff “even when things are difficult.” She describes her open door policy and the challenges of meeting daily work demands with so many different personalities. She often counsels coworkers on interpersonal relationships to ensure harmony and social order in her nursing units. She places responsibility back on them and helps them solve their own problems rather than doing it for them. She believes this helps them to grow as professionals. She also does “rounding” on patients and staff to see that their needs are being met. This is part of her regular routine to build relationships. Candy is proud of her nursing departments, which score among the top in staff and patient satisfaction. Two other participants in the study recognize Candy for these positive relationship-building attributes.

Senior leaders who wield a large degree and scope of control also face relationship-building challenges unique to their level. With anywhere between 100 and several thousand employees, building relationships on a personal level with so many staff can be nearly
impossible. However, some leaders are very creative, such as Randy. At the top, Randy who
professes that he “loves people,” going far out of his way to connect with others and build
relationships with everyone he can. He tried hard to know more than a thousand people in his
hospital before he was elevated to a system leader with many more staff. He is saddened by the
loss of these personal relationships and reflects back on his hospital days, which were something
of a challenge. Randy claims that he “parked his car in a different place every day,” and went to
the cafeteria deliberately seeking out people outside of the other executives who normally
surround him. The cafe experience gave him an opportunity to talk with the cook or the
housekeeper about their vacations and families. Other leaders who know Randy are astonished at
his ability to recite the names of so many staff members and also know the status of their friends
and family. There is strong sense of loyalty between them. Randy’s colleague, Steve, talks of
their many social gatherings and parties over many years together with the leadership team and
physicians. Social functions were important means of creating a sense of family and
commitment, according to Steve. He and Randy both agree that personal relationships made their
organization strong. In the non-secular health system, Quinn builds relationships inside his
organization every day. He feels that his work and personal lives are one and the same. He
develops skills and relationships in his personal life that contribute to his work life, including
activities such as Bible studies with friends

**Honesty**

Eight participants cite honesty as an important moral value. Leaders at all levels are
concerned about honesty in their dealings with each other, as well as with supervisors or
subordinates and the patients they serve. Many stories about honesty and transparency emerged
from the interviews, although Iona provides particular insight into an employee she contemplated
letting go, and the resulting mutual benefit of being honest with her colleague in spite of how
difficult it was. Iona tolerated the passive-aggressive behaviors of an employee longer than she should have. She believed that the employee’s poor behavior was due to personal wounds from her past. Iona did not want to hurt her, thinking that she could “just love her into wholeness.” The person had a very different personality from Iona’s. When her efforts failed, Iona confronted her own fears by learning how to “speak the truth with grace, which is with great love, compassion, and respect.” She accepted that the outcome was not hers and that this individual would respond “with her own spiritual journey.” If she could “hold the tension for a while,” they would get through it. A year passed and “amazingly, we did” get through it, resolving the issue. From her perspective, Iona learned to be more honest and assertive, stating that “sometimes we are the teacher, at times we’re the student, at times it’s both.”

An experienced senior leader, Ellen, describes the importance of honesty from leaders in all they do, which is sometimes difficult. “I think leaders are so naive to think that staff don’t watch every move they make,” says senior leader Ellen. Genuine and honest leadership is expected by the staff, but also by board members and the patients whom they serve. Ellen recalls a few difficult situations over the course of her successful career in which patient outcomes were not what they should have been, and her honesty and integrity were at stake:

I think some of my most defining moments [in my career]…were some of the most difficult times, like when we had the suicide at the hospital and we have to admit we were somewhat gullible and having to, not having to, but apologizing to families when the outcome wasn’t what we had hoped it would be…I remember sitting around a table in the board room and [telling them about some] very sad and painful circumstances such as the nurse [who] was diverting the drugs for herself and that I had to admit it…. I think if I reflect on them now, at the time I was embarrassed and feeling like it was a sense of
failure, but now I feel like my tears were because I had a reflection now, I think a greater sense of spiritualness…the family in particular thank[ed] me for my honesty and my compassion.

Honesty is an attribute that spiritually grounded leaders possess, according to midlevel leader, Tony. He believes that helping patients to face their own situations honestly is an important part of the healing process:

I will never hand someone who is crying a Kleenex box because that’s about me that’s about my discomfort with your tears…verses you know, thank God you’re crying. Thank God you are finally being real. You’re being honest that this is really difficult. My goal is not to take the pain away, but to take you through the pain. That’s someone that I think is spiritually grounded uh, one that is spiritually intelligent.

As a leader, Tony is also compelled to educate the frontline supervisors in particular, who deal more directly with patients on the importance of honesty as part of spirituality.

**Mentoring and Coaching**

A third of the participants cited mentoring and coaching as an important moral value that builds upon the behaviors noted above. Candy focuses on mentoring “rather than fixing” the leaders who report to her. She keeps open a door leading into her office, and routinely offers advice to staff having relationship concerns with peers, or even in their personal lives. She provides guidance and support to a nurse who is recovering from alcoholism. She is confidential and supportive while she tracks her progress and honors her pride and dignity. She provides encouragement for work on self-development, and finds her own ways to meet her spiritual needs. Marge provides bidirectional mentoring, which occurs when she exposes her own vulnerabilities to her staff from time to time as a means of showing her humanity, and as a way to demonstrate how they may help themselves. When Marge helps her colleagues, they, in turn,
feel comfortable helping her when she is in need. Iona is “sometimes a student and sometimes a mentor,” as she helps her colleagues through personal challenges that affect their performance. Gail and Tony, at the midlevel of leadership in both secular and non-secular organizations, provide education and serve as ongoing coaches to all members of their organizations. They do so as part of their responsibility to help individuals grow personally and professionally, and to create a culture of excellence across the organization.

Alignment and Structure

In this subtheme, participants in both secular and non-secular healthcare systems seek alignment at all layers, especially the frontline. Top leaders intentionally structure their organizations in a way that keeps them informed at the frontline, where patients are served. This connects them—and all leaders and staff—to the mission and values which in turn, maintain the culture. Two subthemes include: leadership changes at the top affect alignment; and frontline leaders are the most important leaders in the chain of command.

In his role as a top leader, Randy notes that “on a daily basis [leaders are] having discussions and making decisions” at all levels—choices that must be consistent with the values of the organization. He feels it is important to stay informed by engaging with leaders at all levels in order to remain truly abreast of the lives of the patients. As Randy’s hospital grew over time into a thriving health system with a large number of employees, he expressed concerns about staying in tune with the people and what was happening on a daily basis with patients: “I need to touch and feel and see. I needed to know employee names.” Although Randy believes that a similar culture can be created in a variety of organization sizes, fewer employees created a span of control that allowed him to “be close to where the mission is made.”
Non-secular health system leader Quinn sees a flat-matrix structure as “more of an empowered versus hierarchical” organization, one that therefore allows more decision-making at the bottom of the typical pyramidal structure of most hospitals and health systems. His organization avoids rank-and-status subculture creation to the fullest degree possible. Senior leader Ben states that his non-secular hospital is not big on using titles such as vice president, preferring to use the term “director” to diminish the gap between entry-level employees and those at the top. “We are a flat organization,” says Ben. He and senior leader Quinn—like a senior leader in the secular realm, Randy—prefer to be close to frontline staff and to the patients, where the mission is realized. Quinn and Vicky stay close to newly-hired employees, meeting with them privately before they begin their jobs in order to reinforce organizational values and thank them for choosing their organization as a place of work.

**Top Leader Change May Disrupt Alignment**

Seven participants with a progression of leadership roles within different healthcare systems say that it is important that leaders align themselves with the mission and vision of the organization. They share unique insights that came in part from job changes that occurred following the retirement of a CEO or the merger/acquisition of their hospital or health system. As Louise rose from a staff position to a senior executive leadership position, she always “needed” to work in a place where the top leader’s values aligned with the mission and were authentic. When leaders change, the new leader’s values may differ from those of the existing culture. Senior leader Louise and frontline leader Patti have both experienced leadership changes from above, where their values no longer aligned with those of the new leader and the direction of the organization. The resulting organizational restructuring following a merger left them in situations where they had to defend their jobs and/or apply to different ones. Both survived short-term changes but later found that the new CEO’s values and beliefs were not consistent with
their own or those of the preceding culture. Discouraged, they left to seek employment in different healthcare systems that were a better match for their values.

Commenting on another merger between a secular and non-secular health system where she was employed, Farrah described a “mission advocate on the executive team.” The advocate’s job was to report to the Sisters regarding what mission activities were in place. In that situation, she felt that religious beliefs were forced upon her. Farrah’s voice raised and her posture stiffened as she spoke: “You know what it felt like? It felt like this organized religion as opposed to spiritual connectedness.” She went on to say that she is connected to the mission of the organization where she works now:

> I think it starts with being true to the mission. If there is a sense that the mission is just words on paper or words of convenience to substantiate the decision, then there’s this dissonance, even in a way of values conflict. And values are a part of my spiritual center.

Farrah also experienced a positive merger involving a non-sectarian health system led by a nun, and a secular system with a CEO who was “a very wonderful professional man.” The CEO was a spiritual person who predicted long beforehand that a merger would occur between these two top-performing organizations “They were two good cultures, but they were very different…there was no attempt to infuse the faith based principles onto the staff.” She perceived that the merge was a success, “but I don’t know that it was related to religion or nonsectarian.”

Gail talks about the role of middle leaders where “you are cascading [the mission] down to the next level.” She first refers to “the role model person,” whose values “start from the top and work their way down.” She believes that the person in the middle must share these values or else there is strong potential for internal conflict:
It starts to cause you to question whether or not the organization matches your beliefs and whether or not it’s going to be a conflict for you as an employee of that organization…if you are an individual leader who has values and beliefs that don’t necessarily align and you’re in that middle, it’s a pretty ugly place to be.

An alignment with values at the top permeates all layers of leadership. The leaders in the middle described many job changes, with some moving to healthcare-related industries outside of hospitals/health systems when a change of leaders above them altered the culture of the organization. Many middle and senior leaders also look to the frontline leader to align the values of the organization directly with those of the staff.

**Frontline Leaders**

Half of the participants acknowledged that frontline leaders are the most important layer of leadership. They referred to these leaders as individuals who “know” what is happening in an organization. While several top leaders expressed a desire to be close to staffs that interact with patients directly, participants in both organizations believe that the frontline leaders’ responsibilities are “where the rubber meets the road.” Frontline leaders are authentic, respected and highly regarded, according to mid-level non-secular leader Tony, who calls on frontline leaders when he needs information about what is going on inside the organization: “I have to be smart enough to ask.” Olivia is a frontline leader who believes spirituality can be present “even if the [upper] leadership doesn’t get it.” In contrast with mid-level leaders, she is not concerned about what goes on at the top. Olivia has many years of experience and is driven by a commitment to do her best to affect her patients directly and positively. She goes about her duties supervising staff, and finds her meaning and purpose by focusing on meeting the needs of the patient at the bedside. Olivia welcomes the opportunity to provide upper management with information about what is happening in her department, while admitting that it is “more difficult
and has more roadblocks” when superiors do not understand the needs of her staff or patients. Frontline leaders Patti and Henry also count on the authenticity and support of higher-level leaders to reinforce values and behaviors among the ranks.

**Accountability and Retaining the Right People**

The second theme is that accountability to defined values and retaining the right people are crucial to maintaining the culture of an organization. Leaders at all levels in both organizations recognize that beyond stating the organization’s values, they must hold themselves as well as others accountable for demonstrating the values in their behavior. Leaders intentionally work toward maintaining the culture using defined strategies. Four subthemes explain the strategies that demonstrate accountability on the part of leaders: accountability to standards of behavior for service, language, structured feedback, and adhering to hiring/termination practices with people who share values.

Both secular and non-secular organizations share similar values, which provide context and meaning for their missions and attract and retain certain people to their organizations. “Whether it’s a Catholic or a non-Catholic institution, it is what are the values you stand for that somehow differentiate you,” says Steve, a secular leader. He rhetorically asks how to “make the organization more than just a place to work,” and answers that what makes this difference are the values his organization lives by. Randy emphasizes the importance of identifying values and then challenges leaders to “prove that you mean it. You must convince employees…that the organization does in fact care.” He holds his leaders and himself accountable for the values and for demonstrating associated behaviors. Vicky seeks to inspire individuals to join her non-secular hospital for its values and deep religious-based roots. She jokingly offers that potential employees who are not a fit for her organization can “gladly go to the competition.”
Both organizations believe strongly that their own missions and values distinguish them from other competing organizations, indicating that while others may use the mission language, their people do not dramatize them through authentic, lived action. Louise, a senior leader in the secular organization, argues that pictures can demonstrate values as easily as the words found in written mission statements. She points to evocative photos lining the hallways of clients being served by her more recent employer, a non-hospital healthcare organization. The emotions on the faces of caregivers as well as recipients in the photos are effective at communicating the intent of the mission without words, just as Louise had expressed. Louise credits the insights of her CEO for setting the tone through pictures.

**Standards of Behaviors**

More than two thirds of participants (15) believe that holding themselves and colleagues accountable to their organizations’ standards of behaviors helps to reinforce their organizational values. Both health systems have similar values and service standards of behavior that provide clear accountability for individual performance. The written values that emanate from the mission include such things as respect, care, compassion, joy, excellence, and competence. For each value, standards of behavior are written to explain what the value means and how it can be seen in work performance. Employees in both organizations are provided with copies of the values and several specific behaviors that relate to each of the values. The behaviors are stated in a way that employees can relate to. For example, to demonstrate the value “care,” some of the standard of behaviors include: “I will greet people with a smile,” and “I will follow safety standards,” and at the non-secular hospital in particular, “I will have awareness and sensitivity to cultural and religious beliefs that differ from my own.” In another example, the value “respect” has several interpretations for behavior, such as, “In every interaction I bring positive energy by acknowledging the patient, introducing myself, providing explanations, setting expectations and
thanking them.” The descriptions of appropriate behaviors help staff know what their leaders expect of them when they serve patients and each other. Both organizations agree that when values are transmuted into actionable behaviors, it is easier to hold individuals accountable to them. They are considered part of employee performance appraisals.

Lay leader Quinn refers to the behavior standards as a guide for mission integration in their non-secular hospital. Vicky relates how proud she is of their successful model inspired by their founding patron saint: “It is all about building relationships. It’s about the values. It’s about the mission.” They pay attention to everyone, holding all employees—“including the leaders and including the colleagues”—accountable by conveying from the beginning that more is required of staff than simply being technically competent. Senior secular leader, Farrah, follows a similar practice and feels as strongly about her organization’s values and performance standards:

But what I did tell my perspective candidates for positions was, “this is what our culture is here and we embrace this culture, we believe we are striving for excellence. Now that’s clinical excellence, but we are doing so in a way that our patients and their families love us and it feels wonderful to be working in a place like that because that’s very synergistic and we measure this. We measure it by patient satisfaction surveys and you need to know that your job performance is about not just doing your job well clinically, but being in this culture and embracing it. And if you can’t commit to that you’re not going to be in the right position here and the first people who will bring this to your attention will not be your supervisor, it will be your coworkers. They will let you know that this is not how we work here, how we treat each other, how we treat patients, how we treat families; so you need to know that up front.
In the secular hospital, midlevel leader Nancy’s staff successfully modeled the behavioral standard “care” by demonstrating the practice of “presence.” Some of her colleagues needed help, according to Nancy; they inquired of her, “So, what does presence really look like?” To answer this question, Nancy had chairs placed at a patient’s bedside for staff to sit in briefly, where they could connect with the patient and offer her non-judgmental listening. Her team created pocket reference cards on which they recorded the actions that demonstrated “presence.” Nancy was delighted when others caught on, including some of the doctors, and replicated the behavior. In her work as a mid-level executive, Nancy uses many of the tools she discovered in the RISEN program to help others understand how values can translate into actionable behavior.

**Spirit Language**

Five of the fifteen participants within the secular health system believe that overtly using the word “spirit” as part of the values proposition helps people to learn its meaning and gives them confidence to speak openly about spirituality. In the secular healthcare system, caretakers registered concerns about their patient satisfaction survey scores, data that suggested the hospital had not been meeting patients’ spiritual needs for some time. When the systematic review showed their performance for “meeting patients’ spiritual needs” was below expectations, a group of formal and informal leaders consisting of direct care and indirect care managers, staff, and executives from a cross section of the broad healthcare system—not just the hospital—formed to take action. Together they established a pilot program using the acronym SPIRIT with related spiritual standards of behavior, as the basis for an educational campaign aimed at improving patients’ spiritual experience while hospitalized. They added the SPIRIT acronym to the longstanding values proposition, at least temporarily, that had been in place at the health system for at least two decades. If the pilot were successful, they would consider the word “spirit” as a permanent addition to the values proposition. The SPIRIT steering committee
created many strategies and tactics, including a video and several presentations aimed at helping members of the organization understand why the pilot project would improve the patient experience. “This isn’t something that you can just say ‘Great! Let’s bring in the magic bullet and spirit happens.’ It requires a tenacious attitude by the leader of the department,” says executive sponsor of the project, Farrah. Gail, Marge, Louise and Henry were strong advocates of the pilot project designed to expand the dialogue about spirituality. They hoped the pilot project would increase understanding of spirituality, help staff distinguish it from religion, and reduce fears and anxiety about the topic. Making it “safe to talk about” was important to staff, and once they understood it better and received clearance from leaders to discuss it, they vigorously engaged in numerous activities to aid patients’ spiritual experience. It was well-received by staff engaged in the pilot.

