BRITE DIVINITY SCHOOL
TEXAS CHRISTIAN UNIVERSITY

NURTURING SPIRITUAL COMPANIONSHIP IN A MULTICULTURAL, MULTIFAITH HEALTH CARE SETTING

A PROJECT THESIS/REPORT
SUBMITTED TO THE FACULTY IN CANDIDACY FOR THE DEGREE
OF DOCTOR OF MINISTRY

BY
JENNIFER HOLDER ROWLEY

DECEMBER 16, 2006

As author of this paper, I grant permission to the Mary Couts Burnett Library, Texas Christian University, to provide a photocopy of the paper to any requesting institution or individual, with the understanding that it be for scholarly use only.

Signature

Date

Notice: WARNING CONCERNING COPYRIGHT RESTRICTIONS:

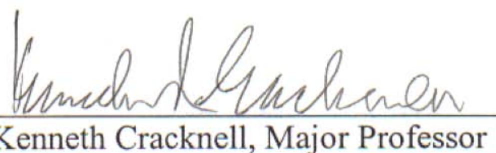
The copyright law of the United States (Title 17, United States Code) governs the making of photocopies or other reproductions of copyrighted material.

Under certain conditions specified in the law, libraries and archives are authorized to furnish a photocopy or other reproduction. One of these specified conditions is that the photocopy or reproduction is not to be used for any purpose other than private study, scholarship, or research. If a use makes a request for, or later uses, a photocopy or reproduction for purposes in excess of "fair use," that user may be liable for copyright infringement.

This institution reserves the right to refuse to accept a copying order if, in its judgment, fulfillment of the order would involve violation of copyright law.

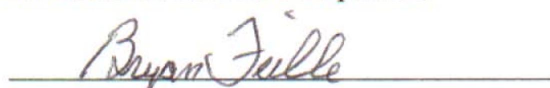
To the Dean of the Brite Divinity School:

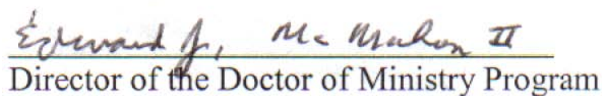
I am submitting herewith a project report and thesis written by Jennifer Holder Rowley entitled "Nurturing Spiritual Companionship in a Multicultural, Multifaith Health Care Setting." I have examined the final copy of this paper for form and content and recommended that it be accepted in partial fulfillment of the requirements for the degree Doctor of Ministry.



Kenneth Cracknell, Major Professor

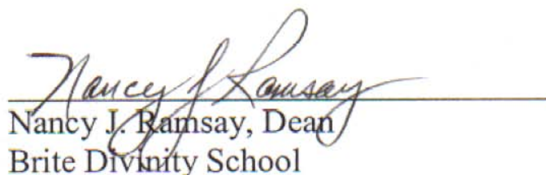
We have read this professional paper and recommend its acceptance:





Director of the Doctor of Ministry Program

Accepted



Nancy J. Ramsay, Dean
Brite Divinity School

DEDICATION

This paper is dedicated to the memories of my son, Jonathan Worth Gordon; my father, Worth "Pop" Holder, and Elizabeth Boumbulian, the wife of my friend and mentor, Paul Boumbulian. These three people taught perpetually, through long illnesses and finally through death, that spiritual companionship is truly one of the greatest gifts one human can give to another. By their sufferings, they created in our hearts a conviction that health care professionals first, and foremost, are called to compassion, kindness and soul care. If spiritual companionship comes first, quality clinical care follows naturally.Jonathan, Pop, and Elizabeth were healed by death; others are healed to live. This D.Min. project is a way of thanking them for our awareness that healing is, to a large degree, a spiritual matter, one best attended by a spiritual companion. My prayer is that this project serve as one milestone of a lifetime with a passionate dedication to teaching others the beautiful art and great reward of spiritual companionship.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS x

ABSTRACT xi

Chapter

INTRODUCTION. 1

1. ADDRESSING A UNIVERSAL HUMAN NEED. 5

2. BUILDING THE SPIRITUAL COMPANIONSHIP PROJECT . . . 23

3. RESEARCHING BEST PRACTICES IN SPIRITUAL COMPANIONSHIP 29

4. CHOOSING SACRED VOCATION AS BAYLOR'S APPROACH TO NURTURING SPIRITUAL COMPANIONSHIP. 37

5. IMPLEMENTING SACRED VOCATION 41

6. EVALUATING RESULTS OF SPIRITUAL COMPANIONSHIP PROJECT 55

7. ONGOING IMPACT AND POTENTIAL OF SPIRITUAL COMPANIONSHIP PROJECT. 62

CONCLUSION 64

Appendix

A. D.MIN PROJECT PROPOSAL

B. SPIRITUAL COMPANIONSHIP PROJECT PROPOSAL TO BAYLOR UNIVERSITY MEDICAL CENTER ADMINISTRATION

C. ROSTER OF MULTIDISCIPLINARY SPIRITUAL COMPANIONSHIP PROJECT COMMITTEE

D. SAMPLE MEETING MINUTES PREPARED FOR SPIRITUAL COMPANIONSHIP PROJECT COMMITTEE

E. INQUIRY BRIEF: THE ADVISORY BOARD COMPANY, WASHINGTON,D.C.

F. SACRED VOCATION PROJECT PROPOSAL TO BAYLOR UNIVERSITY MEDICAL CENTER ADMINISTRATION

G. PRELIMINARY INTERVIEWS WITH PATIENT CARE TECHNICIANS

H. SACRED VOCATION ORIENTATION FLIER

I. SACRED VOCATION SESSION FLIER

J. SACRED VOCATION FEATURES IN SPIRIT OF EXCELLENCE NEWSLETTERS

K. SAMPLE POINT OF SERVICE PATIENT QUESTION REGARDING SPIRITUAL/EMOTIONAL CARE PROVIDED BY PATIENT CARE TECHS

L. JOB SATISFACTION SURVEY GIVEN TO TECHS BEFORE/AFTER SACRED VOCATION PHASE I SESSIONS

M. SACRED VOCATION PARTICIPANT EVALUATIONS

N. SAMPLE GRADUATION CERTIFICATE

O. SAMPLE GRADUATION PHOTOS

P. SACRED VOCATION COPING TIPS WRITTEN BY PATIENT TECHS

Q. SACRED VOCATION OATHS BY PATIENT CARE TECHS

R. PATIENT CARE TECHS JOB SATISFACTION BEFORE AND AFTER SACRED VOCATION PHASE I

S. BLESSING SERVICE FOR WORLD HEALTH DAY WITH BLESSING OF HANDS BY SACRED VOCATION GRADUATES

T. LETTER TO SACRED VOCATION GRADUATE FROM GRATEFUL PATIENT

U. THE ROTHKO CHAPEL IN HOUSTON TEXAS

BIBLIOGRAPHY

VITA

ACKNOWLEDGEMENTS

The following persons have been indispensable in their contributions to this D.Min. Project:

Lyle Rowley, my husband
Emily Gordon Moore and Mark T. Gordon, my children
Paul Boumbulian, Community Advisor to the Project
Howard and Karen Stone, inspiration providers
Kenneth Cracknell, invaluable teacher, mentor, project advisor and friend
Edward McMahon and Bryan Feille, Brite Faculty
Mark Grace, Travis Maxwell, Mike Mullender and Jann Aldredge-Clanton, Pastoral Care Colleagues
John McWhorter, Teresa Schardt, Lisa Hill and the Spiritual Companionship Project Committee (Appendix C), Baylor University Medical Center
Rabbi Samuel Karff, Ben Amick, III, Ph.D., Christine Plourdes and Jessica Tullar, Sacred Vocation Project Development Team
Pauline Sanders, my son Jonathan Gordon's devoted caregiver and spiritual companion
Denita Wade and Chick Deegan, Sacred Vocation Facilitators
Kitty Lewis, Nita Taylor, Cindy Bivins, Jane Smith-Stage, Jan Hosse, Jacqueline Haden and Gerry Sobel, friends who cheered me on
Father Gerald Sevick and St. Anne Parishioners
Ron Somers-Clark, my supervisor,and Sister Irene Aztemborska, fellow Clinical Pastoral Education resident at Children's Medical Center who taught me much about Spiritual Companionship
John Cabrera and Marilyn Hulse, computer wizards who helped the project move from mind to matter

ABSTRACT

Project Director: Kenneth Cracknell. The goal of this D.Min. project is to nurture the ability of patient caregivers at Baylor University Medical Center (BUMC) in Dallas to provide emotional and spiritual care to patients, families and co-workers. A multidisciplinary Spiritual Companionship Project Committee led by the D.Min. student researched best practices in spiritual and emotional care among health care providers and selected the Sacred Vocation Program, developed by Rabbi Samuel Karff at The University of Texas Medical School in Houston, as the vehicle to accomplish the project's goal. From September 2005 through May 2006 more than 220 patient care technicians, who provide more direct patient care than any other health care professional at Baylor, were trained through the Sacred Vocation program to see themselves as healers providing spiritual companionship, and to understand their work as a sacred vocation. Increased patient satisfaction with spiritual care and tech job satisfaction following the Sacred Vocation program demonstrate the project's positive results and goal attainment.