Over the six-month study, patients’ satisfaction with meeting their spiritual needs improved in the two-patient care departments involved and stayed about the same in the indirect care unit. The SPIRIT pilot program began to help the secular staff embrace not only the term spirit in their interactions with patients and each other, but also helped them understand and demonstrate associated spiritual behaviors. Once staff understood this, they may have felt more comfortable using the language in a safe manner, and they were able to have spiritual conversations with patients and one another. The program aided in a number of ways, but for the most part, it gave staff permission to use the language openly. In some cases it allayed the fears of staff who felt they might infringe on individuals’ religious beliefs. While the pilot was deemed successful, the pursuit was suspended for other reasons and “spirit” was not added to the values proposition.
From the perspective of the non-secular hospital, spiritual language is not overt and not stated directly in their values statements or standards of behavior, either. However, spiritual language is present in general communications and in artifacts of the organization. Vicky and Quinn point to the obvious fact that people who choose to work at their hospital are often attracted by its religious foundation. They likely anticipate intuitively and openly talking about religion or spirituality. The organization is also careful to convey the fact that religious discrimination is not acceptable, and they protect patients against religious practices that might be offensive. Quinn describes taking down a cross in a patient room to respect a non-Christian patient’s wishes, for example. In Ben’s non-secular hospital (in the same health system), the daily inspirational message paged overhead for all patients and staff is based on organizational values of their patron saint, not their stated religion. These brief, 60-second daily messages are spiritual in nature and cause for reflection and conversation.

**Structured Feedback**

Eleven participants report routinely obtaining structured feedback through the practice of “rounding.” Rounding is a structured practice routinely used by leaders in both organizations, whereby leaders systematically (rather than randomly) circulate across the entire organization feedback from staff and patients. They do so using structured questions on important matters to the organization and then acting upon them. This intentional process involves relationship-building with staff and patients, observes behaviors and conditions in the environment, attempts to resolve concerns, and provides opportunities for reward or recognition of individuals for their performance. Leaders hold themselves accountable for the frequency and questions used for rounding. Questions asked may include such things as, “Are there any tools or support you need to do your job better?” or “Is there anyone you would like me to recognize for their work?” or “Do you have any recommendations to make a safer or higher-quality experience for our
patients?” When rounding is completed, follow-up occurs, and reports are compiled to demonstrate that appropriate actions are taken by leaders to improve the work experience and relationships among leaders, staff, and patients. Participants in both organizations use rounding or structured feedback as a method of leadership accountability and formal strategy for relationship-building.

Quinn describes how, at his non-secular hospital, senior leaders round a prescribed number of times each month. Senior executives choose topics for rounding each month that focus on mission-integration strategies. Hospital executive reports are forwarded to health system leaders to demonstrate efforts toward embedding values and continual improvement. Rounding occurs at the secular health system as well at all levels, and is assigned to leaders at specific times of each day or in specific departments. Leaders, in turn, report findings and actionable items to superiors to let them know that their leaders are engaged with staff and meeting their needs. Henry reviews the results of the secular hospital’s patient satisfaction surveys to help leaders focus rounding questions on important matters. Questions leaders might address while rounding include such things as how well patients perceive their pain is managed, or how well they perceive their nurses and doctors treat them while they are in the hospital. The resulting rounding reports that are accumulated and compiled establish a dialogue about what is and is not working, and provide opportunities for leaders to offer assistance and together make improvements. He believes that this practice helps to build relationships between and among all parties involved, and reflects the authenticity of leaders. When Nancy rounds and makes positive findings, such as from an appreciative patient, she offers praise and recognition to staff involved with verbal and written thank-you notes. When she makes negative findings during her rounds, such as a dysfunctional piece of equipment, she helps staff find solutions. Although rounding is a
deliberate and intentional method to validate values, Quinn, Nancy, Candy and others find personal joy in connecting with patients and staff during the process of rounding.

**Hiring/Termination Practices**

Hiring people with congruent values while also releasing those whose values are incongruent is critical to sustaining the culture, according to 10 participants. Both secular and non-secular leaders have specific practices for hiring “the right people” who share the organization’s values. They believe that hiring people who share their values will result in a better fit for the organization and the staff member in the long term. Although this “fit” is difficult to determine in the interview process, according to Vicky, those applicants who don’t share their values are not hired. Once hired, new employees are held accountable for demonstrating appropriate behaviors. Performance reviews are done regularly for all employees. If they do not continuously strive to meet the values and standards of behaviors expected of them, they are released from employment. Participants from both organizations believe this discipline is necessary to maintain and perpetuate the cultural values desired.

Gail, a secular mid-level leader, recalls putting the new hiring process in place at her health system. When the organization began developing hiring criteria using Erie Chapman’s Radical Loving Care model based on the individual’s values, she was encouraged and believed it would be successful. Using the new values-based criteria, the candidates’ personal values were given as much weight as years of experience: “[T]hey hired for it and they fired for it,” she says. Gail believes that values are just as important as critical thinking and clinical experience, and that employees lacking the shared values could be harmful: “The night nurse with 27 years of experience could be your worst patient advocate.” Gail believes that “one person represents the whole. So when folks used to start I used to say, ‘From this point forward you are [the health system], and what you do could be described as what all of us do.’”
Ellen has a long career, with experience ranging from staff nurse to executive leader in her secular organization. She stresses the importance of hiring the right people with shared values, noting that you can identify and teach technical skills, but “[y]ou can’t teach people to care.” Quinn believes that articulating the values and using them as criteria for recruitment helps new employees in his non-secular hospital know what will be expected of them. To this end, he personally meets with every new colleague hired to reinforce the organization’s values while demonstrating his authentic interest in their person. He expects all of his colleagues to “reveal and embody” the core values. To that end he must hire people who agree with that philosophy. On the other hand, Patti, who has worked in both secular and non-secular hospitals, realizes that insisting on the same values may be presumptuous. Reminiscing on being hired into the organization that asked about her values, she says, “Did I drink the Kool-Aid? Yes. But it was the right Kool-Aid.” She is grateful that the organization gave her a chance to prove herself.

Eight participants noted that when the individual hired proves ultimately to be not a good match for the culture—due to “values dissonance” or other reasons—the leader helps move them out of the organization. Farrah described a previous workplace where she experienced values dissonance with the leaders of her organization. It was compromising for her and she was compelled to leave the organization. Terminating an employee for differences in values can be very difficult. Gail describes the importance of doing so in a caring way with the best interests of the individual in mind. She describes past employees whom she helped exit her department. They later thanked her for helping them to a better place in their life’s journey. She did not judge them as bad people, but believed that they were not happy in the job role or environment and would find inner peace in another setting. Because of the loving manner in which she helped these people transition, they continue to be friends today. Ursala is in a position where she is
now able to help employees who don’t fit the culture to find other alternatives for work. She and Vicky encourage some unhappy people to find their meaning and purpose in other environments that may be outside of healthcare.

**Shared Responsibility for Spirituality**

The third theme, meeting patients’ spiritual needs, is shared by direct and indirect caregivers and is strongly associated with “presence.” Whether working directly with a patient or indirectly in a supportive role, participants believe that all members of their organizations, regardless of occupation, share in the responsibility to provide spiritual care. Three subthemes include: demonstrating “presence” with patients is an important spiritual behavior seen in housekeepers and nurses; pastoral care professionals have a significant but not universal role in a spiritual culture; and physicians play a limited role in meeting hospitalized patients’ spiritual needs.

Participants unanimously agree without hesitation that every person in their organization has a role in spirituality. They do not distinguish by profession, even if far removed from patient care. Wanda, who leads direct caregivers, believes that the spirit is unpredictable and that all healthcare direct and non-direct workers may have some impact. “You never know when the spirit speaks. It can be with the person delivering the tray versus the person drawing blood versus the person cleaning the room.” Vicky believes that everybody impacts the patient, whether in the business office, administration, nursing, or plant operations: “We are equal and expect the same thing from every colleague.” Quinn states the shared responsibility most eloquently from his view at the top:
Fundamentally we have the same job…we are here to serve our patients through the people who report to us. We are here to represent the mission and inspire people that their work does make a difference in the context of this mission.

In another instance, Ursala, an indirect caregiver who works with all staff, says, “If you are not caring for the patient, you are caring for someone who is caring for the patient.” Farrah believes that people go into healthcare, whether they are clinical or not, for the same reason: “Most people tell me, if they are in marketing or wherever they want to be, they want a sense of purpose and they want to know they are helping people, even though they are not a direct caregiver.”

Gail sees the roles of all members of the organization as spiritual. She believes that the mission is “carried out by each person in some way, shape, or form to eventually touch the people that we serve. I think the essence of the RISEN program [brought] people to another [level].” Helping people understand this connection can be a challenge for the non-direct caregivers. The SPIRIT pilot project offered by the secular hospital included non-direct caregivers in order to determine whether there may be a difference. The central registry department was chosen to participate in the pilot. Six participants, who were members of that project team, found ways to help these staff members understand how to connect with patients and uniquely serve their spiritual needs. Registry staff who make doctor appointments for patients who phone into their call center had opportunities to demonstrate spiritual values but needed some guidance. The standards of behavior created to demonstrate spiritual values were applied. Registration clerks were asked to answer phones with the following behaviors in mind as they spoke with patients: inquire with love; practice presence by being patient and listening, even when patients are upset; stop and focus with kindness to every patient, even if the caller
before was challenging. The staff applied these techniques during the course of the six months of the pilot study. While some found the guidance helpful, the department scores for improving patient satisfaction remained nearly the same. Despite this, participants who analyzed results believe improvement opportunities were still possible. Moreover, they feel that registration clerks and other non-direct caregivers who are not at patients’ bedsides are able to connect spiritually with these patients.

Presence

Slightly more than half of the participants believe that all non-direct and direct caregivers share responsibility for spirituality in the culture, with the practice of “presence” as the most frequently cited means of providing this. While all organizational members are responsible, housekeepers, who are non-direct caregivers, are cited most often, followed by nurses as direct caregivers. Even nurses, who are generally trained to some degree in spiritual practices, may need help in being present for their patients. Nancy talked to the nurses about what they were thinking about the behaviors that demonstrate presence to patients. They had decided to sit in the chairs located at the patient’s bedside, if even for a moment, to relate to the patient. She then realized,

We didn’t have chairs in the rooms to sit down. So we literally bought folding chairs and attached a hook behind every door…What was amazing to me is the doctors caught on to that too… you would actually see [people in] other disciplines [use the chairs as well]!

Nancy and her staff found that by role-modeling presence themselves, they were able to influence others to do the same. Teaching others this technique as one of many ways of being “present” helped many professionals to become comfortable with the concept and to be more effective in serving patients’ spiritual needs.
**non-direct caregivers: housekeepers.**

Eleven participants from all levels and both healthcare systems told stories of non-direct caregivers, specifically housekeepers, who positively affect patients’ spirituality by virtue of connecting intentionally and non-judgmentally with them. As non-direct caregivers, housekeepers contribute to the spirituality of patients by virtue of connections they make with these patients, and by focusing on what might be important to each individual rather than focusing on the patient’s illness. Housekeepers’ physical presence as they go about performing cleaning tasks in patients’ rooms offers that opportunity. Participants cite housekeepers doing kind acts for them, regardless of whether they realize their role in spirituality.

Louise who tells the story of the housekeeper who, of her own accord, brought country music CDs from her personal collection to play in the patient’s room as a measure of comfort. The housekeeper found a personal connection with this patient and performed this deed out of the goodness of her heart. Another story was told of a housekeeper who brought peace to a dying patient by singing to her in an unconscious state in her final days. The patient’s family was extremely appreciative, to the surprise of the manager who had judged her actions as inappropriate. Both Louise and Ellen, who were at one time staff nurses, value housekeepers beyond their traditional roles. They see the latter as partners of the nursing care “team,” even though they have no official role or responsibility assigned to them for direct caregiving. Louise told a story of another housekeeper who shared observations she had made about the patient’s medical condition with the responsible nurse. As she cleaned a room of a patient she had come to know, she observed a noticeable change in her skin color. Although not a job requirement, by immediately reporting the change of the patient’s condition the housekeeper made an important medical contribution that helped the responsible nurse deliver better patient care. Olivia believes
that housekeepers can sometimes have a bigger impact on patients’ spirituality because they are spending more time with the patients than the nurses:

    The nurse comes in and drops off, ‘Here’s your pills, here’s your this,’ and I have to go be with four more patients down the row!’ Housekeeping comes in and they are mopping and they are taking the time and ask, you know, ‘Geez, what channel are you watching today?’…they actually have a bigger time span in which spirituality could potentially be raised.

    Although positive contributions to spirituality by housekeepers are described often, senior leader Darla is concerned about the judgmental attitude by some staff who view housekeepers as less important caregivers. She believes that hospital cultures where many professionals have status by virtue of advanced degrees are a contributing factor. Regardless of degrees, housekeepers who are non-direct caregivers are seen as important assets in providing spiritual care, regardless of whether or not they realize their significance.

  **direct caregivers: nurses.**

    Seven participants credit nurses as the most important team members and as the determinants of spiritual care, primarily by virtue of being “present” in their work. Nurses function as the largest occupational subculture in a hospital, and have the primary responsibility for providing direct patient care. Senior executives in both healthcare systems see nurses as “the gate,” and thus the most important care team members present with patients in the hospital around the clock every day. According to Randy, “they’re responsible for the way in which we are judged.” How nurses exhibit spiritual values, especially presence, in their professional practice at the bedside, is extremely important to participants. Louise recalls a situation when she was a young nurse caring for a dying young patient. As she tried and failed to be present in a
professional manner for the young woman dying of cancer, she in turn felt that the patient was present for her, as was her colleague, both of whom helped her as a caregiver to cope with this tragedy. “Isn’t that an amazing story?” she says. The frontline leader/nurse working in radiology, Olivia, was present when she respected the wishes of a patient to “be in a better place than here,” and demanded that imaging staffs refrain from resuscitating him. While participants would like nurses to be present for their patients, Vicky and Ellen are distressed by the demands that electronic health records charting makes on their time: they believe the records charting detracts from their ability to be present for the patients. Nurses “don’t take the necessary time to be present for patients, for each other.” Vicky keeps a graduation photo of herself as a young nurse wearing a traditional cap proudly on display behind her. She indicates that she would like to see the nurses she supervises today take more time to assist patients at the bedside, as they did when she began her career and there were fewer documentation and technology demands. When they recently launched a new computer system at her hospital, a patient’s husband remarked that “the nurse took care of the computer, not my wife.” Rather than multi-tasking, Vicky believes that simply being present for and more attentive to patients and colleagues would make a significant difference.

Pastoral Care Distinct Role

Eleven participants state that pastoral care colleagues have a significant role in the direct provision of spiritual care; however, they do not view them as universally responsible for spirituality in the organization. John and Ben are both professionally trained ministers, leaders who do not directly provide pastoral care services. Both broadly view the field as important professionals in their own right. They serve, too, as adjuncts to the religious leaders who provide direct spiritual counsel to help meet the patients’ and family members’ spiritual needs.
Moreover, they provide spiritual care for colleagues. While this is true especially in times of great spiritual distress, they would agree that spirituality is the responsibility of every person in the organization. As a mission leader in the non-secular health system with the pastoral care department reporting directly to him, Ben deeply understands their distinct role in not only caring for patients, but facilitating and supporting the spread of spirituality among colleagues as part of the organizations’ mission and culture. Whether helping colleagues traumatized by the loss of a patient or helping them cope with a stressful work situation or home life, he believes pastoral care professionals are an important asset to delivering holistic care of the “mind, body and spirit.”

Quinn posits that pastoral care members at his hospital play an important role as “mission leaders,” thereby sharing common tasks with spiritual leaders, although they do not carry quite the same status. In his non-secular hospital, lay chaplains are slowly replacing members of their religious order in providing direct counseling to patients and family members in the greatest of spiritual distress. Their service includes, for example, family care following a tragic death, or visitation with patients who are frightened about the spiritual consequences of their illness. The trained chaplains or lay ministers who are not assigned the additional responsibility of serving specific mission leader roles are not generally in leadership roles. As staff members rather than leaders who manage others, chaplains may influence but are not charged with the responsibility of embedding the culture with spiritual values. It is the appointed leadership who is responsible for “creat[ing] the culture that supports the behaviors you want.”

Physicians’ Role

Physicians play a specific yet limited role in meeting hospitalized patients’ spiritual needs. Five participants identified physicians as contributors to spiritual care, with another three
participants who portray physicians as not engaged. This compares to research that indicates that a majority of patients want their physician to provide spiritual care when they are ill (Koenig, 2005; Williams et al., 2011). Participants have differing views about physicians’ roles. Ellen, a member of a senior executive team, views them as vital contributors to spiritual care: “I think our physicians are perceived by our customers as part of our continuum [of care], so for them not to be on board from a spiritual perspective would be a detriment to what we are trying to provide.”

Ellen and other leaders in her secular hospital engaged their physicians’ leadership in creating the organization’s values and mission. A small group of them actively promotes holistic, mind-body-spirit concepts that are often considered “alternative medicine” approaches to care. One of the group’s key leaders is a young physician whose father promoted holistic medicine years ago. The second-generation physician leader spearheaded the effort in close association with executive leadership, providing education for their very large medical staff regarding physicians’ role in spiritual healing. As an extremely spiritual and religious person herself, Ellen holds her physicians in high regard and also holds them accountable to their organization’s mission and service values. Participants recognize that hospitals cannot function without the critical resource of physicians, yet several secular leaders defer primarily to nurses rather than physicians as the most valuable professional resource in the hospital when it comes to meeting patients’ spiritual needs.

Participants in the non-sectarian hospital highly value and respect their physicians, identifying a few specific doctors whose spiritual leadership inspires them. However, they describe the lack of time available for physicians to engage with patients and families as they go about the business of assessing patient status and writing orders for other professionals to deliver care, i.e. nurses, laboratory and imaging technicians. All the while, spiritual matters are being
“managed” by well-run pastoral care professional programs assigned with such responsibilities as blessing and praying with patients and their families.

While physicians generally focus on the more technical aspects of providing care, this does not negate the possibility that they may “be on board from a spiritual perspective,” as noted by both secular and non-secular participants, who point out pockets of physicians with spiritual inclinations. Physicians may be interested in meeting patients’ needs, but may also be limited in their capacity to do so, due to their actual role and function that does not allow them much time for interacting directly with patients.

**Investment in the Spiritual Development of Individuals**

The fourth theme arising is that that both secular and non-secular participants believe that intentionally invested resources in the spiritual development of individuals positively impacted the organization’s culture. Two subthemes emerged: that the RISEN (ReInvesting Spirituality and Ethics in our Networks) program helped participants to grow personally and professionally, and helped to differentiate religion from spirituality; and that top leaders commit to a learning culture and individual empowerment for spiritually congruent work lives.