INTRODUCTION

It was a summer evening in Cambridge, England. The occasion for me was celebrating the end of writing the first draft of a book called *Parting: A Handbook for Spiritual Companionship Near the End of Life* commissioned by the Foundation for End of Life Care and published by University of North Carolina Press at Chapel Hill. Along with co-author Jann Aldredge Clanton and a research team including Mike Mullender, Bob Duncan and Mark Grace, colleagues and chaplains at Baylor University Medical Center of Dallas, the book was the product of two years of researching best practices around end of life care across many religious traditions and many cultures. The task was to weave that learning into a book of use to persons of any faith or cultural background as they went about the work of caring for someone nearing death. Now printed in the U.S., U.K., Korea and China, the book appears to accomplish its mission.

It took a three-week writing sabbatical at Cambridge, an ocean away from job, family and church responsibilities, to write the first working draft of the book, with the daily editing assistance and encouragement of Karen and Howard Stone, editors.

As we ended a memorable dinner and walked back to Wesley House, where my hospitable writing cell looked over the peaceful, lovely green courtyard below, Karen said, "Your next step should be a D.Min. project using what you

have learned from writing this book in some way." "Right," I thought cynically while silently promising myself never to voluntarily research or write anything again.

But her suggestion of that summer night in 2000 was not to be dismissed. It followed me doggedly. The book project taught me the art of spiritual companionship and how it is the common work of compassion. It knows no cultural boundaries, has no particular faith tradition, and speaks no certain language. It is not the purview of ministers, but of any person endowed with basic kindness and respect for humans struggling through rough places.

So two summers later, I was back at Brite's door with a D.Min. project in mind. I first approached Howard Stone, thinking it was a pastoral care project in orientation. He wisely coached me to take the idea of enhancing spiritual companionship to all patients, families and staff at Baylor University Medical Center, where I am now the palliative care chaplain, into the world of Kenneth Cracknell. Spiritual companionship across cultures and faith traditions, Stone said, required not more work in pastoral care, but more work in understanding and respecting diversity. It would take broadening my worldview, experiencing other cultures and other forms of worship. It would take walking alongside Cracknell through two years of study, tracking his mind through readings he recommended, experiencing firsthand at his gentle urging Passover Seders and Sufi Dervishes, Sikh worship and fellowship, kneeling in prayerful devotion to God with other women in rows behind the men inside a Fort Worth Mosque.

I thank God Stone veered me in Cracknell's direction. Discovering how to fearlessly extend myself and seek hospitality in a diverse world and learn the many universal aspects of spiritual companionship was the work I needed to do. In the process, as I will describe in this project report, I did find a fulcrum that is already enhancing the spiritual and emotional care offered at Baylor University Medical Center at Dallas, one that will continue to do so for many years to come. There is no D.Min project that could offer more satisfaction to me than this one, dedicated to helping people find loving kindness while in the throes of illness, crisis or loss.

As I wandered along this path, seeking how to nurture spiritual companionship in our bustling, multicultural workplace, I became a proving ground for my own theories. Never in my life have I needed spiritual companionship more than in the past year, while my son, Jonathan, nearing his life's end at only 26 years old, was cared for by some of the same gentle hands of those on the palliative care team on which I serve at Baylor. Because of our mutual journey into the realms of suffering, transcendence, abject sorrow at the thought of death's interruption of a life so loved, and the joy of trust in God's certain presence at this time and glad welcome into a fuller life to come, I know firsthand why spiritual companionship matters.

There is no cure at life's ending, but there is the sublime medicine of compassionate words, gestures, and touch. There is no escape from death, but there is the balm of friends and loved ones who stayed right beside Jonathan and me until death trumped earthly existence. There were no bargains left to strike

with God, but there was joy for every extension of even one morning. There was no energy left in me, it seemed, but there was a Divine infusion of spirit and grace for another go round, buoyed by spiritual companions who offered their strength, their hugs, their time, their ears to hear my lament, their arms and legs to help. My project has, due to my personal circumstances, touched my very soul, and created a conviction that a lifetime of work nurturing spiritual companionship for those in need of it would be a life well spent. I hope this report can do justice to the project that has meant so much to me and to Baylor University Medical Center already.