Participants at all levels in both organizations who participated in the RISEN program described it as a positive experience for themselves and the staff who attended. Alberta, a midlevel leader in a non-secular hospital, strives to be the best person and best leader she can be. She believes that her leadership role centers on helping others along their personal journeys in life. Alberta states:

So I really see that essentially our mission is to see the good, see His presence in other people around us. So that is why I have always tried in my roles in healthcare leadership to see the good in everyone and realize that wherever people are they are on a path to get
where they should be. It may not be where they are, but if we can help them get to where they are destined to be or want to be or aspire to be, it is better for everybody. It is part of who the person is.

Alberta is among several participants who were enthusiastic about the RISEN learning experience. In response to the question of whether or not the RISEN experience had an impact, Nancy, a midlevel secular leader stated enthusiastically, “Definitely! Yes. I thought I knew the answers. I really didn’t. It just really intrigued me to learn more and be more attentive to people in general and understand where people are coming from.” She learned through RISEN that as a leader, she did not always have to have the answers. Like many others who participated in the program, she uses the tools it provided her and the knowledge she gleaned from it. She gained a better understanding of others through reflection, asking better questions, or by simply being quiet and listening. Ursala, a frontline non-secular leader, is another enthusiast who continually strives to improve and enhance her connectedness with her higher power by many means. When asked about her interest in RISEN, she relished the opportunity for personal development. Ursala already had a strong spiritual base and felt that the RISEN training helped her grow even more:

It was a calling for one thing. It was like a tap on the shoulder, ‘Hey! This would be a really good thing to explore.’ I have always had my antennas up for self-development opportunities and I saw this as one that would be worth going to. And it was tenfold more than worth going to.

Gail had a strong spiritual foundation, however she was not as enthusiastic and was among a few initial skeptics of the program. In the beginning Gail felt she already understood spirituality. “So why on earth do I need to go to a class?” she wondered. After the training, she claimed that RISEN “reinforce(d) the idea of the individual in the story and [provided] a
reminder that everyone is different and that our experiences cause us to be at different places.” Olivia, a frontline leader for direct care staff, reported one member who did not want to attend, but did so anyway: “From the first day on she was negative about coming and was not sure she should be here. Then, when it opened up to her, she was so happy [that] she came!” The staff member felt that meeting away from her daily work environment provided a sense of safety and security in which to discuss issues openly.

Candy and four others not only participated in the program, which they found to be beneficial, but also became mentors for other staff members who participated in RISEN. As mentors, they met regularly with their mentees over a six month period of time to help them put into practice the skills they had learned in the RISEN program. They reported that meditation, presence, and self-reflection were among the subjects taught in the classroom that applied both to their home lives and work environments. Patti was among many who said they experienced personal growth as a result of the RISEN program. She was particularly grateful for the social skills she learned from her involvement. Leaders at all levels, and staff who participated, benefited in many unique ways from the RISEN program.

**Differentiating Religion from Spirituality**

Seven participants from a mix both organizations believe that the RISEN program experience helped them to understand the difference between religion and spirituality, which made them more effective leaders. Although participants had many different professional and personal backgrounds and training, and were at very different points in their personal spiritual development, most of the participants were excited to attend when the RISEN program became available to them.

Wanda, a frontline leader in the non-secular health system, works part-time in her leadership role and part-time at her local church, helping to lead educational services and doing
other volunteer work. She comes from a family steeped in the Catholic tradition with several family members in the vocation including an aunt who is a nun. Wanda needed no convincing. She “was thrilled to attend,” and greatly appreciated the added benefit of being away from the work environment, where she experienced a very special retreat center with a warm ambience. The time away from the challenges of her daily work and the offsite location provided her with a sense of safety and security in which to discuss issues openly. This kind of educational opportunity is rare for Wanda and for the frontline hourly workers she supervises. Even though Wanda felt well-grounded spiritually before attending, the program made her an even better leader and advocate. Middle and frontline leaders in the secular healthcare system, Nancy, Patti, and Gail felt they had a strong sense of spirituality going into the program. After the educational experience, they all felt they could better articulate the differences between spirituality and religion, and had more confidence in leading others on their spiritual journeys.

**Top Leaders Role in Training**

Top leaders influence the spiritual development of individuals and the organization by providing spiritual resources and empowering individuals to participate in them. While only five of the ten senior executives fully participated in RISEN training themselves, those who did not relied upon recommendations they received from trusted senior executive colleagues about the program’s value to the organization. All top leaders support and endorse the program for its impact on individuals and the culture at large.

Top leaders endorsed the program based on a belief that its values matched their culture and needs for spiritual development. When asked whether he supported RISEN as a good strategy for educating others, Randy, CEO of the secular health system, credited the leader of the nursing division in his hospital; she advocated and convinced him of the program’s worth. “I had implicit faith in my team,” said Randy. She championed the idea for the organization with a
business case he could not deny. Although he did not personally attend the training, he lent his full support. He stayed abreast of feedback and learned that the nursing leader and many other staff who attended were “extremely pleased.” The top two leaders in the non-secular organization who chose not to participate in the RISEN training felt they adequately understood the approach and materials due to their own formal ministerial training. They fully supported making it available to their colleagues and participated in some of the activities as time permitted.

While leader training was required for midlevel and frontline leaders, it was optional for staff at the frontline of the organization. This was based on the premise that leaders needed to fully understand and model the desired behavior in order for the training to be successfully implemented. RISEN training was available, but not required for all other staff to participate as they desired. The leaders who attended provided encouragement, as appropriate. The positive personal experiences and enthusiasm had an influence on the decision of others to participate.

*investment in individuals.*

Five participants were impressed by top leaders’ commitment of financial resources for personal growth and development of individuals. According to these participants, the wages paid for the hours spent at RISEN retreat sessions alone go well beyond training opportunities typically provided for specific technical skills by their healthcare organizations. Senior leaders of both the secular and non-secular institutions like Ellen and Quinn, who are responsible for large staffs, budgets and training programs, were themselves impressed that their top leadership would approve, calling the training “a gift” for those who choose to partake. Given the considerable expense for mandatory training to meet federal regulations and standards, as well as to maintain essential clinical skills by staff, providing optional training funds dedicated to personal
development is not customary in most hospitals. Marge and Darla, also senior executives, described the RISEN program as “an investment in people” that goes beyond technical skill development. Gail, a midlevel proponent, states, “The value part was investing in the care and nurturing the spirit of the people [whom] we expect to care for and to nurture other people.” Participants recognize the extraordinary organizational commitment for personal spiritual growth, and are pleased for the opportunity not only for themselves, but others in their organization.

other investments.

In addition to RISEN, healthcare leaders in both organizations committed resources to other types of training and strategies intended to broadly enhance the development of a spiritual culture. In the non-secular system, participants frequently referred to numerous mission-integration strategies that are systematically cascaded throughout the health system such as retreats, orientation, and training options. Senior leader Darla was responsible for leading a team of colleagues from across the secular healthcare system in creating a strategic community work plan with new strategies for enhancing their culture spiritually. Many layered learning strategies were deployed “in a systemic way” including the spirit pilot program, and RISEN, which had been in place a few years. There were, moreover, other optional and mandatory trainings designed to engage and empower people at all levels of the organization. Other tools, such as Samueli Institute, patient advisory councils, holistic medical practices, and more were part of the strategic plan to educate and expand knowledge and build upon the spiritual culture of the organization.
Summary

An overall finding was that healthcare leaders play a significant role in meeting patients’ spiritual needs. They influence the values of the organization and the development of a culture where spirituality can flourish. The four themes emerging from the data indicate that the experience of the multidisciplinary health system leader has an impact on an organization’s success or failure at meeting patients’ spiritual needs in multiple ways.

First, the top leaders’ spiritual beliefs and moral characteristics embody the culture of the organization, while leaders at all levels align with them. Marker events that affected each organization in midlife resulted in the establishment or reestablishment of values by the top leaders. Three attributes are significant to the leader’s personal spiritual development. These include implicit beliefs, an inward nature, and the need to replenish spiritual reserves. Moral characteristics are observable, including trust, presence, relationship-building, honesty, and mentoring/coaching. The leaders and the structure of the organization are directly aligned in their values and actions in a way that allows spirituality to be embedded in the culture.

Second, participants hold themselves and others accountable to defined values and behaviors and hire/retain staffs whose values are congruent with those of the leader. They enforce accountability for standards of behavior for service, they have a structured process for feedback from staff and patients, and they adhere to similar hiring/termination practices.

Third, participants indicate that meeting patients’ spiritual needs is a result of actions by both direct and indirect caregivers, and is strongly associated with “presence”. The training experience helped some participants to differentiate religion from spirituality. The top leaders have a significant influence on training, which requires a commitment of resources for individual and broad cultural development.
Fourth, participants believe that intentionally investing resources in spiritual education positively affects individuals’ spiritual growth personally and professionally, and promotes an organizational culture of spirituality. The RISEN program positively impacted participants’ personal and professional growth and helped to differentiate religion from spirituality. Finally, top leaders are committed to learning from and empowering individuals who impact the spiritual culture.

CHAPTER FIVE: ANALYSIS

Introduction

In the previous chapter I presented the findings of interviews with 22 multidisciplinary healthcare leaders from all levels of leadership, inquiring about their experiences in meeting patients’ spiritual needs. The intent of this current chapter is to analyze and make meaning of these findings. The leaders’ responses are grouped according to how this knowledge can be used to affect spirituality for patients in a healthcare setting. I present the results of these analyses through the lenses of various theories: Fowler’s Theory of Faith Development (1989); Kohlberg’s Theory of Moral Development (1989); Thompson’s Congruent Life Theory (2000); Schein’s Theory of Organizational Culture (2010); and Fisher and Torbert’s Developmental Model of Work and Leadership (1995). I also compare the findings to research described in the literature. Overall, I attempt to discover why the findings occurred and what others can learn from this study. The following expands on each of the four findings with participants’ comments.

I arrived at the four findings through the prevalence and strength of responses within participant interviews and across participant responses. The findings identified in the data were:
1) that the top leaders’ personal spiritual development and moral characteristics embody the culture of the organization, and leaders at all levels align with them; 2) that leaders hold themselves and others accountable to defined values and behaviors, and retain people with congruent values and behaviors to maintain the culture; 3) that nurses and pastoral care professionals are direct caregivers primarily responsible for providing spiritual care for hospitalized patients, however, indirect caregivers such as housekeepers have a role as well, predominantly through their presence (alternatively, physicians have a limited role in meeting hospitalized patients’ spiritual needs); and 4) intentionally investing organizational resources in spiritual awareness and development for staff positively affects the spiritual growth of individuals and helps engender a culture of spirituality.

The Flavor of the Sundae Starts at the Top

The first finding is that the top leaders’ personal spiritual development and moral characteristics embody the culture of the organization, and leaders at all levels align with them. “I like to think that the flavor of the sundae starts at the top,” says Louise. She and other participants place great significance on the role of the top leaders in establishing the values of their respective organizations. In the context of Schein’s (2010) theory of organizational culture and leadership and his views on organizations’ founders and alignment of other leaders, I reviewed the separate and distinct marker events that occurred at the mid-life of both the secular and the non-secular health systems. I, moreover, examine the resulting actions the top leaders took to reaffirm their organizations’ missions and values and align the organizational structure. Following Thompson’s (2000) theory of a congruent life where leaders’ personal and work lives are grounded in spirituality, I consider the process by which the spiritual development and moral characteristics of top leaders are revealed and embodied and sustain a culture of spirituality.
These two hospital/healthcare systems, which grew from similar origins, reached a level of maturity, or “midlife,” where each faced a critical event that marked the need for change in leadership practices. Schein’s (2010) theory describes midlife events that mark a turning point in the lives of organizations. Such events may be, for example, transitions from founders to the next generation of leaders, as noted by the non-secular organization losing its religious leaders, or other critical events that challenge an organization’s values, such as the abortion issue that challenged the top leader in the secular organization. According to Schein (2010), when a change occurs with top leadership, the cultural values and processes that have become embedded in the organization may be forced into the open for reconsideration. An important stage in the transition to new leadership is the re-establishing of what the organizational culture is and what it is doing for the organization, regardless of how it came to be (Schein, 2010, p. 281). In the literature, Chapman (2009) believes that the commitment of the healthcare CEO is the single most important element in creating a culture of caring in hospitals. The leader serves as its moral compass, earning the trust of the people, empowering them to be their best, and modeling ideal behaviors themselves. The cultures of organizations are established through founders’ and leaders’ actions (Schein, 2010). Leaders, like the religious founders and the top leader of the secular hospital, must decide which elements of the organization need to be changed, preserved, or integrated in order to maintain the cultural mission and values. Unique marker events that occur during the midlives of each of these healthcare organizations caused them to respond in ways that reinforced the values of the top leaders.

The marker event at the midlife of the secular organization was apparent when the relatively new CEO faced a significant values conflict among the physicians and staff, one that challenged the core values embedded in the longstanding culture:
If I had to cite challenges to the organizational ethic, probably the most dramatic, and it remains the most dramatic for us as a society, it is the abortion issue. We were grounded enough to work through an issue that just torments people and I think we proved that to our employees.

The CEO recognized the divisiveness of this social issue and its impact on the culture of the organization and its core values. He made pleas to the staff to be open to others and nonjudgmental, which was important, as was the process of building consensus for a resolution that would keep the culture intact. By calling a retreat among the leadership, he gave voice to the deeply held values of leaders steeped in the longstanding culture. The leadership team developed the resulting written mission statement and values, which helped resolve the ethical dilemma, and these cascaded throughout the organization for all members to embrace. The CEOs’ leadership actions in the face of adversity and in navigating through leadership change are consistent with Schein’s (2010) theory that the top leaders establish values and cause them to flourish in the culture. The CEO credits the leaders, who helped reestablish the values statements in written form, with resolving the issue: “I don’t create values, though. I identify as a group (the) values.” Creating and sustaining the environment is more than a program or project, according to Craigie (2010). It requires a radical approach firmly entrenched in the consciousness of the organizational stakeholders in order to withstand time. Craigie (2010) further credits good spiritual leadership with helping people find meaning by connecting with the core things that really matter, including relationships, social causes, and workplace directions. Accordingly, this ability to connect others on matters of importance generally enlivens and sustains healing, especially amid adversity.

During the same time period, a stressful midlife marker event occurred in the non-secular organization that reaffirmed its values. The founders, whose intentions serve as the culture’s
bedrock (Schein, 2010), were losing their heirs apparent. “What are we going to do when the Sisters and Father are no longer here?” was a fear expressed as participants observed the last feeble remaining religious leaders. The impending loss of these religious leaders affected many participants deeply and left them wondering about their future. The marker event—that is, the inevitable transition to lay leadership—caused a response. “They had a strategic sense about them,” say participants as the nuns began developing mission integration and spiritual formation strategies. Accordingly, many Catholic hospitals began creating new positions to maintain the integrity of Catholic identity during this time period (Cullen, Richardt, & Hume, 1997).

Consistent with Schein’s (2010) theory that a leader response is essential to carry an organization through a midlife crisis, this non-secular organization demonstrated its concern for preserving the mission and the religious-based nature and spiritual values of the culture for future generations. Senior leader Quinn accepts this responsibility and views him and other lay leaders as vessels entrusted with carrying out the founder’s mission: “(We) must reveal and embody faith in the same way that Christ did for His followers.” Quinn fulfills his inner spiritual desire to better understand himself and to inspire others by deliberately creating opportunities for personal spiritual renewal, such as attending retreats and Bible studies: “You can’t do it unless you can know yourself.” Quinn’s views reflect Fowler’s (1981) faith development theory, whereby leaders’ highly developed spiritual nature is evident. Craigie’s (2010) description of spiritual embodiment capitalizes on Fowler’s (1981) theory. He uses it as an interpretive approach to thinking about spirituality for leaders in healthcare. Spiritual embodiment is rooted in the ways spirituality informs who we are, as people and as healthcare practitioners. It informs the mission and culture and the spirit of the organizations we serve. It encompasses, too, how “the spiritual” is embodied and given life in the experience of patients and in ourselves, and what we view as
vital and sacred. The techniques we can use, such as prayer and meditation, are examples of methodologies that contribute to this larger picture of embodiment.

Thompson’s (2000) theory that well-grounded individuals exhibit spiritual congruency between personal and work life is evident in participant responses. In the literature, Watson (2005) also asserts that, by virtue of choosing a healthcare profession based on caring for others, individuals exhibit their spiritual nature. The outlook of non-secular participant Alberta reflects these theories: “Spirituality,” she states, “is a way of being. It is who I am.” The relationship and connectedness with a higher power drives her in her daily life at home and at work. Spiritual congruency and embodiment means that our beliefs inform who we are as people and as practitioners, and how we in turn inform the mission and culture of the organization (Thompson, 2000). Craigie (2010) contrasts spiritual embodiment with what he views as a “specialty model” of providing spiritual care that is found in healthcare. Healthcare professionals tend to use a specialty model framework to define clinical services such as cardiology or oncology, wherein the process of care involves doing a specific activity. Spirituality framed as a specialty means that it is an activity that you sometimes “do” to the patient as a clinical methodology and sometimes “don’t,” rather than applying spirituality as a way of being. According to Craigie (2010), this application of spirituality by doing “it” would mean that “it” (the activity) takes place only in certain circumstances. By contrast, spiritual embodiment is present in everything that one does. Contrary to Craigie’s views of healthcare clinicians in general, participants in this study, such as Louise, embody their spiritual nature. It was her spiritual being that led her to her first career as an oncology nurse, where she deeply connected with patients in relationships filled with meaning and purpose, helping them through the healing process: “Relationships are
everything to me.” Caregivers like Louise who embody spirituality have a powerful bearing on the healing process.

The *inward nature* of spirituality, which 17 participants describe, is consistent with spiritual embodiment and is expanded upon by Thompson’s (2000) theory of a congruent life. In his theory, effective leaders embody spirituality as a life orientation in which the individual is devoted to a higher reality. Spiritual leaders are fed by the inner spirit more than outer strivings. Ultimately, the individual achieves meaning and purpose in all aspects of his or her life, along with congruency between work and private life. Participants point to the most obvious of congruent leaders, the nuns and priests who sometimes live at the hospital. However, it is seen across all participants to a greater or lesser degree. Participants like Steve find congruency between their social conscience and connectedness with their colleagues at work, in their social lives together, and in the community. Steve’s life fluently moves between work and play. Ursala’s spirituality comes from “deep within her soul” and is part and parcel with who she is as a healthcare professional and as an individual. She changed the direction of her career to better fit who she is, and fulfills her desire to help others identify their own inner callings. The “generative behavior” or concern for the growth of others, seen in Ursala’s actions, shows moral maturity at Kohlberg’s (2000) stage-five conventional level of development. At this stage, individuals demonstrate self-awareness and recognition of personal values and how they connect with others. Ursala, Iona, Farrah, Henry, Alberta, Quinn, Vicky, and other participants identify spirituality and their implicit beliefs in “the spiritual,” the “higher power,” the “universal force” that influences and connects them with others to complete their lives.

*Faith traditions* influenced the implicit beliefs and development of five participants. Fowler’s (1981) theory that faith does not necessarily refer to religion or religious beliefs, but
can instead encompass a person’s way of making sense of life, is evident in many participant responses. Bazan (1999) emphasizes that healthcare professionals must recognize that religion is meant to serve our spirituality, not vice versa. He believes that we may have a common spiritual nature but not necessarily a common religious tradition. Secular participant Farrah tells a story from her adolescence, when she participated in religious activities, but later chose her own spiritual pathway. Other participants in both secular and non-secular health systems made choices about participating in a specific religion at some time, yet they distinguished their religion from their spirituality. Steve sees himself as spiritual but not religious. Randy has a strong personal faith base; however, he views his spiritual nature as “an agreement with society” in a broader moralistic sense of spirituality beyond himself. At the same time, he states that people are drawn to his secular community hospital “to fulfill their inner calling.” John was more heavily influenced by his religious roots and a “calling” he recognized during his childhood. John’s worldviews and beliefs stemmed from summer Bible camp, where he felt he first encountered God as an adolescent and was inspired and renewed. Not having words for these feelings and not able to express himself in a public school, John turned to his Bible and prayer for inspiration. At this critical developmental juncture in his young life, John’s experience reflects a high level of faith development at a young age. According to Fowler (1981), adolescents at stage four faith development extend their worldview beyond family. Interpersonal perspectives and capacity for thinking, reflection and meaning-making occurs while youth connect values and beliefs that form and also conform to the personalities and religious beliefs of others. As John questioned the revival preacher who he realized was not “saving him,” and as he recognized his feelings from within, he began moving toward stage five, individuative-reflective faith, where independent judgment and critical thinking skills emerge. John describes how his
religious experience as a youth served as a foundation for his spirituality; however, it is not his spiritual identity. He now works happily in an organization with a different faith base from his own, and finds that his spiritual beliefs and values are similar despite the difference from his religion.

The *inward nature* and strongly held beliefs of some participants—their “inner calling”—is indicative of Fowler’s (1981) individuative-reflective stage of faith development. At this stage, one re-examines deeply held beliefs as a precursor to developing a distinctive identity and sense of self-worth. As participants shed themselves of “egocentric preoccupations,” they ceased to be self-directed, thereby gaining the freedom to become “God-directed.” Tony asked himself, “Who am I outside of my role in the family or occupation or professional identity?” The critical distancing from his family’s value system that uncovered “layers of nurture” resulted in a departure from fundamentalism and a new self-awareness. Tony’s progression toward personal responsibility for his lifestyle and belief systems demonstrates his independent judgment and critical thinking skills, consistent with Fowler’s (1981) individuative-reflective stage of faith development. At this stage, one re-examines previously held beliefs as well as the faith traditions of others. An individual may now accept or reject what had been his or her familiar, or traditional, faith, assuming responsibility for his or her newfound personal beliefs and lifestyles.

*Replenishing spiritual reserves* is a common practice among participants. They are renewed by routines that help them maintain balance in their lives and refresh their spiritual energy. Participants strive to balance the challenges of work with those of their personal lives, integrating activities such as meditating, prayer, exercising, and music into patterns of living. This is characteristic of true spiritual leaders, who move harmoniously between the personal and professional (Thompson, 2000). Maintaining a personal balance requires intention and practice,
and is an essential leadership characteristic for modern organizations, according to Thompson’s (2000) theory of congruent lives. Self-mastery requires “assiduous attention to the inner life [so] that such self-knowledge can grow” (p. 151). Leaders need to cultivate their inner lives.

Participants such as Alberta and Henry provide examples of thorough introspection and self-awareness by setting aside time each morning for reflection on how they will manage the day ahead. Kohlberg (1981) describes the process as individuation, or becoming self-directed, which comes naturally at later stages of adult development. These individuals are more aware of themselves, their assumptions and prejudices, and of the differences between themselves and others, and gain the freedom to be “God-directed.” Charles de Foucauld (in Thompson, 2010, p. 137) states that “The soul will bring forth fruit exactly in the measure as the inner life is developed,” suggesting that daily actions and behaviors reflecting spirituality become a way of life.

Observable moral characteristics that participants describe include trust, presence, relationship building, honesty, and mentoring/coaching. The participants’ moral characteristics are derived from a sense of social justice for others, and are in alignment with Kohlberg’s (1981) theory of moral development. They can be seen as a set of operating principles for individuals as they grow and develop in stages over their lifespan.

More than half of the participants identify trust as an important moral characteristic representing equal respect for all people. Kohlberg’s (1981) theory of moral development at a post-conventional level known as the universal-ethical-principle orientation is recognized by reciprocity and equality between and among individuals. In the secular organization, Randy and Steve exemplify Kohlberg’s (1981) theory when they implicitly trust their executive colleagues’ advice, believing that they will develop and maintain a spiritual culture in a manner consistent
with their mission. The reciprocal exchange of shared values between leaders and staff
demonstrates this theory. The categorical imperative is the Golden Rule, or doing unto others as
you would have others do unto you. Candy, Ursala and Gail, who view themselves as confidants
for others, offer other examples of trusting relationships. They create environments where people
will trust that they are safe to openly discuss any matters of concern and vice versa. Several
participants also cite transparency about leadership activities and actions by both the secular and
non-secular organization as an important quality that increases trust between and among leaders
and staff. Trust is an underlying condition of Fisher and Torbert’s (1995) theory of work and
leadership and the description of “achievers.” Achievers have well-developed interpersonal skills
with a deep sense of responsibility for one another. They will go to great lengths to avoid hurting
others, and they accept personal feedback as a means of helping others toward goals.

Eleven participants report that presence is an important moral characteristic for them.
Presence cannot be underestimated as a means of relating to the spiritual needs of others, and
manifests itself in many ways (Thompson, 2000). It can be glimpsed in the active, non-
judgmental listening and empathy that Candy, Olivia, and Wanda practice in order to meet the
emotional needs of their direct care staff. It also manifests itself when participants make
intentional efforts to connect with patients. According to Craigie (2010), people want
compassionate presence from caregivers and for each other in times of need, rather than answers
to concerns. Listening empathetically and having the ability to genuinely understand the
perspective of others is a critical business skill as well (Fisher & Torbert, 1985; Thompson,
2000; Schein, 2010). Intention and presence—which leaders can evince by listening to staff as
they de-escalate from difficult working conditions in the emergency department, or listening to
patients who are distressed by their illness—can aid in healing. Intentionally and non-
judgmentally being present may create an honoring and safe space for patients to be forthcoming about their lives, their fears, and their values, and is strongly correlated with meeting spiritual needs (Craigie, 2010). Participants shared many stories about housekeepers and nurses who were present for patients or for each other.

Relationship building is an important moral characteristic, according to Gail, Candy and other participants. Gail respects new colleagues and treats them as persons first. She applies “the golden rule,” hoping that they will in turn respect her. By doing so, she reflects both Schein’s (2010) theory of culture, wherein shared values are developed and taught to new members of the organization. Randy’s deftness at relationship-building, which “comes naturally” to him, can be seen in his ongoing efforts to connect deeply with as many people as possible in his vast organization. This is a practice he thoroughly enjoys, and one that has garnered him the admiration of his colleagues. Connecting with others in the organization on a routine and frequent basis is a practice that also embeds values and builds the culture of his organization (Schein, 2010). Stage four of Kohlberg’s (1981) theory of moral development describes individuals who are conscientious of others while they begin to form deepening relationships. Social order becomes important. This is seen in another situation where Candy works at building relationships and maintaining social order with her staff “even when things are hard.”

Iona and seven others cited honesty as an important moral value. High levels of both moral and faith development are reflected in the participants’ actions as leaders. Fowler’s (1981) conventional level, stage five, conjunctive faith is a level characterized by reflection with a critical recognition of one’s social unconscious—the myths and prejudices that reside deep within oneself—and the ability to adapt one’s thinking to a new reality. This is exemplified by Iona, who provides particular insights into honesty and the morality of a leader, explaining how
she contemplated terminating a colleague. While she was dissatisfied with the behavior of a staff member who reported to her, she went through the lengthy reflection process about how to handle the concern. She ultimately realized and confronted her own need to be honest with the colleague, and was willing to “speak the truth with grace, which is with great love, compassion, and respect.” The employee stayed on staff in the end, benefiting both her colleague and herself. Iona’s lengthy reflective process of more than a year resulted in positive reciprocity between the two parties involved. Maintaining the basic social rules of reflection, honesty and reciprocity in the work environment follows Kohlberg’s (1981) conventional level, stage four moral development. Iona’s compassion and constructive intent to salvage her colleague could also be interpreted as a movement toward Fowler’s (1981) stage six, the universalizing stage of enlightenment, wherein application of the universal principles of love and justice prevails.

Mentoring/coaching is a moral characteristic that a third of the participants describe. Two theories apply, including Schein’s (2010) theory of leadership, which indicates leaders must provide guidance and support while allowing individuals to improve their own situations; and Kohlberg’s (1981) conventional level, stage four of moral development, where individuals help others achieve their own goals. These theories are reflected by participants Candy and Marge, who focus on mentoring staff rather than “fixing” them. The mentoring is bidirectional, meaning that both individuals in the relationship mutually benefit from the mentoring exchange. Both Candy and Marge encourage their colleagues to find their own ways of resolving personal and professional concerns. The colleagues grow in their confidence and stay happily employed while the leaders maintain a healthy work environment. Iona sees herself as “sometimes a student, sometimes a mentor, or at times both.” She helps others and at times they help her. The coaching and mentoring skills participants demonstrate show an awareness of individuals’ need to express
their personal values and opinions. Coaching and mentoring correspond with Kohlberg’s (1981) theory at stage four, demonstrating that good “societies” like these healthcare organizations provide benefits for all people by maintaining healthy cultures of care.

In addition to the spiritual and moral characteristics embodied by the top leaders, the other leaders at all levels of the organization align with the top leader to fully embody spirituality in the culture. Schein (2010) indicates that the values held and communicated by senior management, in particular, establish expected behaviors that become embedded in the organization. Alignment occurs at three distinct levels: 1) aligned organizational structures are created by top leaders; 2) midlevel leaders provide a bridge between the layers; and 3) frontline leaders are viewed as the most important direct bridge to patients and frontline staff.

Alignment and structure with top leaders is important in both organizations. Alignment is viewed somewhat differently at each level of leadership, senior level, midlevel and frontline. Participants discuss alignment both in terms of the reporting relationships in the organizational structure, as well as alignment by virtue of common values that are embedded in the culture.

Schein’s (2010) theory of culture and leadership indicates founders and leaders have strong theories about organizational design for maximum effectiveness. While some create a tight hierarchy with centralized controls, others prefer flatter organizations and assume that their strength is in their people. In this study, senior leaders followed the latter view. Senior leaders Randy, Ben, and Quinn, who work at both secular and non-secular organizations, indicate that the reporting relationships and organizational structures for their organizations are intentionally designed to be flat rather than hierarchical. They explain that they prefer flat organizations so that, as top leaders, they can be closer to the staff rather than separated by many layers of leaders. As the number of people increase in organizations, it becomes increasingly difficult to
coordinate activities (Schein, 2010). The typical solution for growth is to create additional layers of hierarchy so that leaders have a manageable span of control. Ben indicates that they are not “big on using titles” or creating levels of status. Regardless, Schein (2010) indicates that organizations form subcultures based on rank or status, typically found in their executive, middle, and frontline layers. The shared experience of the new group members at each subculture level can be contrasted with leaders at other levels. The difference in perspectives between layers is clearly seen among participants in this study. According to Schein (2010), executive subcultures predominantly focus on finances; middle managers have neither power nor autonomy and live in an ambiguous environment; and first-line supervisors are most likely to identify with the rank-and-file and management. Decisions are made based on the dominant belief systems of the major constituents of each subculture, according to Schein (2010), with each group developing assumptions about human nature and how to manage employees.

Participants in this study follow similar patterns, with some variation noted.

Although finances are a likely subject for top leaders, three senior executives who addressed their organizational structure indicate their desire to stay in touch with what is happening at all levels of their organizations. Consistent with Schein’s (2010) theory indicating that it becomes increasingly difficult to coordinate activities as organizations grow, Randy emphasizes this: “I need to touch and feel and see. I needed to know employee names.” He lamented the growth of the organization from a hospital to a much larger health system with many more people. Another layer on top of the hospital Randy once led was formed for a health system corporate leader, the role which Randy assumed. The promotion and system-wide growth caused him to move off the hospital campus, even though he preferred to “be close to where the mission is made.” Senior non-secular leader, Quinn, indicates that his roots are in operations, and
that he prefers to be at a level close to that of the people who serve the patients. Senior participants believe that by maintaining flat organizations and aligning the leaders below, they can help sustain the cultures of both the secular and non-secular organizations. The organizational design and structure creates manageable spans of control and facilitates—or, conversely, discourages—relationships between layers of leaders and staff.

Midlevel leaders provide a bridge between the layers and are the most vulnerable layer of leaders, according to Schein (2010). Seven midlevel participants, who had experience with other organizations during their careers, point to change in the top-leadership that disrupts alignment as a large concern for them. Midlevel leaders reported being “caught in the middle” when mergers caused change at the top of the organization, noting the values of new top leaders were not in alignment with their own. Merging organizations of any kind creates a challenge for a leader who wishes either to maintain compatible existing cultures or create a new culture (Schein, 2010), and a challenge for the participant caught in the middle. Midlevel leader Farrah had more than one experience of being caught in a merger, with one merger being very good and the rest negative. One positive experience that occurred between a secular and non-secular health system followed Schein’s (2010) theory, where a slow infusion of cultures with leaders of similar values was successful. Farrah spoke with high regard for both of these leaders, who had for many years anticipated the merging of the culturally similar organizations. When the actual merger took place, employees hardly noticed it. Thompson (2000) points to transformational leaders like those whom Farrah described, who seek to create fundamental, non-incremental change by aligning the individuals’ core values with their own. Alignment occurs when the leader’s vision infuses the organization’s work with spirituality and meaning, intrinsically
motivating employees like Farrah. The resulting employee behaviors enhance the organization’s performance.

Louise and Patty, on the other hand, did not have a good experience when their hospitals merged and the new top leaders’ values proved incompatible with their own. They and certain of their colleagues, frustrated by their lack of power and compatibility, either left the organization on their own or were terminated. Old cultures can be destroyed by eliminating some of the people who carry the old cultural values and behaviors, according to Schein (2010). Gail affirms that when the organization’s beliefs do not match your own values and beliefs, and “don’t align and you’re in the middle, it’s a pretty ugly place to be.” New cultural elements will only be learned if new behaviors lead to success and the satisfaction of the people remaining. The many midlevel participants whose careers were disrupted due to mergers or top-leader changes—events over which they had no control—are consistent with the lack of power and autonomy of the middle manager subculture described by Schein (2010).

Frontline leaders are viewed as the most important direct bridge to patients and frontline staff, according to participants. The first-line supervisor subculture is the group most likely to identify with the rank-and-file and management (Schein, 2010). Olivia, for example, is not concerned with what happens in leadership levels above her, and will perform at her best “even if the (upper) leadership doesn’t get it.” Olivia’s high personal level of spiritual development—her years of experience in an organization with deeply embedded spiritual values—gives her confidence that she is aligned with the mission. Her convictions run deep, and she is not swayed by the idea that some of the top leaders may not understand. Olivia also provides a theoretical example of the challenge of changing an existing culture. She offers support for Schein’s (2010) belief that a leader can impose new ways of doing things and articulate the goals and means, but
a culture change will not occur unless it proves to be better and the members share experiences that validate the change.

Frontline leader participants in this study are sought out by both top and middle leaders like Tony as a source of information about the effectiveness of patient care activities, and they validate the organizational values. They also help to fulfill the inner need of upper-level leaders to connect with them and the patients they serve. In turn, the frontline leaders like Patti and Henry wish to be consulted and to receive affirmations from their top leaders that acknowledge their value. Schein’s (2010) theory suggests that providing reward and recognition for organizational members is important to the process of alignment. Recognition of shared values also reinforces desired behaviors in the culture.

**Accountability: Creating and Sustaining the Culture**

The second finding is that leaders hold themselves and others accountable to defined values and behaviors, and retain people with congruent values and behaviors to maintain the culture. Accountability to defined values, and retention of the right people, are crucial to maintaining the culture of an organization. Participants at all levels in both organizations went beyond stating the organization’s values, holding themselves and others accountable for their behaviors and intentionally maintaining the culture. I will discuss accountability from the perspective of Schein’s (2010) culture and leadership theory and three specific strategies found in the study: 1) standards of behavior, 2) building interpersonal relationships, and 3) hiring/termination practices.

Accountability starts with clarity around the organization’s mission and values (Schein, 2010). One of the most central elements of any culture is the assumption that members of the organization share their identity and mission. Secular leader Steve stated, “Whether Catholic or
non-Catholic…our mission is the difference.” He and other participants from his organization look toward their organization’s values and standards that differentiate them from competing institutions. Non-secular leader Quinn expects appointed leadership “to create the culture that supports the behaviors you want.” Values are reinforced and deeply embedded in the organizations in many ways. Written standards of behaviors are described upon hiring and evaluated regularly in performance reviews. Primary embedding mechanisms for values (Schein, 2010) such as written mission statements, videos explaining their heritage, and emotional stories of caring for the underserved, are used by participants to communicate their mission of healing and service in action. Louise notes that photographs of staff interacting with clients that line the hallways visually illuminate her organization’s values of compassion, caring, and joy. According to Schein, (2010) these serve as examples of physical “artifacts” that can be seen, heard, and felt in the environment and reinforce the culture.