CHAPTER 1: ADDRESSING A UNIVERSAL HUMAN NEED

Heeding the Cry for Spiritual Companionship in Health Care

About suffering they were never wrong,
The Old Masters: how well they
understood
Its human position; how it takes place
While someone else is eating or opening a
window or just walking dully along.
W.H. Auden[1]

Understanding the impetus for a project that enhances spiritual companionship for patients is as simple as remembering the last illness that afflicted you, personally, or a loved one. When in the throes of illness, diagnostic acumen and clinical expertise are tops on the priority list. But barely a degree below them is the need for human compassion, a kind touch, a sympathetic recognition that life as you expect it has come undone, sometimes for a while, sometimes unto death. The human spirit needs spiritual care at these times just as acutely as the human body needs physical care. When suffering takes place, the heart cries for someone to notice, and not, as the poet Auden says, to just keep "walking dully along."

While the last half of the 20th Century seemed fairly consumed by technological advances in medicine—cardiac bypass surgery, amazing diagnostic imagery, solid organ transplantation, technology to save wee struggling neonates, surgery revolutionized by staple sized incisions, amid myriad others-- the 21st Century is asserting a new demand for improved spiritual and emotional care. The

[1] John Shea, *Spirituality and Health Care* (Chicago: The Park Ridge Center, 2000), 32.

mighty and influential Joint Commission on Accreditation of Healthcare Organizations (JCAHO), whose standards must be met for a hospital to be reimbursed for the care provided to Medicare patients, added a standard requiring that institutions address the spiritual needs of patients just as they do the physical needs. Another powerful health care body, the American Hospital Association, issued a document in 2003 entitled "Patient Care Partnership," replacing "The Patients Bill of Rights." This new guideline stated unequivocally that spiritual well-being is a vital component of a patient's overall well-being and encouraged patients to raise issues of their spiritual needs with the health care team providing their care.[2]

In the Spring 2001 issue of *Nursing Administration Quarterly,* Kathleen Krebs noted that author J. Naisbitt, writing in *Megatrends 2000*, said "It has been predicted that our greatest advances in the next decade will not come from technology but from our deeper understanding of what it means to be a human, spiritual being." She continued with a quote from pollster George Gallup Jr., speaking at a conference on Spirituality and Healing in Harvard University's Mind/Body Institute (an institute which in itself is a sign of the times): "If the focus of the 20th Century has been on *outer* space, the focus of the 21st Century may be on the *inner* space. We are entering a new era of discovery—not of the world around us, but of the world within."[3]

---

[2] Emily McClung, Daniel H. Grossoehme and Ann F. Jacobsen, "Collaborating with Chaplains to Meet Spiritual Needs," *MEDSURG Nursing* 15 (June 2006): 147-156.

[3] Kathleen Krebs, "The Spiritual Aspect of Caring—An Integral Part of Health and Healing," *Nursing Administration Quarterly* 25 (Spring 2001): 55-60.

Before beginning my search for a way to further unleash the kind force of spiritual companionship on the patients and staff at Baylor University Medical Center, I needed to explore further what spirituality and spiritual care really were. I learned much on the subject through my son and the many ways people cared for our souls and spirits during his lifetime of serious and physically disabling health struggles. Etched on a mother's heart was one important criteria of spiritual care: Spiritual care *enables* the human spirit to find hope, joy and meaning in life despite what *disabling* circumstances of illness vex the human body. I found other spiritual care definitions that were helpful. Krebs, an R.N. clinical manager in a hospital, says, "Spirituality is referred to as the practices, beliefs and attitudes that an individual might have toward God, a higher power, or supernatural forces in the universe. It is our search for 'wholeness' that gives meaning and purpose to our existence." [4]

I returned to the book I co-authored with my colleague, Jann Aldredge-Clanton, to revisit the definition of spirituality put forth by profoundly spiritual health care professionals assisting on our work. Larry Churchill of Vanderbilt University says, "spirituality embraces the widest possible range of meanings without subscribing to any particular beliefs or practices. In this sense, spirituality is a common human activity, an activity of seeking deeper meaning in oneself, and relationships and in life. Eventually, every person's spiritual search will include a

[4] Ibid., 57.

need for spiritual care, as he or she confronts the meaning of life's end and the ultimate loss of death." [5]

Mark Grace, director of Pastoral Care and Counseling at Baylor University Medical Center, provided an illustrative, soulful list of the components of spiritual well-being which are the desired outcome of spiritual companionship.

> *Wholeness:* The sense of being complete in oneself. A sense of basic inner integrity.
> *Belonging:* The feeling of being at home, or at the proper place in time. A sense of participation in one's world, of connectedness to others and to one's environment.
> *Gratitude:* An awareness of and receptivity toward the gifts that enrich one's life. Recognition of the presence of resources, experiences, relationships, and objects that have no connection to one's efforts.
> *Humility:* The ability to love oneself in spite of oneself. Acceptance of limitations, awareness of capacities, respect for the mysterious aspects of oneself all are part of humility.
> *Reverence:* A sense of wonder and awe; of vastness, greatness, complexity; of being taken outside of oneself.
> *Perspective*: Seeing deeply into things. An intuitive awareness of meanings. Insight or wisdom about oneself or one's life situation.
> *Trust:* Moving into and with the current of an experience or relationship. Surrendering control of outcomes and conditions. Depending on persons or forces outside the range of one's immediate control.
> *Devotion:* Commitment to care for someone/something. Experiencing the other (or an aspect of oneself) as a valued part of one's life.
> *Release:* The experience of being liberated, unburdened, or rescued from compulsive drives or anxieties.[6]

Grace's list of spirituality's core attributes comes from a chaplain, a pastor, a right-brained thinker to the nth degree. But it shares common themes, though different semantics, with the listing of the trademarks of spirituality researched and

---

[5] Jennifer Sutton Holder and Jann Aldredge-Clanton, *Parting:A Handbook for Spiritual Care Near the End of Life* (Chapel Hill: The University of North Carolina Press, 2004) 4-6.
[6] Ibid., 5-6.

compiled from noted sources by the more clinical, left-brained minds of RN/ PhDs Donna Marsolf and Jacqueline Mickley of Kent State University:

> *Meaning*—the ontological significance of life; making sense of life situations; deriving purpose in existence.
> *Value*—Beliefs and standards that are cherished; having to do with the truth, beauty, worth of a thought, object or behavior; often discussed as 'ultimate values.'
> *Transcendence*—experience and appreciation of a dimension beyond the self; expanding self-boundaries.
> *Connecting*—relationships with self, others, God/higher power, and the environment.
> *Becoming*—an unfolding of life that demands reflection and experience; includes a sense of who one is and how one knows among other things.[7]

Marsolf and Mickley advocate P.G. Reed's definition of spirituality using components of this list, which they found in a 1992 issue of *Research in Nursing and Health:* "Spirituality refers to the propensity to make *meaning* [italics added] through a sense of *relatedness* [italics added] to dimensions that *transcend* [italics added] the self in such a way that empowers and does not devalue the individual."[8]

However defined, whatever characteristics describe it, spirituality is part of the human experience, and a basic component of each man and woman. A chaplain colleague, Georgia Gojmerac-Leiner, of Emerson Hospital in Concord, Massachusetts, puts it eloquently:

> Thus spirituality is something present in the human being as is his or her DNA. Both spirit and DNA are invisible without awareness and technology. Awareness of spirituality arises out of the need for it, like a tree composting its own leaves to nurture the soil around itself, sending forth roots to anchor itself. Or, again, a tree with its roots can keep the

---

[7] Donna S. Martsolf and Jacqueline R. Mickley, "The concept of spirituality in nursing theories: differing world-views and extent of focus," *Journal of Advanced Nursing* 27 (1998): 294-303.

[8] Ibid., 295.

> soil from eroding thereby maintaining the bank on which it is growing as well as itself. [9]

Caring men and women who work in health care have always been conscious at some level of their role as spiritual companions. Brushing up daily against the lives of sick and dying patients and suffering loved ones take them beyond the realm of routine physical care to soul care. But what was once an aside for the health care professional has moved into center focus. Symptomatic of that shift is when the intuitive art of spiritual care became a Joint Commission accreditation standard. The 21st Century acknowledgement of spirituality as a fulcrum of wholeness and health creates a mandate to infuse the entire hospital with competence in spiritual companionship. Patients are open to accepting spiritual care, indeed, almost desperate for it to be offered.

Author John Shea puts his finger on the pulse of spiritual need in patients:

> For many patients, this openness to the spiritual is an overt plea for help. It is a search for a cure that doctors may not be able to accomplish or may only be able to accomplish with divine help. It is an attempt to bring the spiritual into the situation in the hope that it will contribute to successful physical and mental outcomes. At other times the openness to the spiritual comes about as patients realize the inevitability of loss and limit. They ask the questions, "How will I 'do' with this limit? How will I relate to this loss?" Some observers have said that on entering patienthood there is a centrifugal force. So much seems to be moving away from the center of the person who has become a patient. What is sought is a counter force, a centripetal movement that brings things back to the center of the person. The

[9] Georgia Gojmerac-Leiner, "Revisiting Viktor Frankl: His Contributions to the Contemporary Interest in Spirituality and Health Care," *The Journal of Pastoral Care and Counseling* 59 (Winter, 2005): 375-379.