Discovering what real and relevant information is, how to interpret it, and even more specifically, how to act, become important functions of leaders, especially those in large macro organizations such as healthcare institutions (Schein, 2010). This was found to be true as participants in both secular and non-secular organizations influenced their healthcare cultures in many ways: holding staff accountable for demonstrating standards of behavior that exhibit their values, using specific language, building interpersonal relationships, and adhering to hiring and termination practices described below.

Standards of behavior are well developed and uniquely written for staff to demonstrate in both the secular and non-secular organizations. Two thirds of the participants indicate that the standards of behavior with specific examples of the way staff are to perform their work, aside from technical tasks, provide their members with guidance and inform them of cultural
expectations. Schein’s (2010) theory suggests that when leaders pay attention to, measure, control, and reward certain values and ideals, their doing so is the most powerful tool for communicating their beliefs. Many of the established behavioral standards for both organizations are similar, and include such things as: demonstrating care by responding with compassion and concern for others; being team players; recommending and implementing improvements; and showing positivity through smiles, appreciation, and recognition of one another for acts of kindness.

As participants in both health systems implement their standards of behavior, Schein (2010) suggests that they are better equipped to share feelings, emotions, attitudes, and values at the deepest cognitive level. Nancy provides an example of one of their standards of behavior and the sorts of things she and her nursing team pay attention to. In order to demonstrate the behavior of “presence,” they created cards with an explanation of how nurses can demonstrate this concept with their patients. They modeled the presence behavior by placing a chair at a patient’s bedside so that nurses could sit beside their patient, if even briefly, to listen to the patient compassionately and without judgment. Once nurses understood what being present looked like and they were successful at performing it, some of the doctors who witnessed the nurses’ behavior and success followed suit. Nancy believes this had a positive impact on their patients’ satisfaction. By helping staff to put values into action in a process that is simultaneously emotional and behavioral, they are embedding the culture (Schein, 2010).

Using specific language such as “spirit” or “spirituality” was an important embedding mechanism in the secular hospital for participants, who sensed that staffs were fearful that such language was inappropriate and/or implied religious beliefs. The use of language is another primary means of embedding values and beliefs into the culture (Schein, 2010). According to
Farrah, saying the word “spirit” does not alone impart greater spirituality to a work environment; rather, such a change “requires a tenacious attitude by the leader of the department.” The SPIRIT pilot program began to help the secular staff embrace not only the term “spirit” in their interactions with patients and each other, but also helped them understand and demonstrate associated spiritual behaviors. The program proved helpful in a number of ways (as indicated in the last section), but for the most part it gave permission to staff to use the language. In some cases it allayed the fears of staff that felt such language might infringe on individuals’ religious beliefs. Once staff understood they felt more comfortable using the language in a safe manner, they were able to have spiritual conversations with patients and one another. Thompson (2000) indicates that experienced business/faith-based leaders not directly associated with the church use terms such as service, stewardship, and calling. These words may be more acceptable to some and make spirituality easier to address.

*Interpersonal relationship-building*, emphasized by eleven participants in both organizations, is another example of what Schein (2010) calls a primary embedding mechanism of values. Kohlberg’s (1981) conventional stage of interpersonal concordance is a level of development where leaders respect different opinions, rights, and values of others, and promote the general welfare of all.

The practice of rounding by leaders with staff, which Quinn and Nancy described, is a specific strategy used by both the secular and non-secular hospitals. The rounding process, where leaders meet with colleagues who report to them and/or patients on a prescriptive and routine basis, is designed to build interpersonal relationships while modeling values, teaching colleagues what is important, and coaching them toward success in their work and relationships with others. Nancy also uses her time rounding to identify positive attributes of the work
performed by staff, and follows up by sending them thank-you notes or providing public recognition.

When rounding is done genuinely with constructive intent, the process lends itself to Thompson’s (2000) theory of a congruent life. When leaders have developed mature inner-personal attributes, they have a solid foundation from which to build interpersonal and organizational skills necessary for understanding and dealing with a diverse workforce. With a deep understanding of self and others leaders, can model empathy, vulnerability, tolerance and empowerment.

Participants Quinn and Steve are genuinely interested in all members of their organization, regardless of their professional roles. They formally and informally build relationships by other means, too. They see their work as an extension of their lives and pay close attention to what is important to others. Quinn’s social life includes activities such as Bible studies with friends, which benefit him in both his personal and professional lives. Steve enjoys the fun social events with work colleagues that cross occupational and hierarchical boundaries and help people bond. He spends time creating bridges and building bonds on and off duty.

Hiring and termination practices were identified by ten participants in both organizations as important for preserving the culture. Schein (2010) theorizes that the criteria used for recruitment, selection, promotion, and termination allow leaders to communicate their values both implicitly and explicitly. Gail, Ellen, and Quinn express their beliefs about the importance of hiring the right people with shared values with comments such as “One person represents the whole,” “From this point forward you are the [health system],” and “You can’t teach people to care.”
According to Schein (2010), the selection process and integration of new members is one of the subtlest yet most potent ways through which leaders can embed and perpetuate their assumptions in an organization. Evidence of this is clear in the statement by Quinn that he articulates his organization’s values before hiring candidates, and communicates that new employees will “reveal and embody” the same core values as others. He and Vicky meet every new employee recommended for hire by frontline managers, and do so again before they begin working. They show videos of their founders during orientation to reinforce the organization’s values.

Culture evolves by patterning and integration, according to Schein (2010). The culture adapts and integrates new members who are taught the correct way to perceive, think, and feel in relation to problems. As both a product and a process, culture relies on prior organizational members such as Quinn, Vicky, Gail and Ellen, who possess knowledge and experience, and is constantly renewed as new people join the group and become the keepers. Another eight participants, including Gail and Farrah, indicate that they release employees who display “values dissonance.” When employees are not a match for the organization, Gail does not judge them, but assists them in exiting.

Given the moral and spiritual values of the organizations as the participants articulated them, the people hired to join the staff for their matching values are likely to have similarly high moral and spiritual values or at least the potential for them. Choosing candidates to match the actual or desired later stages of both moral and spiritual development as defined by Kohlberg (1981) and Fowler (1981) would appear to be the ultimate object for these hospitals; doing so perpetuates their desired cultures. Dismissing those whose values are inconsistent without judgment speaks of a commitment to a higher-level moral maturity. Ultimately, congruency
between an individual’s values and those of the organization has implications for meaningful lives, and for the organizations that achieve their purpose, according to Thompson (2000).

**It’s Everyone’s Job**

The third finding is that nurses and pastoral care professionals are direct caregivers with primary responsibility for providing spiritual care for hospitalized patients; however, indirect caregivers, such as housekeepers, have a role that they exhibit through the practice of “presence.” Physicians have a limited role in meeting hospitalized patients’ spiritual needs. I use Schein’s (2010) theory of culture and leadership to analyze the culture of the two organizations’ housekeepers, nurses, pastoral care professionals, and physicians. The culture is identifiable by shared basic assumptions and the process by which they evolve. Thompson’s (2000) theory of congruent lives shines additional light on the shared basic assumptions held by participants as they find meaning and purpose in their work.

An organization’s culture can be studied at three interrelated levels—the level of its artifacts, the level of its espoused beliefs and values, and the level of its basic underlying assumptions (Schein, 2010). It is necessary to decipher patterns of basic assumptions in order to interpret the artifacts correctly and give credence to espoused values. The essence of a group’s culture is its patterns of shared assumptions that are taken for granted. Patterns of basic assumptions for the roles and responsibilities of both direct and non-direct care professionals are identified and discussed.

Both Thompson’s (2000) theory of congruent work lives and Craigie (2010) support the notion that patients cannot receive good spiritual care unless staff is spiritually grounded and supported in a healthy work environment where spirituality is everyone’s job. While doing so is a challenge, efforts to achieve this are required at micro levels by individuals and macro levels
by organizational leaders (Schein, 2010). Participants agree with Quinn, who says, “Fundamentally we have the same job—we are here to serve our patients...and inspire people [to know] that their work does make a difference in the context of this mission.” Likewise, Farrah believes that people in marketing and other non-direct care positions go into healthcare essentially because their values align with those of the mission, and they seek meaning and purpose in the work they do. Ursala makes a profound statement that connects all the staff: “If you are not caring for the patient, you are caring for someone who is caring for the patient.”

Participants agree that maintaining a culture of spirituality is a shared responsibility, yet helping people endow their roles with meaning and purpose is a challenge. As Gail states, “It is carried out by each person in some way, shape, or form to eventually touch the people we serve.” She believes that the RISEN program and the SPIRIT project she participated in at her secular hospital helped her and others to make the connection. Regardless of either program’s results, organizational leaders’ intent in providing these programs was to reach everyone in their unique roles, regardless of occupation. In the literature, Craigie (2010) suggests three domains in a healthcare organization where creating a culture of spirituality can be achieved: the personal, clinical, and cultural, buttressing the notion that everyone has a role in spiritual care, not merely clinicians. This model supports a domain where specific clinicians, i.e. nurses and pastoral care professionals, directly connect with patients in a spiritual manner. It also supports a culture of empowerment and affirmation that brings out the best in staff, i.e. the housekeepers, and patients. In the personal domain, individual responsibility centers on the idea that all individuals cultivate their own character, stay connected to their own purpose, and remain grounded in intention and presence. The virtues of intention and presence can be seen in the actions and behaviors of the housekeepers, nurses, and pastoral care professionals.
Eleven participants cite *housekeepers* as essential members of the organization for the presence they demonstrate in providing patients’ spiritual care. Theories by Kohlberg (1981) and Fowler (1981) regarding moral and spiritual development at conventional and post-conventional levels describe people who act in solidarity with both friends, i.e. their nursing colleagues, and strangers, i.e. the patients they serve. These non-direct caregivers in both organizations play a significant role in caring for patients, and exhibit intention and presence with patients as well as with one another. Thompson (2010) believes that intention and presence are the two most important elements of spirituality in one’s life. Participants like Louise, Ellen, and Olivia describe in detail a number of stories involving housekeepers and their positive effect on patients. The non-judgmental presence and acts of kindness bestowed on patients, such as providing music or conversation with patients who may be barely conscious, suggest an intentional connection or attachment that a housekeeper might make with the patients. While housekeepers are intentional in their actions towards patients, they may or may not be aware that their connection is of a spiritual nature. Parker (2010) points to the fact that even unconscious efforts are part of moral and spiritual development. Housekeepers acted on their natural inclinations toward other human beings, which points toward their having higher moral and spiritual development.

The stories told of acceptance and empowerment of housekeepers as part of the clinical nursing team, and other stories espousing their virtues, suggests that the housekeepers’ actions foster a spiritual culture of care. While Fowler (1981) affirms that faith transcends all rational categories of class, one participant expressed dismay that some hierarchical subcultures may not see the value of housekeepers in a spiritual culture. The other participants, however, describe housekeepers’ effect on patients with affection and incredulity, as though housekeepers might
not be expected to contribute to a spiritual culture in such a powerful manner. Although housekeepers’ primary job is not directly caring for patients, the time they spend with the patients in their rooms while performing their work creates natural conditions for connecting and relating to others. Thompson (2010) states that connecting individual’s own meaning and purpose to their work is important. It can result in the spiritual care of patients. In an example by Olivia, a housekeeper cares for the caregiver, i.e. the nurse. By taking it upon herself to bring vital patient information to the nurse, a housekeeper affected the patient’s care directly. Housekeepers have some advantages over other non-direct caregivers by virtue of their proximity to patients when doing their jobs. However, other non-direct caregivers are capable of contributing to spiritual care, and often do. Examples were inferred by the descriptions of the importance of the many other processes carried out by non-direct caregivers to complete the patient’s experience. They include such things as reassuring patients while scheduling them, providing accurate billing services, offering themselves as a supportive human resource function to help hire and retain the right people, and so forth. 

_Nurses_ are cited by seven participants as the most important team members and as the determinants of spiritual care, primarily by virtue of their being “present” while providing hands-on care directly to patients. Nurses were cited less frequently than housekeepers, which may be due to assumptions about their clinical function and role. The literature confirms the obvious: nurses spend more time with patients than other professionals, perhaps with the exception of nursing assistants, owing to their evaluation responsibilities and requirement by most organizations to conduct spiritual assessments of patients (Joint Commission, 2011). Randy states that nurses “are responsible for the way in which we are judged.” Although other professionals are not excluded from participating in meeting patients’ spiritual needs, nurses are
generally present in times of patients’ spiritual distress (Carson, 1989). Nurses are relationship-oriented and engage in high levels of interaction with each patient, each other, and with other professionals (Puchalski & Ferrell, 2010). Examples provided by Louise and Olivia demonstrate the relationship orientation in the way they respectfully and compassionately provided spiritual care for both patients and each other when they needed it most. At the same time, both Vicky and Ellen express their concern about nurses’ ability to provide medical care while demonstrating presence for patients, due to new demands on their time to document the patient care they render. New electronic medical records stood in the way of one nurse’s ability to be present, as noted by a participant who said a patient complained that “the nurse took care of the computer, not my wife.”

Respect for the dignity of human beings as individual persons (Kohlberg & Hersh, 1977), and an endeavor to manifest God’s goodness and love through actions (Fowler & Del, 2004), characterize individuals with high levels of faith development. Nurses described by participants, such as Olivia, serve as examples of goodness and love with highly developed faith. Olivia was present in spirit when she respectfully listened to the wishes of a patient to “be in a better place than here.” She followed through in the moment of greatest spiritual distress for her patient by advocating for his wishes and reminding staff to refrain from resuscitating him. Her selfless act of courage on behalf of another person demonstrated that she respected the desire of her patient to allow him to die in peace and transcend to a better place (Fowler, 1981).

*Pastoral care professionals* were cited by 11 participants as having a distinct role in providing spiritual care, though not a universal role in affecting the culture. According to Young and Koopsen (2010), chaplains who see an estimated twenty percent of hospitalized patients are the trained specialists in spiritual care who provide counseling from their knowledge of theology.
and psychology. Participants from both secular and non-secular hospitals have pastoral care departments. Participants John and Ben are both professionally trained as ministers who understand the role of pastoral care professionals or “chaplains” better than most. They describe the professional’s daily tasks of directly providing spiritual guidance for patients who may be fearful of a surgery, or for families who may be waiting to learn about the health status of a loved one. Non-secular leader Ben understands the importance of professional training and the need for chaplains not only to counsel patients, but also the staff at times, who themselves need spiritual care for both professional and personal reasons. Yet he and other participants are adamant that spiritual care is everyone’s responsibility.

Chaplains assume the primary role of a clinician with “tasks” to perform to meet patients’ spiritual as well as religious needs, especially in times of significant spiritual distress. Much like nurses and housekeepers, who are considered by Schein (2010) to be part of a subculture of “operators,” they provide the hands-on work of the organization with individual patients and families. While chaplains are not seen in the same light as the “top spiritual leaders” of the organization, they are sometimes assigned the responsibility of becoming “mission leaders.” Quinn describes chaplains at his hospital who have replaced members of the religious order to take on the primary function of mission integration leaders. Schein’s (2010) theory of the role of top leaders or the “executive subculture” is more in line with the mission leader’s role to foster spiritual practices broadly across the organization, and embed them deeply in the culture. Quinn substantiates this fact, noting that while pastoral care professionals have an extremely important role in spiritual care, it is truly the appointed leadership’s responsibility “to create the culture that supports the behaviors you want.”
Physicians were identified by five participants as contributors to spiritual care, while another three participants portray physicians as not engaged in such care. This compares to research that indicates that a majority of patients want their physician to provide spiritual care when they are ill (Koenig, 2005; Williams et al., 2011). Chapman (2006) and Puchalski and Ferrell (2010) suggest that physicians’ time for patients is minimized to just a few minutes in order to maximize productivity goals. They attribute this concern to the healthcare industry’s primary virtue of efficiency over care, which makes it difficult for patients or caregivers to feel a sense of dignity. Participants have differing views of physicians’ roles in providing spiritual care. In the secular hospital, Ellen and others indicate efforts to elevate physicians who are already interested in the subject of spirituality into influential positions within the organization. Nancy provided an example of physicians who took a cue from nurses about sitting, if even for a moment, to be present for patients. Non-secular participants honor the physicians’ role in spirituality, yet express concern about the available time they have to be intentional and present. Bazan (1999) goes on to say that physicians may become spiritually depleted as a consequence of these demands on their time, and of their loss of a work-life balance. At the same time, Bazan believes that physicians can develop their spiritual dimensions, and he encourages them to “bring their own inner spirit to the practice of medicine” (p. 148).

Another paradoxical view is presented by Schein (2010). He provides important insights about a physician’s role in organizational culture that run contrary to what patients desire according to the literature. Schein (2010) identifies three common subcultures that reflect the hierarchy in any organization: operators, executives, and engineer/designers. Applying these subcultures in hospitals, physicians for the most part function similarly to “engineer/designers,” as they concentrate on assessing and directing the technical aspects of a patient’s care to render a
diagnosis and treatment plan. They spend much of their time behind the scenes ordering tests, medications, and developing therapeutic treatment plans rather than spending their time directly with patients.

This contrasts with the way nurses function. Nurses act as “operators” who spend considerable time at the patient’s bedside executing the orders and directly monitoring the patient’s changing condition. They have far more contact time with patients than physicians do. Nurses are the critical resource who meet all of Schein’s (2010) criteria for the “operator” subculture by accomplishing the following: 1) receiving training and skill sets requiring the use of the organization’s core technology, i.e. the medical devices and electronic health record; 2) dealing with unpredictable contingencies while monitoring a patient’s conditions; 3) learning, innovating and dealing with surprises of all kinds; 4) demonstrating their interdependence with a collaborative team, working with everyone including housekeepers and doctors; and 5) demonstrating their dependence on management to provide them with proper resources, training, and support to get their jobs done.