> spiritual embodies such a centripetal power. It reestablishes the center of the person who is beset by loss and limit.[10]

My quest to nurture spiritual companionship at Baylor came from an understanding of the importance it plays in finding any semblance of peace, hope and emotional health in the midst of a personal illness or one of someone well loved. I see the need before me every day I am a chaplain visiting patients. It shows in the painful expressions of the patients, in the weary eyes of the family and friends. It is reinforced by the eager welcome of a hug or the squeeze of a hand. I found in reading the book *Spirituality and Health Care: Reaching toward a Holistic Future,* a reason beyond those I thought of for nurturing spiritual care, and an affirmation of the D.Min. project I chose:

> As it is the patient's "turn," so eventually it will be everybody's turn. We are all patients-in-waiting. As patients reach for both medical and spiritual resources, they create the foundational spiritual interest within health care. Every other spiritual interest is in some way related to this first and foremost reality—the human person in the struggles of health and illness. [11]

Developing A Theological Rationale for Inclusive Spiritual Companionship

The word inclusive, I believe, speaks to the very heart of God, the very soul of ministry as Christ envisioned it. I see inclusiveness as the essential gateway through which one must pass in order to offer spiritual companionship in a multifaith, multicultural world. The challenge is to find out to how to practice inclusive spiritual

---

[10] Shea, *Spirituality and Health Care*, 37.
[11] Ibid., 33.

companionship for all persons to whom we minister… how to make persons of any faith or any culture feel equally as welcome.

Our founder, Dr. George Truett of First Baptist Church Dallas, challenged us to do that more than 100 years ago, envisioning Baylor University Medical Center of Dallas as "a hospital where persons of all faiths, and those of none, can come for care with equal confidence." In that one powerful and forward-thinking mandate, he opened the door for inclusiveness. But how is that degree of sacred hospitality formed and extended through inclusive spiritual companionship for our patients, visitors and co-workers? Five important influences introduced by dialogue with Kenneth Cracknell during this project development and readings shape my thinking on how to seek God's common ground of mutual respect and communal love for those whose paths lead them to us for spiritual care and healing.

First Influence: Gaining New Perspectives on Scripture Passages

Kenneth Cracknell's latest work, *In Good and Generous Faith: Christian Responses to Religious Pluralism*, provides theological grounding for my instinctive bent toward inclusive and culturally sensitive ministry. He takes examples from Scripture, and shows how they support openness to seeing other religions as valid paths to God and building human relationships in good and generous faith toward one another.

The illuminating discussion of the concept of the Word, based on the scripture reference from John beginning this section, was a beautiful example of revisiting Bible verses. That small section of verses from John 1 has been used to narrow the

gateway to God by defining the Word as referring exclusively to Jesus Christ. Interpreted in that way, only Christians can experience fullness of life here and beyond. Cracknell instead shows the evolution of the concept of the Word through Old Testament scriptures, Wisdom literature and Jewish-Hellenistic philosophers. "As the dynamic expression of God, the Word is God turning to human beings in self-revelation; God calling human beings to a communion of life; God at work to save and to heal."[12]

To read Cracknell's absorbing look at ancient minds and how they interpreted the concept of "the Word" felt like sitting with bare feet in a cool brook. The words of Irenaeus… "because the Word implanted in their minds moves them and reveals to them that there is one God, the Lord of all"; or Clement of Alexandria… "the way of truth is therefore one. But into it as into a perennial river, streams flow from all sides"; or Athanasius, who said of the Logos, "He gives himself without losing anything of himself, and with him is given the Father, who makes all things by him, and the Spirit who is his energy."[13]

Other beautiful depictions of God as an inclusive lover of all creation came in Cracknell's look at the story of Noah, which he says is a "covenant of both preservation and redemption" that covers the entire cosmos, the sum of humanity.[14] Or he turns to the disciple Peter's assurance of God's blessing on people living

---

[12] Kenneth Cracknell, *In Good and Generous Faith: Christian Responses to Religious Pluralism* (Peterborough, Great Britain: Epworth, 2000), 41.
[13] Ibid., 50-53.
[14] Ibid., 9.

"outside the Covenant." Peter says, "I truly understand that… in every nation anyone who fears him and does what is right is acceptable to him." Even in the book of Revelations, Cracknell shows us words of comfort that, as he says, "suggest that God's final victory will embrace all people and all creation." What a wonderful forecast he makes, based on Revelations, of a city needing no temple or house of worship of any variety, because God is present there with all God's people.[15]

Wandering through biblical texts, thoughts from classic minds, glimpses into other faith traditions and their experiences of 'the Word' all gave me the grounding I lacked before to understand why a posture of inclusivism and a passion to learn the sensitive art of ministry in a multicultural, multifaith setting is at the center of my Christian faith. I thought, before, these "bents" of mine created a tension with my Christian roots. *In Good and Generous Faith* showed me instead that embracing all persons, from all religions and cultures, is instead at the very heart of the message of Christ. Christ, one expression of "the Word", is my avenue to God. What I learned is that, by God's grace, there are many, many other expressions of this holy "Word" equally valid and transformative.

Second Influence: Distinguishing Common Ground From Passing Over

Another significant influence on my thinking about inclusive spiritual companionship was the attention given by several authors to the concept of "passing over and returning back." At the beginning of the study, I was interested in seeking common ground where persons of any faith and culture could meet and comfortably

[15] Ibid., 34.

share space. Now, I am much less invested in that idea. Common ground now seems akin to the melting pot theory that dots American history, which is an unhelpful myth that robs persons of their cultural heritage.

Passing over and returning is much more inviting to me now, an image of two persons mutually approaching one another for an exchange of thoughts, ideas and religious leanings, then respectfully disengaging and returning from whence they came. In this image is no room for proselytizing, for dissuading or persuading, for pressing what I have come to call "the irrational need to be right." It is passing over from respectful curiosity, and coming home better off than before.

Interesting looks at the "passing over and coming back" approach came through the voices of Kenneth Cracknell, Israel Selvanayagam and S. Wesley Ariarajah. When I visited the Sikh Temple in Irving with him and other classmates, I learned firsthand what Cracknell describes in saying: "There is a spirituality which recognizes that there is 'a time for keeping silence' in which Christians may sit or kneel in loving contemplation surrounded by their friends and companions of other devotional paths."[16]

That was a life- defining experience of passing over and coming back. I sat in silence and loving contemplation of my brothers and sisters as they worshipped in Sikh fashion, and then, because of their mutual love for their guests, learned the basic tenets of their religion, and ate their common meal sitting cross-legged alongside them. Beautiful children, families, people old and young welcomed us to pass over

[16] Ibid., 118.

into their lives, with no agenda but hospitality. I "came back" to my world not ready to become a Sikh, but fully aware that God had visited all of us in this interchange.

From Cracknell's writing, I learned the origin of the expression that has become a hallmark of interfaith study. It was John S. Dunne, a Roman Catholic theologian, Cracknell says, who wrote in *The Way of All the Earth* that "passing over is a shifting of standpoint, a going over to the standpoint of another culture, another way of life, another religion. It is followed by an equal and opposite process we might call 'coming back' with new insight into one's own culture, one's own way of life, one's own religion."[17]

Then Cracknell makes the concept even easier to understand, comparing the crossover of religious exploration to the crossover of language exploration. In both instances, we all have a "mother tongue" or "mother faith" which is our linguistic and spiritual home. We can learn another language, certainly, but it takes years of immersion in that language before we cease to continually translate from our mother tongue to it and begin to think in it outright. Likewise, Cracknell explains, we can pass over to explore another faith, but it is very hard to convert to that faith from our mother faith. Yet much is gained from gaining even a small understanding of another language or another faith. Our minds stretch; our imaginations are freed to play in new and foreign lands.

To pass over takes courage. Cracknell calls it 'negative capability.' He describes that for Christians as "this ability to live with uncertainties, mysteries,

---

[17] Ibid., 128.

doubts, without an irritable reaching after fact and reason, alongside a single controlling vision of Jesus and their commitment to him."[18] The reward for developing this negative capability, he says, is to develop deep friendships with those of other faith traditions, and appreciation for not only other sacred texts but for the individuals who use them as plumb lines for living.