Patients may perceive that physicians function more like direct care “operators” instead of functioning in the role of “engineer/designers.” Physicians’ job functions reflect the six basic assumptions of the engineer/designer subculture (Schein, 2010): 1) the real work of solving puzzles and overcoming problems relates to physicians’ primary job of diagnosing or solving the puzzle of a patient’s condition when they are in the hospital; 2) the solutions are based on science and available technology, such as results of laboratory tests or imaging studies used to identify the problem; 3) the elegant machines and processes work in harmony. If the machines falter, physicians may assume it is the people who are the problem. They are taught that problems have abstract solutions that can be implemented in environments free of human error;
5) physicians are trained to believe that nature can and should be mastered and that which is possible should be done. It is the essence of practicing medicine and helping cure illness or remedying the natural process of death; and 6) physicians’ work is oriented toward yielding useful products and outcomes.

In the minds of patients, physicians play a significant role in meeting their spiritual needs while they are hospitalized, according to the literature (Koenig, 2012). The expectation for the time and depth of these encounters may be unrealistic in today’s healthcare environment (Chapman, 2006; Puchalski & Ferrell, 2010). While physicians are not exempt from emulating the spiritual values of the healthcare organization, they can support patients and other staff in times of need by being intentionally present to the best of their ability in the same way as other members of the organization. Realistically, contact time with patients in the hospital to meet spiritual needs is limited, making it more likely that nurses who are more present at the bedside will influence hospitalized patients spiritually.

**Organizational Commitment To A Personal Journey**

The fourth finding is that intentionally investing organizational resources in spiritual awareness and development for staff positively affects the spiritual growth of individuals, and has a positive impact on a culture of spirituality. Participants across both secular and non-secular health systems praise their system for intentionally investing in the spiritual development of individuals by providing spiritual programs and experiences such as RISEN. These findings are supported by Thompson’s (2000) theory of congruent lives, Craigie’s (2010) positive spirituality in healthcare, and Schein’s (2010) theory of culture and leadership with focus on learning organizations.
Secular workplaces can achieve spirituality according to Thompson (2000). He believes that in the secular workplace, which would include the secular health system in the study, individuals seek a deeper sense of meaning in work and in life. In his congruency model, secular leaders like those in this study may be oriented toward the growth and maturation of their inner spirit. Mature leaders progress toward inter-personal development that manifests itself at an organizational level. As these leaders grow they can move individuals, including themselves and their organizations, toward congruent lives. Craigie (2010) indicates that spirituality can thrive in any healthcare setting regardless of their secular or non-secular affiliation. He indicates that healthcare workers in general are interested in spirituality for themselves and those they care for. Healthcare workers may however be concerned about the time it may take to provide spiritual care, and moreover may harbor fears of invalidation (inability to help someone in their suffering) and/or lack of skills. By having a better understanding of spiritual suffering, healthcare workers may help others on their journey toward health, coping, dignity, and wellness. Schein’s (2010) theory of organizational learning applies in any setting including the two healthcare organizations in the study. He indicates that helping to change individuals’ ways of thinking and being through learning experiences, which could include RISEN, is the basis of culture creation. The RISEN program was offered as a means of changing participant’s ways of thinking and being. The program provided the participants with clarity on the subject of spirituality, and offered tools to help them continue their own self-development. The confidence they gained allowed them to be better leaders and to encourage others to learn.

The RISEN training program development coincides with the movement of Catholic healthcare systems that created training programs aimed at developing spiritual skill sets and strategies for lay leaders (Cullen, Richardt, & Hume, 1997; Richardt & Magers, 1997).
Distinctions were made between spirituality and religion, as well as between human development and human formation. Human formation is viewed as beholding the mystery of life without controlling or manipulating it (Richardt & Magers, 1997). Using this as a premise, leaders and staff in the non-secular health care organization focus on emulating and embodying Christ’s healing mission.

All participants found value in the RISEN program experience. Schein (2010) indicates that leaders must create the necessary psychological safety for people to learn. Top leaders agreed to support the program, requiring it for all members of their leadership team and making it optional for staff. The participants shared their sentiments about the program itself and about the value of developing the people around them. Alberta, a midlevel leader in the non-secular hospital, sums it up best. She believes in helping others on their personal journeys in order to meet the mission of the organization. She sees the presence of a higher power in those around her: “…I have always tried in my roles in healthcare leadership to see the good in everyone and realize that wherever people are, they are on a path to get where they should be…” Alberta is willing to help those around her to reach their own aspirations, and in the end “it is better for everybody.”

Some participants came into the program already well grounded in spirituality and felt they grew as a result of the RISEN experience. Nancy and Ursala were enthusiastic about attending, while Gail was not. She attended only because she was required to do so. In the end she and all others were glad they had participated. Ursala was especially pleased to have attended: “… it was tenfold more than worth going to.” Olivia described a direct care staff member who attended the program voluntarily but skeptically, and “then, when it opened up to
her, she was so happy [that] she came.” Providing a peaceful off-site space for training away from the hospital created a safe learning environment, which proved important.

Patti and four others from all levels of the organizations became mentors in the program. They each described personal growth they experienced as a result of participating in RISEN with a mentor of their own and their desire to mentor others through the same experiential process. According to Nancy, “I thought I knew the answers. I really didn’t.” Schein (2010) views education and ongoing learning such as the RISEN program to be an embedding mechanism for the culture. Thompson (2000) indicates that spirituality must be experienced before it can be understood. The RISEN program first provided training and then provided a mentor for each individual to apply the knowledge in their own practice of spirituality in both professional and personal lives. As a result of the extended mentoring period participants indicated that they not only helped others, but the process also deepened their own personal spiritual development and growth. By practicing these skills, they became more capable of leading, and also more willing to encourage other staff to participate in training.

Differentiating religion from spirituality is a result of the RISEN program experience, as cited by seven participants from both organizations. Participants like Wanda, who works in a non-secular hospital and has deep religious roots, found that the safe environment created in the training program allowed her to speak openly about her views. Middle and frontline leaders in both organizations who felt grounded in their own spirituality—but not confident enough to discuss openly and/or lead others in the dialogue—learned to articulate more clearly the difference between religion and spirituality as a result of their participation.

All top leaders endorsed the RISEN program even though not all attended. Those who did not attend were just as supportive of it as a means of enhancing the spiritual nature of the
organization as those who did. The five senior executives from both secular and non-secular health systems who did not attend believed the training program was consistent with their own/the organization’s values, and therefore lent it their support. Three of the non-secular top leaders had professional ministerial training with the expertise to recognize the program’s value and endorsed it. Two top leaders in the secular organization implicitly trusted in the recommendation of a member of the executive team because they share implicit beliefs and values.

Top leaders are the original source of the beliefs and values they wish to preserve in their organizations, according to multiple theorists and authors (Craigie, 2010; Schein, 2010; Thompson, 2000). Leaders do not manipulate people; instead, they provide the means to help others find their own meaning. Like these participants, leaders serve as role models and take steps to mold the organization, or reshape it when necessary, modifying or reimagining its culture. Schein (2010) describes the importance of learning in organizations. He calls upon leaders to be learners and culture managers. Learning leaders have faith in people, provide resources, and create the necessary psychological safety for them to learn. Top leaders required all other leaders in the hierarchy to attend training, which is an alignment mechanism according to Schein’s (2010) theory. Doing so helped to ensure that they understood spirituality and could model the behavior for staff to follow. Several midlevel and frontline leaders indicated that although they felt they had a good personal knowledge of spirituality, attending the RISEN program did indeed enhance their knowledge and contribute to their being more effective leaders.

Five participants saw investing in individuals’ participation in RISEN as an important commitment of organizational resources. Senior leaders Ellen and Quinn, who are responsible
for large budgets and dispersing funds for many priorities in their sphere of influence, know the challenge of meeting so many demands. They saw the RISEN program as a “gift” and a sign of true commitment to the mission and to the people of their organizations. Marge, Darla and Gail describe the educational program opportunity as an investment in people’s spiritual development. They believe their leaders are concerned with the welfare of the staff, and wish to give them the opportunity to achieve a high level of spiritual and moral development.

Training was not optional for mid-level leaders who were expected to understand the program, encourage others to participate, and model appropriate behaviors. As it happened all the midlevel managers, including those who were initially reluctant, ultimately agreed that the training benefited them. However the staffs were allowed to participate at their discretion. Allowing staff to participate when they felt personally ready for spiritual growth and/or wished to satisfy their curiosity about the RISEN program is consistent with the thinking of many theorists. Neither learning (Schein, 2010) nor spiritual growth (Craigie, 2010; Thompson, 2000) can be imposed on individuals. Participants understand that spiritual and moral development is an individual and personal growth process that comes from within, as described by Fowler (1981). Individuals have their own “ways of knowing,” and as they grow in their own development, they are able to reach out to others. The program experience was an opportunity for those ready and willing. By offering it over several years, the number of staff members with the training grew over time, inciting growth at the core and instilling the spiritual values in the culture.

Investment in the culture of both organizations was not limited to the RISEN program. Schein (2010) believes it is important that leaders become perpetual learners in a fast-changing, complex and diverse world. He endorses a learning culture that is proactive, committed to
learning, and positively oriented toward the future. While timely interventions such as the RISEN training program were important, other strategies were deployed simultaneously to impact the culture more broadly. Mission integration strategies were ongoing in the non-secular health system, according to participants. The secular health system also “layered” a number of strategies to inform their culture, such as the SPIRIT pilot project and more. The RISEN program was one of many designed to encourage participants to reflect deeply, discern, and apply over time. In the process of assimilating and building shared knowledge, participants articulated what the experience had been and what it had meant to them.

A Blended Theory Model: Congruent Personal and Organizational Values

The theoretical basis for spiritual leadership in hospitals where patients’ needs are met holistically—through attention to mind, body, and spirit—can best be understood by a combination of four theories that can be fully integrated with one another: Schein’s (2010) theory of organizational culture and leadership; Kohlberg’s (1989) theory of moral development; Fowler’s (1989) theory of faith development; and Thompson’s (2000) theory of a congruent personal and work life.

A model for hospital leaders to achieve holistic care for patients that includes spirituality is built upon the top leader, whose mission and highly developed values are embodied by, and integrated into, the entire organization’s culture. An authentic top leader or founder exemplifies the hospital mission and values, with highly developed levels of moral and spiritual development shared by all others in the culture. By intentionally aligning internal processes and structures, or “the way of doing things,” and artifacts in the physical environment, and by fostering the spiritual development of individual members of the organization, the spiritual culture develops and grows to higher levels of achievement. Members of the organization find meaning and
purpose in their personal and spiritual lives, and congruently in their work lives—with patients and each other—and this, in turn, enables spirituality as part of holistic care to flourish.

This high-level developmental model can also be viewed in three concentric layers, with the top leader/founder at the center developing from within toward the outer layer, where all people in the culture embody spirituality. The highest level of development includes three essential elements at the apex of the pyramid: 1.) The mature leader understands faith as a way of making meaning (Fowler, 1981), with moral development (Kohlberg, 1981) at the highest developmental level in a post-conventional state. The leader is a reflective thinker able to examine their personal values in relation to those of society (Kohlberg, 1981), and balance the tensions of multiple perspectives and paradoxes (Fowler, 1981). At this stage, the leader has unconditional love and the capacity to embrace all people regardless of variables. Their high-level moral values represent justice, reciprocity, dignity and the human rights of others. 2.) The inner orientation of the leader is highly developed, with inner-personal traits, interpersonal abilities, and organizational skills that are congruent with the hospital workplace. The authentic leader organizes meaning and personifies the organization’s vision in all aspects of their lives, providing meaning for all others (Thompson, 2000). Individualism and relatedness are balanced and democratized to empower employees to meet their own inner spiritual needs without manipulation, and ultimately meet the spiritual needs of the patient. 3.) The leader’s deeply-held values and assumptions serve as social principles or philosophies that guide behaviors in the hospital, creating a broad framework for organizational routines and practices that focus on excellent clinical outcomes and patient satisfaction, as well as staff satisfaction. The deeply held values and espoused beliefs communicated by senior management, in particular, are embodied by all staff, who are guided by embedded, consistent ways of doing things. These same values
are reinforced by artifacts in the physical environment such as chapels, crucifixes, overhead paging of daily reflections, etc., that convey the hospital’s mission.

In the ideal state, where the holistic needs of the patient are met, the combination of personal and organizational elements at the highest level of development are embodied by the leader as well as all members of the organization. An organization with a spiritual culture is built upon the highly developed moral and spiritual values embodied by the top leader, and in alignment with others who share and maintain the values through intentional processes and behaviors. Spirituality begins with a foundational moral and spiritual inner self, and matures to embrace all people unconditionally, encompassing the organizational culture.

Assimilating this blended model theory of holistic care into healthcare organizations suggests that any hospital regardless of affiliation can rise to meet the spiritual needs of patients. It is incumbent upon the top leader to recognize her or his personal commitment to strive toward the ideal and “become” the spiritual leader who embodies the moral and spiritual values and organizational mission for others to follow in both their personal and professional lives. For a healthcare CEO, this is a daunting task and an audacious responsibility that is humbling at the same time. There may be great disparity between who we are and who we aspire to become. Leading a league of professionals in the mission of healing calls for a level of commitment and relentless self-improvement that can be countered by a reminder that we are truly only human and may not achieve that for which we strive. As individuals we are all a work in progress. We simply must follow our calling and trust in our higher power for guidance. For if we do that others will see our humanity and walk with us on our journey. Together we will, as a spiritual community, provide a service for mankind.
Table 5.1. Blended Models of Leaders Role in Meeting Patients’ Spiritual Needs

CHAPTER SIX: DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

Discussion

I became interested in spirituality as a dissertation topic while coordinating a project on spirituality in a secular healthcare organization. I had a transformational experience that altered me personally as well as professionally. I learned to understand spirituality in a more personal way following the loss of a loved one, and in a more professional way by seeing how healthcare leaders could have a greater impact on the spiritual experience of patients. I subsequently began working in a non-secular healthcare organization, where I started to compare the two similar yet different approaches to spirituality. Both organizations were providing extraordinary service with very high overall patient satisfaction and both were deeply concerned about meeting patients’ spiritual needs. I wondered about their common threads and why these two were different from other hospitals in meeting patients’ spiritual needs. I believed that a study involving these two organizations could unravel the mystery.

During my lengthy healthcare career, I have observed that most healthcare leaders believe that their organization provides holistic healing of the mind, body, and spirit for patients. Yet I have met very few leaders who can describe how this occurs beyond referencing their pastoral care or nursing professionals who “do it,” or their chapel as a place for individuals to
“go to.” It was not until I began coordinating a spirituality project in the secular hospital where I worked that I recognized what spirituality in healthcare really meant and what its true potential might be. I was introduced to many new ideas, including the RISEN program and Erie Chapman’s book, *Radical Loving Care*, where Mr. Chapman described his experience of transforming the culture of a secular hospital. After completing work on the spirituality project I moved to a non-secular hospital that had just lost several aged and irreplaceable religious leaders. That non-secular hospital was concerned about its ability to maintain its spiritual culture without religious icons present who had provided direct spiritual care for both patients and staff. All the while, my father-in-law was dying and I was sensing that his hospital experience lacked the spiritual care I felt he deserved. In light of my new experiences I began to view spirituality, in theory and in practice, very differently than I had in the past. I wondered why I was making this discovery so late in my career. Considering that I had been a healthcare administrator for many years as well as a preceptor for aspiring healthcare CEOs pursuing their master’s degrees, I felt that if I had overlooked scholarly knowledge regarding spirituality for patients, then surely others in healthcare leadership had missed it as well. I was compelled to fill the knowledge void, not only for myself but for other healthcare leaders who truly embrace holistic, patient-centered care, yet need a better understanding of what spirituality means to them, their staff, and the patients they serve.

Perhaps the most important aspect of this study is that it is one of only a few that places responsibility on the top leaders’ personal and professional spiritual development and intention that establishes a spiritual culture of care. I found that having a top leader who fully embodies spirituality and intentionally embeds it into the organizational culture is the key to meeting patients’ spiritual needs. Fusing theories pertaining to the spiritual and moral development of
individuals with those concerned about embedding the broad culture with spirituality, I arrived at the conclusion that spirituality can be embedded into any healthcare organization, secular or non-secular, as a means of optimizing healing.

Second, I found little research on the effectiveness of providing training for the spiritual development of individual staff. The effectiveness of spirituality training to meet individuals’ personal needs must go one step further to determine whether this, in turn, affects patients’ perceptions. Culture surveys can provide some general idea of whether staff senses that their efforts are meeting the patients’ needs. This study raises the issue of providing training for individuals, and identifies a need for research that demonstrates its ultimate impact on meeting patients’ spiritual needs.

Third, this may be the first study to clarify the common role that all caregivers, beyond the clinical direct care professions of pastoral care or nursing, have in maintaining a culture of spirituality. The study provides practical considerations for how indirect caregivers participate and connect with patients through their presence and intention. While clinicians have specific assessment and conventional interventions responsibilities to provide spiritual care in a traditional sense, such as prayer and discussions with patients surrounding transcendence or religion, there are practical considerations for housekeepers and other indirect caregivers to connect with patients in meaningful spiritual ways. I have sought to provide insights into the impact of non-direct caregivers on both the patients they serve and the other clinical direct caregivers they serve.

Fourth, this study may help clarify the role of physicians in meeting the needs of hospitalized patients, and set realistic expectations in the future for their capacity to do this. Research has focused on the need for hospital physicians to be “better at” meeting their patients
spiritual needs in ways that may be unrealistic, especially in view of today’s delivery of medicine. Traditional independent physicians are not enculturated by most hospitals to focus on meeting patients’ spiritual needs, but rather to focus on providing fast paced service to meet economic demands. Spirituality is more likely to be understood by those physicians who are employed by hospitals that orient them toward, and educate them in, their mission and values systems. By educating employed physicians to understand their roles as part of the larger culture of spiritual care, and by making hospital staff more aware of their roles, healthcare organizations can establish more realistic expectations for the spiritual care they provide patients.

I interviewed a sample of executives at all levels in two organizations that had participated in the RISEN training program. These leaders were not all “believers” in spirituality prior to having begun this program. After the RISEN learning experience, virtually all 22 participants understood and supported the program, feeling that they, as well as others in their organization, greatly benefited from it. Many believed that the program was a foundational experience for their own spiritual self-development, and believed that RISEN contributed to the development of the core spiritual values among others in their respective organizations. As I asked questions of the participants, I not only listened but watched carefully how passionately and/or emotionally they spoke of its effect on them personally as well as professionally, and how their patients and their staff benefited and healed in the end. A strength of this study is that the sample participants spanned across all levels of leadership in both direct and non-direct care positions, providing a rare broad perspective that cuts across many silos and boundaries that exist in typical healthcare organizations.

Prior to conducting this study, I assumed that the spiritual needs of patients were not being met in hospitals, and that meeting patients’ expectations would be a challenging task for
leaders. This is based on years of leadership experience in a variety of healthcare settings. In concluding the research, I found that it is possible and begins within the heart and soul of the leader herself.

**Conclusion**

Based on the findings of this study, the experience of health system leaders does have an effect on their ability to meet patients’ spiritual needs, as Schein’s theory of culture and leadership underscores. He states that organizational cultures start with “the beliefs, values, and assumptions of founders of the organization” (Schein, 2010, p. 235), which is further embedded in the way things are done within that organization. This study shows, that overall, there are few differences in the spiritual culture between these secular and non-secular health systems. The highly developed sense of spirituality embodied by these health systems’ top leaders—and other leaders—is exhibited in their beliefs and behaviors, parallel with Kohlberg’s (1981) highest level of moral development. The development theory at its highest level includes “universal principles of justice, of reciprocity and equality of human rights, and of respect for the dignity of human beings as individuals” (p. 19). Participants like Iona—who says that spirituality is her “way of being,” which is based on her growing faith, not just religious beliefs, and practiced in her personal and professional life—also lend credence to Fowler’s faith development theory (1981). That is, faith which may be seen as religious is not necessarily so, nor should it be equated with a specific belief; rather, it is a person’s way of making sense in life. Whether in a secular or non-secular setting, these leaders demonstrate congruency seamlessly in their lives and work, where spirituality “is not adherence to a creed or dogma but a life-orientation that finds meaning and purpose through devotion to a higher reality in all aspects of one’s life, including productive work” (Thompson, 2000, p. 2).
This study demonstrates that spiritual cultures that impact patients can and do thrive in both secular and non-secular environments when the top leaders’ spiritual beliefs and values are intentionally embedded in the organization. As organizations work toward accomplishing their missions, their leaders’ assumptions become shared, disseminating throughout the culture and defining “the way things are done” (Schein, 2010). Leaders at all levels in both organizations are aligned with the top leader’s spiritual beliefs and values. According to Schein (2010), organizations are definitely influenced by the values and beliefs introduced by new members. Participants thoughtfully hire like-minded people with shared values and retain them to sustain their culture. They also remove members if and when they discover that the member does not fit their organization’s values and expected behaviors. Leaders account for the behaviors of others through several means, such as rounding and intentional presence, with which they connect to members of the organizations in meaningful ways and build interpersonal relationships.

Leaders have many methods of embedding their beliefs, values and assumptions to create spiritual cultures. They do so primarily through the structures and systems they establish to align the organization (Schein, 2010). The underlying assumptions of the leaders are expressed in the mission and values. Their espoused beliefs are embedded in the culture through rounding, storytelling, recognizing others, hiring and retention practices, and training. Many visible artifacts in the physical environment show signs and symbols of spiritual intentions.

Healthcare literature generally promotes the concept of “teamwork” for the spiritual care of patients as a responsibility that involves direct care professionals such as nurses, pastoral care professionals, and doctors (Frampton, Gilpin, & Charmel, 2003; Kolouritis, 2004; Watson, 2005). The literature fails to address the role of non-direct caregivers. Non-direct caregivers such as housekeepers identified in this study contribute to spiritual care. Participants told many stories
of housekeepers who were present for patients and staff yet often unaware of their positive spiritual impact. Participants also commended nurses for demonstrating presence. Nurses’ perceived lack of time for being present is a barrier that can be overcome with better understanding of the practice. Intentional presence is an effective means of providing spiritual care and affecting the culture of the organization (Craigie, 2010; Thompson, 2000).

Participants understand the significant and important role of pastoral care in providing direct spiritual intervention. Using their training and knowledge in mission-integration roles would allow them to more broadly affect the organizational culture of spirituality. Pastoral care professionals, like housekeepers and nurses, are part of a subculture defined by Schein (2010) as “operators” who are responsible for the core service of direct care for patients. Physicians are part of the “engineer/designers” subculture that is preoccupied with defining medical problems and prescribing remedies. Independent physicians in hospitals generally spend little time with patients, especially when compared to nurses, pastoral care, or housekeepers. While the literature clearly indicates patients’ desire for physicians to render spiritual care (Buryka et al., 2008; Koenig, 2007; Williams et al., 2011), it may be more likely that patients will receive gratification while in hospitals through nurses, pastoral care providers, housekeepers, or other “operators” than through physicians or “engineers/designers.” This finding does not exempt physicians from responsibility for contributing to spiritual care through their own intentional presence, or from spiritual self-development consistent with the values of the organization.

Intentionally investing in the spiritual development of individuals through the RISEN program has a positive impact on personal and professional growth and on the overall culture of the organization. Based on my own experience, few hospitals/healthcare organizations invest in the development of individuals’ spiritual growth unless their organization is religiously affiliated.
Religion and spirituality are not the same (Fowler, 1981; Kohlberg, 1981), and participants in this study hold beliefs ranging from deeply religious, to those trained in the clergy, to another who claims to be atheist. Despite their religious beliefs or lack thereof, all participants describe the positive contribution of the RISEN program experience to individual faith development and to overall cultural development. The program experience includes an extensive time commitment with the support of a mentor to provide participants with added support for spiritual practices, acts that help them to internalize and discover their own spiritual nature.

Participants appreciate the undistracted time away from work in a safe environment that encourages them to be open to sharing and learning. Some participants felt that providing this opportunity while on paid work time demonstrated an unusual commitment by the organization’s leaders and contributed to the program’s acceptance and credibility. These distinctions differentiate this program from typical didactic approaches to learning, which may compound its perceived effectiveness. While RISEN is seen as a valuable tool for embedding spirituality in the culture, it is not the only tool available, nor the only one used by the organizations for spiritual development of staff. The literature includes other models for healthcare organizations to embrace spiritual philosophies and tactics for implementation, such as Samueli (2012), Planetree (2013), and Radical Loving Care (Chapman, 2006, 2009). Regardless of the model that is adopted for learning, efforts to create a spiritual culture must be intentional and authentic on the part of the leadership, rather than, as one participant phrased it, “the flavor of the month.” It requires leadership to intentionally prioritize and invest necessary organizational resources of time and money. The literature confirms that higher-performing organizations make these types of investments (Craigie, 2010; Schein, 2010).
The literature also confirms that predominantly pastoral care professionals receive formal education in spirituality, as do nursing professionals to varying degrees, while other healthcare professionals for the most part do not (Craigie, 2010; Frampton, Gilpin, & Charmel, 2003; Kolouritis, 2004; Watson, 2005). All healthcare professionals could benefit from more or better academic training in spirituality. Organizational development efforts within the hospital setting aimed at training all healthcare members to help them personally develop their own spiritual nature is mandatory for those hospitals that wish to succeed. Focused efforts on educational experiences for individuals, combined with broad organizational strategies, stand to have a more powerful effect in helping hospitals achieve their goal of meeting patients’ spiritual needs.

While physicians share responsibility for meeting hospitalized patients’ spiritual needs, engaging physicians is challenging. The economic tension between, on the one hand, spending time in spiritual training and, on the other, self-development efforts that take physicians away from revenue-producing activities centered on treating medical conditions, may be a barrier to physicians’ ability to provide care in a holistic manner. Hospitals may be less able to influence independent physicians who are not employed by the health care systems and not aligned with their mission and values. Unfortunately, patients generally do not understand that physicians are not employed by the hospital where they seek care, and they may or may not harness the desired spiritual support from them when in the hospital. With or without physicians’ support, patients may still have their needs met by nurses, pastoral care, housekeepers and others in a hospital culture steeped in spirituality.

The spiritual training of multidisciplinary, direct and non-direct care hospital and health system leaders has an effect on an organization’s culture. One sees this in the overwhelming support for, and perceived impact of, the RISEN program experience by participants in both
organizations. Organizations are influenced by the learning experiences of its members as they evolve, making a thoughtful approach to training essential.

**Recommendations**

As a result of this study I offer the following seven recommendations that fall into three categories: application in the workplace, research on the spiritual practices of individuals and organizations, and academia/professional training recommendations. Top leaders in healthcare systems are called to action to establish and prioritize practices that influence hospital cultures that produce positive spiritual patient and staff outcomes. Healthcare systems must address the lack of data from which to establish and benchmark current and future spiritual practices. It can do so through research aimed at improving patient outcomes for holistic care that includes the vital role of spirituality. Academic and technical institutions who prepare professionals for the workforce are also called to influence patient outcomes by designing curriculums that include spirituality as a vital component of holistic healing of the mind, body and spirit.

**Application**

Recommendation 1: The top leader of the healthcare organization must first and foremost authentically embody spirituality, striving for spiritual maturation that emulates “a way of being” for the entire organization.

Responsibility for meeting patients’ spiritual needs begins with the top leader, who lives an authentically spiritual life. Top leaders who seek a holistic healing experience for the patients served in their hospitals must recognize that spirituality starts within their own hearts, and is not a delegated task for others to perform. “Your vision will become clear only when you look into your own heart. Who looks outside, dreams; who looks inside awakens,” professes Carl Jung. Patient care starts with the top leader. The CEO who looks inside and truly understands his or her own inner nature is able to connect with others and their suffering. Humanity grows with a
foundation of compassion and unconditional regard for others. Bringing forth positive
expectations, faith, and hope is way of being that exemplifies spirituality. The CEO’s positive
intention and presence permeates the organization and hence reaches its patients. Through their
own personal spiritual journeys to find meaning and purpose and to experience connectedness
with others, CEOs establish a culture where spirituality is a way of being for everyone engaged
in healing.

The CEO must continually develop his or her own spiritual nature, aspiring to a high
level of maturity and finding balance in life. Given the emotional and physical demands of most
healthcare jobs, hospital leaders who improve their inner spiritual needs will be more effective
than those who do not (Thompson, 2000). As leaders grow spiritually and morally they will be
better prepared to address dissonance, provide energy, and act as a force to help others find
meaning and purpose.

Nothing in the process of becoming a spiritual leader is linear or a straight line, however
it is not coincidental (Thompson, 2000). How the CEO authentically seeks and expresses
meaning and purpose and connects to his or her own higher power, to the moment, to self, and to
others is an ongoing effort that requires practice. A conscious and intentional effort toward a
spiritual life requires a lifelong commitment. Leaders must practice the art of reflection and self-
care using personalized techniques such as meditation, listening, exercise, music, prayer, or some
other uniquely fulfilling means of restoring themselves and finding balance in work and life.
Participant Farrah noted that leaders who take care of themselves will be better equipped to “take
care of the people who take care of the patients.”

Recommendation 2: Hospital leaders must help colleagues understand what spirituality is
and is not. Distinguishing spirituality as “that which gives meaning and purpose to life” as a
concept separate from religion will help colleagues to focus on the power of their healing intention and presence in connection with one another, including their patients.

Healthcare leaders, and their staffs in general, misunderstand spirituality, and often confuse it with religion, which can create artificial barriers to its acceptance. They also lack the confidence to address patients’ spiritual needs in a work environment where fixing health problems is vital and where the fear of failure is high. Notwithstanding the intrinsic value and importance of religion in healing for many, there are many others who are not religious and who also are in need of spiritual healing. Healthcare professionals thus question their knowledge and capabilities to aid patients. Healthcare leaders can remove staff members’ psychological barriers and fears about both religion and spirituality. They can provide education and experiences that help colleagues to understand how they can be successful at meeting spiritual needs. Even the most deeply religious of participants indicated that once they understood these things and changed their ideologies and practices, they grew personally and professionally in their own lives and felt more confident in their efforts toward healing patients spiritually.

Healthcare professionals must recognize that spirituality is not adherence to a creed or dogma, but rather a life orientation that creates meaning and purpose in all aspects of our lives (Thompson, 2000). Helping professionals build confidence in their own spiritual nature and in their healing presence with others is vital. Like the CEO, individuals must learn the art of self-care and developing their own spiritual natures first, before expanding to embrace patients. By addressing spirituality in the hospital mission, vision, and values, CEOs foster dialogues about spirituality and about religion. Embracing religions of all kinds through physical artifacts, religious icons, multicultural symbols, healing spaces such as dedicated worship areas, nature trails, or gardens, demonstrates a commitment to spiritual well-being.
Teach all colleagues how to be “present in the moment,” even when contact time with one another is limited. Provide techniques and tools to help colleagues connect with patients and each other, such as focusing before entering a room, or sitting at a patient’s bedside or a colleague’s side for a few moments while listening in an undistracted manner. These methods will help individuals connect in healing moments where people compassionately open themselves to one another. Whether being present while cleaning a room, or kindly responding to a phone call, or assisting a colleague who is caring directly for a patient, every person who works in healthcare is engaged in the provision of loving care and meeting spiritual needs. Once colleagues understand and embrace these concepts, spirituality can truly flourish.

Recommendation 3: Healthcare leaders must invest in individual colleagues’ spiritual growth by providing ongoing funding for spiritual self-assessment, mentoring, and a variety of optional training programs and experiences tailored to meeting individual spiritual needs.

Healthcare leaders typically fund clinical and technical training for their staffs in order to assure that quality care is provided. However, funding for personal awareness and self-development is generally reserved for managers and executive leaders. For spirituality to permeate an organization, leaders must invest in personal awareness and spiritual development at a micro level for each individual, as well as at a macro level through a variety of means for all colleagues across all levels of service. Only then will individuals discover their own meaning, purpose, and spiritual nature, which they can draw on as they seek to help each other and their patients.

Education and personal experiences for direct-care clinicians and indirect-care staffs such as housekeepers, receptionists, and all others, regardless of role is essential. Although these top leaders did not all participate in RISEN training, I recommend that all top leaders do participate
regardless of their prior education and experience. Doing so demonstrates their commitment to personal spiritual development, shows empathy with other participants, and encourages colleagues to model spiritual practices.

Leaders must role model, coach, mentor and encourage participation in spiritual training and self-development, not demand it. They must be patient and supportive, encouraging participation when colleagues are ready to engage in a personal spiritual journey. If colleagues are unable to perform their work compassionately and fail meet expectations for providing spiritual care, they should be coached to make necessary improvements in behaviors, or coached out of the organization to find work that is better suited to their needs.

Leaders must plan their budgets to include adequate funding for training and self-development opportunities rich in options to meet individuals’ needs for growth. Spiritual development opportunities should be offered in safe environments where individuals are more willing to share and experience spiritual growth. Mentors and leaders should support individual efforts by releasing staff from normal duties for learning experiences and caring for the needs of their staff. Compensation for their time in direct education should be considered.

Given the unique professional demands of physicians, they may require special consideration for when and how to participate in education and self-development activities. As the engine behind care delivery, physicians, especially those who are independent and not employed by hospitals, may be burdened by time taken away from income-producing activities. To remedy this, programming exclusively for physicians can be offered at times that do not interfere with typical duties and commitments. Incentives for participation could include: offering exclusive physician-to-physician mentors who provide certified continuing education activities in spiritual development, and/or requiring this sort of education as a condition of
medical staff membership. Regardless of the means, physicians are seen by patients as an important part of their spiritual care, and must be expected to participate in education and spiritual self-development with the same level of commitment as all employed staff.

Engage chaplains, spiritual advisors, and well-educated staff in coaching and counseling others to excel in their spiritual lives. Expand these professional roles beyond those of the patient and family support to fully embrace the needs of staff, allowing them the necessary time for education and consultation for colleagues. Place these leaders in approachable roles where peers willingly seek them out for support, maximizing their expertise.

Recommendation 4: Healthcare top leaders must hold all organizational leaders accountable for deeply embedding and maintaining spiritual practices by staffs that move toward meeting spiritual goals for all.

Healthcare leaders must hold leaders accountable for embedding and maintaining cultural practices. Leaders must develop practical implementation strategies with processes for accountability. Align organizational structures by creating more “flat” organizations where leaders have reasonable spans of control and are able to connect with, and build relationships between and among, colleagues and patients. Develop selection criteria to hire people who fit identified cultural values, and hold them accountable to defined behaviors. Invest in the spiritual development of individuals, and if this is not effective, compassionately release those who do not fit, and who may find their own meaning and purpose in an organization better suited to their personal needs.

Establish and maintain leadership rounding schedules for leaders to routinely connect and communicate on matters of significance with those who report to them and others. Implement mission-integration strategies such as providing retreats, daily reflections, and others identified
in this study. Establish communication and accountability-reporting mechanisms that capture improvement opportunities and execute them.

Establish internal spirituality benchmarks for individual and organizational success. Collect data using instruments that can compare progress over time and across organizations. These types of activities take time and use financial resources. They will, however, demonstrate a commitment to the spiritual healing of patients and provide opportunities to support the ongoing spiritual development of the organization.

Recommendation 5: Hospitals and healthcare systems must conduct culture assessments that include the spiritual development of individuals and the organization as a whole. Establishing baseline benchmarks for spirituality will identify opportunities for internal improvements that sustain cultures of spirituality, as well as provide opportunities for industry-wide comparisons and improvements.

Hospital culture surveys that include individual staff spiritual assessments ought to be conducted in every hospital. These would provide a baseline of skill sets and spiritual-development training and mentoring requirements with budgetary implications for planning. Leaders ought to adopt existing model programs such as RISEN for training. They ought to conduct research on the impact on their stated goals to provide evidence of their effectiveness and achievement of spiritual outcomes for improving patient care.

Comparisons between and among hospital and healthcare systems, both secular and non-secular, as well as between hospitals/health systems and the private sector, could identify best practices for creating and sustaining cultures of spirituality. This could lend insight into a variety of different organizational practices and approaches to meeting the spiritual needs of staffs and their patients.
Culture surveys should include ways to determine staff self-awareness, personal orientation toward spirituality, and actions taken toward spiritual growth. The research should include practices that influence the development of moral standards, work ethic, and discovery of work-life balance for all people in their chosen professions in life.

The present day is an especially timely opportunity for research involving non-secular hospitals at midlife as they replace religious leaders with lay leaders. Research studies aimed at non-secular hospitals going through significant changes would provide learning opportunities for those seeking creative solutions for preserving the values of their founders and maintaining their spiritual cultures.

**Research**

Recommendation 6: Healthcare organizations must conduct qualitative and quantitative research studies to more clearly understand hospitalized patients’ expectations for meeting their spiritual needs and strategies for doing so. This will enable leaders to provide evidence of outcomes and to make improvements.

Living in a science-driven culture, healthcare leaders must take more steps toward finding empirical “proof” that better ensures that the spiritual needs of hospitalized patients are met. While there exists abundant research on meeting patients’ mental and bodily needs, research on attending to their spiritual needs is less prevalent.

Hospitals should conduct qualitative research that asks appropriate questions of patients, clarifying what gives them meaning and purpose and expounding on how they derive spiritual satisfaction while hospitalized. Questions could include, “What do you expect of hospital staff in meeting your spiritual needs?” Ask open-ended questions about patients’ expectations for what nurses, chaplains, physicians and the many other direct and indirect staff can do to improve spiritual care. Questions that inquire beyond physicians and nurses providing spiritual care may
help influence and expand patients’ expectations, giving them to expect that a registration clerk, a billing agent, a housekeeper, an aid, or others might offer their presence and healing intention.

The resulting data could provide insights and an improved understanding of what individual patients want, and how individual professionals can better assist them in meeting their spiritual needs. These data could allow the creation of better methods with which staff can achieve spiritual outcomes for patients, and could identify continued opportunities for improvement.

These data could also be used to create a better standardized and universal tool with which to assess the performance of all hospitals regarding how well they meet patients’ spiritual needs. Resulting recommendations could be provided to The Centers for Medicare and Medicaid to compare hospitals/health systems or to state hospital associations to stimulate ongoing improvement efforts across all hospitals/healthcare systems.

**Academia/ Professional Education**

Recommendation 7: Academic and technical healthcare educational institutions must expand formal curriculums for all healthcare professionals to include more focus on spirituality as part of holistic healing. Professional organizations that maintain professional credentials should also provide options for continuing education and curriculums to develop and maintain the skills and spiritual attributes of their members.

Professional education and ongoing professional development on spirituality in healing should be provided and prioritized as a necessary component of jam-packed curricula in higher education and technical programs that have many competing interests. Academic institutions should evaluate the current educational curricula for all healthcare professionals regarding meeting patients’ spiritual needs to provide a foundation of knowledge from which to begin. With empirical data for spiritual curricula across all healthcare professional programs, clear and
consistent spirituality learning objectives can be identified and begin to be reflected in the healthcare workforce curricula of the future.

Nursing and pastoral-care higher-education programs include spiritual education, and generally the curricula for physicians and other healthcare professional education do not. Nursing curricula can expand their educational approaches so that they are more transdisciplinary in nature, and more inclusive of the role of other non-direct care professionals in serving patients. Pastoral care professionals can consider how they can expand their professional curriculum beyond patients, to include the spiritual development of other healthcare professionals. This would allow them to more broadly influence a culture of spirituality where everyone thrives. Other professional curricula can be evaluated and developed as well.

Professional organizations that credential professionals and provide continuing leadership education, such as the American College for Healthcare Executives, the American Medical Association, and other professional associations, could use comparative data to provide professional development programming that includes spiritual self-awareness and self-development, as well as culture development for healthcare organizations. They should encourage executive and professional participation as part of ongoing certification and credentialing requirements.

As the art of medicine evolves from purely scientific approaches toward more holistic and allopathic approaches, physicians in particular cannot deny the cry of their patients who say over and over again that they want their doctor to provide spiritual care. Hospital-employed physicians have a rare opportunity beyond all other medical professionals to lead the way. They must begin by re-examining their own spirituality and intentions, and by incorporating
spirituality into their practice with patients and colleagues. As they do so, other healthcare professionals are more likely to do the same.

**Final Thoughts**

The two healthcare organizations that participated in this study should take great pride in the spiritual nature of the cultures they represent, and in the resulting impact they exercise in meeting their patients’ spiritual needs. The overwhelming majority of participants strove to create the best possible experience for both their colleagues and the patients they served. As authentic leaders themselves, they “walked the walk and talked the talk.” As model organizations for both secular and non-secular healthcare institutions, and as high achievers of patient satisfaction, these organizational leaders demonstrated moral maturity and, with it, an ability to generate a culture of caring through holistic healing of the mind, body, *and spirit* that is alive and well. For me personally, the learning journey has helped me understand my own spiritual nature, and provided motivation for me to rise to a new level of leadership maturity. The greatest gift of doing this work is the knowledge that colleagues ensure better health outcomes for patients and that patients’ suffering is minimized. My hope is that the healthcare industry shares my sentiments and expands its own capacity to contribute to the healing of patients.

**References**


Ehmann, J. W., Ott, B. B., Short, T. H., Ciampa, R. C., & Hansen-Flaschen, J. (1999). Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? *Archives of Internal Medicine, 159*(15), 1803-1806.


**APPENDICES**

Appendix A– Letter Requesting Participation

Month, 2015
Dear (name),

Greetings! I am a past employee of ProHealth Care (or HSHS) and am reaching out to you personally to request your assistance in an important research project on spirituality in healthcare. You have been recommended as one of a small number of potential participants in this important research effort to improve care for patients and I would like to invite you to participate.

Many people seeking hospital care want and need spiritual care as part of the experience, especially during these traumatic moments in their lives. Yet research shows that hospital efforts are often less than effective meeting patients’ spiritual needs. While research concludes that more can be done, understanding how these needs are met by leaders in various roles and levels of an organization may inform education and practice in hospital settings. As a leader who has participated in spiritual education, I hope to discover how your lived experience may affect meeting the spiritual needs of patients.

The purpose of this study is to explore the experience of multidisciplinary healthcare leaders in creating a culture to meet hospitalized patients’ spiritual needs. It has been approved by the UST Institutional Review Board, reference number 621621-1. This qualitative study includes twenty-two leaders in various roles and at various levels of leadership in two different healthcare systems, one secular and one non-secular.

I am reaching out to you to determine your interest and willingness to participate in research study by allowing me to interview you. The interview will take approximately 60-90 minutes and will be conducted at a place of convenience for you. I will audio-record your responses to questions about your personal experience as a healthcare leader with training in spirituality and its potential influence on you, those you work with and patients. All responses will be held in strict confidence with pseudonyms to protect any connection with your name. Full details disclosing what and how the study will be conducted and how the information will be used are included in the attached document called a Consent Agreement. If you choose to participate you would sign this agreement before we begin. You are not compelled and can decline participation at any time once the process begins.
I will be contacting you by email and/or by phone in the next few days to determine your interest in participating in this study and answer any questions you may have. If you are interested we will schedule an interview date, time and location of your choice.

I look forward to reuniting soon!

Sincerely,
Charisse Oland
(262-443-9498)
olandmail@gmail.com

enc: Consent to Participate in Study-detailed information (Found in Appendix B)

Appendix B – Study Participants Intake Form

PERSONAL
Name:
Age:
Gender:
Professional role (department, unit, and professional title):
Hospital or Health System (circle one): Hospital Health System
Length of time in professional role:

Contact Preference:
   Phone:
   Email:

CRITERIA
Appendix C – Consent Agreement

The Experience of Health System Leaders in Meeting Patients’ Spiritual Needs

I am conducting a study of leaders who participated in a hospital/health systems pilot project designed to better meet the spiritual needs of its patients. You were selected because you received training in spirituality (RISEN). I invite you to participate in this research study. Please read this form and ask any questions you may have before you agree to be in this study.

This study is being conducted by Charisse Oland, FACHE, MHA, RD, researcher, under the direction of Dr. Thomas Fish, Department of Leadership, Policy and Administration at the University of St. Thomas. The research study is conducted as a course requirement for the Education Doctorate at the University of St. Thomas.

Background Information:

The purpose of this study is to explore the experience of multidisciplinary healthcare leaders in creating a culture to meet hospitalized patients’ spiritual needs. Many people seeking hospital care want and need spiritual care as part of the experience, especially during these traumatic moments in their lives. Yet research shows that hospital efforts are often less than effective in doing so. While research concludes that more can be done, understanding how these needs are met by leaders in various roles and levels of an organization may inform education and practice in hospital settings. As a leader who has participated in RISEN education, I hope to discover how your lived experience may affect meeting the spiritual needs of patients.

Phenomenological research involving you, the participant, will explore first hand your experience as a healthcare leader some time after having had spiritual training (RISEN). The major research question to be answered is “what is the experience of a multidisciplinary health system team in meeting patients’ spiritual needs?” To shed light on the problem the following questions will be answered:

- Does the spiritual experience of hospital/health system leaders have an effect on an organizations’ ability to meet hospitalized patients’ spiritual needs? If so, how?
- Does spiritual training of multidisciplinary (direct care and non-direct care) hospital/health system leaders have an effect on an organizations’ culture? If so, how?
- Does spiritual training of various levels of hospital/health system leaders have an effect on an organizations’ culture? If so, how?
- Does an organizations’ culture have an impact on meeting hospitalized patients’ spiritual needs? If so, how?
Procedures:

If you agree to be in this study, I will ask you to do the following: After obtaining your informed consent, we will discuss and agree upon an interview site that is convenient and private for you. The initial interview will be between 60 and 90 minutes. I will interview you about your experience as a healthcare leader related to spirituality. I will ensure that there is no way to identify your interview information.

Your interview will be transcribed and you will have the opportunity to review it and make any modifications you feel are necessary. You may be contacted by phone or email for a further interview to clarify and or expand upon topics previously covered.

If you decide to participate, you are free to withdraw within one week of the first interview. If you withdraw after that time, I will de-identify your interview data and will count your input together with similar input from the other participants to identify themes from which to perform and analyze the data.

Risks and Benefits of Being in this Study:

Participation in this study has minimal risks to you other than whatever information you reveal that you may feel is sensitive to you. You may decline answering any question and I will listen respectfully, maintaining strict confidentiality. The subject matter may involve questions or topics that may contain some emotionally evocative or sensitive information that participants choose to disclose. If a question creates discomfort, you may choose to pass on the question. You may withdraw from the study before your data is pulled for content analysis with no penalties to you.

There is no direct benefit of any kind to you or compensation for participating in this study.

Confidentiality

The records of this study will be kept strictly confidential. In any sort of report that I publish, I will utilize pseudonyms for you and any persons described and I will not include information that will make it possible to identify you. There should be no way of knowing that you have participated in this study.

Each interview will, with your permission, be audio-recorded to facilitate my ability to accurately transcribe your responses. I will also take notes during the interview. The recordings will be transcribed by a professional who will sign a form to maintain strict confidentiality. The transcriber I use to transcribe the audio-recordings will sign a form to maintain strict confidentiality and security. The transcriber will return the audio-recordings and all transcription digital files to me for storage in my password-protected (known only to me) digital computer file. The audio-recordings, transcriptions, and notes will be kept in a locked cabinet in my home.
which I, the researcher and my dissertation chair, have access to for the purposes of analysis and potential publication of my dissertation.  

Upon completion of this research, all transcriptions and notes will be de-identified and maintained in this protected state for potential use in future research.  Audio-recordings will be destroyed within one year of the completion of the dissertation.

**Voluntary nature of the study:**

Your participation in this study is entirely voluntary.  Your decision whether or not to participate will not affect your present or future relations with University of St. Thomas, or any other organization with which you are professionally affiliated. If you decide to participate, you are free to withdraw at any time up to and until coding and analysis of transcripts are complete.  Should you decide to withdraw data collected about you will be used in the study. You are also free to skip any questions I may ask without exception.

**Contacts and Questions:**

If you have questions later, you may contact me on my cell phone at: 262-443-9498 or via email at: olandmail@gmail.com.  My advisor, Dr. Thomas Fish may be contacted at the University of St. Thomas School of Education, 1000 LaSalle Avenue, Minneapolis, Minnesota 55403 at 651-962-4436 or TLFish@stthomas.edu.  You may also contact the University of St. Thomas Institutional Review Board at 651-962-6038 with any questions or concerns. You will be given a copy of this form to keep for your records.

**You will be given a copy of this form to keep for your records.**

**Statement of Consent:**

I have read the above information.  My questions have been answered to my satisfaction.  I consent to participate in the study.  I am at least 18 years of age.

______________________________  __________  __________________
Signature of Study Participant Date

I also agree to be audio-recorded:

______________________________  __________  __________________
Signature of Study Participant Date

______________________________ Provide copy? Y/N
Print Name of Study Participant

______________________________  
Signature of Researcher Date
Appendix D – Interview Questions

The purpose of this study is to explore the lived experience of multidisciplinary leaders in meeting patients’ spiritual needs. I will use a qualitative research design with a phenomenological approach.

The approach seeks to identify the perceptions, motivations, attitudes, and lived experiences of health system leaders who have participated in an educational experience aimed at improving the provision of spiritual care. Participants include multidisciplinary leaders at multiple levels of a secular and a non-secular health system that have had healthcare related spiritual education. The derived meaning from individual experiences is anticipated to provide a more comprehensive understanding of multidisciplinary leaders responsible for spiritual care of patients’ from the participants’ perspective.

In the process participants will attempt to answer the following guiding questions, with sub-questions as required to stimulate thoughts and perceptions:

- What does spirituality mean to you?
  - Describe what spirituality feels like?
  - Describe how and when you came to recognize your spiritual nature prior to receiving spiritual education/training?
  - Describe the factors that enhanced meaning making for you? Your staff?
- In what ways do you meet or not meet your own spiritual needs?
- In what ways do you meet or not meet the spiritual needs of staff who report to you?
- Do you perceive your spirituality impacts the way you lead your staff? If so, how?
- How do you determine the spiritual needs of your staff?
- Think of a situation where you successfully assisted a staff member who needed your support. Describe the process. How did it begin, progress and conclude? How did you know it was successful?
- In what ways did the spiritual education/training (RISEN) you participated in impact you/your leadership approach?
  - Describe the spiritual education program you participated in. When was it? What motivated you to participate?
  - What was your attitude and perceptions going into the educational experience?
  - Describe the learning experience. What emotions captured your feelings?
  - Describe what helped and/or hindered your experience?
  - Think about prior to the training as opposed after. What was different?
• Afterwards, did this experience impact your leadership approach? If so, in what ways?
• How did the educational/training experience impact the way you lead today?

• Do you perceive multidisciplinary leaders direct and non-direct, influence each other, their staff, and/or patients to meet patients spiritual needs? If so, how?

• Think about the spiritual nature of leaders in your health system/hospital responsible for direct patient care staff (nursing, pastoral care, other). Describe a situation where they were particularly effective in meeting a staff and/or patient spiritual needs. What occurred? How did you know this was successful?
• Think about the spiritual nature of leaders in your health system/hospital responsible for non-direct caregivers (administration, central registration, marketing, housekeeping, etc.) Describe a situation where they were particularly effective in meeting a staff and/or patient spiritual needs. What occurred? How did you know this was successful?

• Think of an inspired situation where a patient’s spiritual needs were successfully met by a multidisciplinary team of staff with both direct and indirect care givers involved. Describe the various staff members, direct and non-direct, involved in the process and their individual roles?
  • How did you perceive the attitude and experience of the staff involved? How did they influence each other?
  • If there were leaders involved, in what ways did they help or hinder the process? How did you perceive they contributed to meaning making?
  • What efforts do you believe helped or hindered staff in helping patients make meaning?
  • How do you know whether or not the patient’s spiritual needs were met?

• Do you perceive leaders at different levels of your organization impact spirituality? If so, how?

• Think of situation where leadership contributed to meeting spiritual needs of staff and/or patients in your organization. Describe ways in which leaders at various levels assisted or inhibited staff from enhancing meaning making for one another? For patients?
• What was different at each level of leadership? Did leaders at some levels have more impact than others? If so, why?
• Describe the leaders’ attitudes or behaviors? Did this have an influence on the staff? If so, how?
• How do you know whether or not the staff and/or patients’ spiritual needs were met?
• Do you perceive your supervisor impacts your spirituality and the way you lead? If so, how?
• If you could describe the perfect hospital culture where patients’ spiritual needs are always met, what would it look like?
• What do you believe are staff perceptions, attitudes, and lived experiences that help patients’ make meaning?
• What do you believe staff perceive as essential personal knowledge, skills, behaviors, attitudes, and responsibilities for providing spiritual care?
• What do you believe are staff perceptions, attitudes, and lived experience of the multidisciplinary team process to help patients’ make meaning?
• What organizational behaviors are perceived as most helpful or as impediments in making meaning of spirituality for staff and for their patients’?

Appendix E – Confidentiality of Data Agreement for Transcription Services

This Confidentiality Agreement made effective this ___ day of ___(month) in the year 2015 by and between ____________(name), a provider of transcription services, and Charisse Oland, a doctoral candidate.

As part of my dissertation, I desire to hire _________(name) to transcribe audio data files of interviews conducted under an agreement of confidentiality into Microsoft Word files. _____________(name) agrees to maintain files in confidence and not to disclose, distribute or disseminate files to anyone, except to Charisse Oland, the researcher. __________(name) shall exercise a reasonable degree of care to prevent any unauthorized disclosure of files. Disclosure of files by __________(name) to third parties shall constitute a breach of this agreement.

Upon the request of Charisse Oland, the researcher, _____________(name) agrees to immediately return or destroy all written, machine readable or otherwise tangible files received or created.

Transcription Company:____________(name) Researcher: Charisse Oland
Signature: __________________________
Printed name: ______________________