Israel Selvanayagam comments on the courage it takes to pass over by saying it will take nothing short of "a new type of person who can help us to find a place which is new for both of us, yet which at the same time does full justice to our distinctive positions."[19] The conversation partners, he writes, must remember of whom they speak: an enigmatic creator whose very name (YAHWEH) means "liberating presence and being ready to bless and transform, but never to comprehend, investigate or manipulate."[20]

Selvanayagam suggests that, as we receive others who "pass over" to learn of Christianity, "we should tell the story, the whole story and nothing but the story, in which the gospel finds unique expression not in the form of doctrines or dogmas, but in the form of inspiring insights and challenging values."[21]

S. Wesley Ariarajah comments on the act of passing over and coming back many times in his wonderful book, *Not Without My Neighbour*. I was struck particularly by one sentence where he said, "Religions are not fortresses to be

---

[18] Ibid., 132
[19] Peter Lang, *A Great Commission* (Bern, Switzerland: Peter Lang AG, 2000), 267.
[20] Ibid., 274.
[21] Ibid., 278.

defended; they are springs for the nourishment of human life."[22] Thoughts like this and the many reflections on passing over and coming back made me understand how important it is to be willing to use the bridges of intellect, curiosity, sensitivity and love for kindred beings to find paths to pass over. The reassuring aspect of my readings was to learn that the point of passing over is not to mutate or waiver at all from my Christian leanings and root system, but to learn as much as I can that will help my faith grow from others, whose faith grows from different leanings and equally vibrant, life-giving root systems. I look forward to the point in my own passing over that I can experience what Cracknell describes as an exhilarating sense of crossing a frontier… standing within a new circle of relationships and perceptions… becoming another person.[23]

Third Influence: Contemplating the Word Dialogue

Probably no one word will remain more indelibly etched in my head from time spent with this project on inclusive spiritual companionship than the word "dialogue." It has become familiar, understood and important in my thinking about ministry and life in a diverse world. It has become a watchword, influencing how I approach everything from hallway conversations to intentional excursions into learning about one another's faith tradition or culture. From my pile of readings, I know what dialogue is, and what it is not, and how to engage people in it through thoughtful and diligent efforts toward that end.

---

[22] S. Wesley Arairajah, *Not Without My Neighbour*, (Geneva, Switzerland: WCC Publications, 1999), 50.

[23] Kracknell, *In Good and Generous Faith,* 139.

Martin Forward provided a foundation for understanding the potential power of dialogue by dissecting the word in Greek. The first part of the word, he says, "is 'dia-', not 'di-' as many people wrongly infer. In Greek, 'di-' indicates 'two' rather than the 'one' that is signified by 'mono-', but 'dia-' is a preposition that means 'through'. 'Di-logue' could mean *two* people conversing about a worldview; maybe amicably, maybe not; maybe with results, maybe not. But '*dia*-logue' signifies worldviews being argued *through* to significant and potentially transformative conclusions, for one or more participants. It involves a much more consequential encounter."[24]

Short recognizes the 1971 work of the Sub-unit on Dialogue with people of Living Faith and Ideologies of the World Council of Churches in publishing guidelines for dialogue that still hold true:

> Dialogue begins when people meet.
> Dialogue depends upon mutual understanding and mutual trust.
> Dialogue makes it possible to share in service.
> Dialogue becomes the medium of authentic witness.[25]

I read Cracknell's review of the life journey of Paul as told in Acts and saw that we have a powerful precedent there. In the passages from Acts and Ephesians, Paul truly does show, as Cracknell writes, "the way of dialogue is a way of patience, sometimes frustrating, always time-consuming. It shows us, too, that the way of

[24] Martin Forward, *Inter-religious Dialogue: A Short Introduction* (Oxford: Oneworld, 2001), 12.

[25] Ibid., 11.

dialogue means meeting the person on his or her own terms and really attending to what they say, believe, feel."[26]

Dialogue builds a "community of conversation," a "community of heart and mind" across racial, ethnic and religious barriers where people learn to see differences among them not as threatening but as "natural" and "normal", Ariarajah says. "Dialogue thus is an attempt to help people to understand and accept the other in their 'otherness'. It sees to make people 'at home' with plurality, to develop an appreciation of diversity, and to make those links that may just help them to hold together when the whole community is threatened by forces of separation and anarchy."[27]

Fourth Influence: Imagining a World Lived In Good and Generous Faith

It was so heartening during this era we live in to read, and in reading, be able to imagine a world that is different. This world would be one connected with rich dialogue, illuminated with the light cast by the faithful of all religions. To become acquainted with so many individuals who believe that we can achieve a world lived "in good and generous faith," and who are willing to devote a lifetime of working and writing toward that end, was energizing and hope infusing. Such a world offers rich opportunities for spiritual nurturing.

---

[26] Cracknell, *In Good and Generous Faith,* 163.
[27] Ibid., 14.

Fifth Influence: Invitation to Interfaith Activism

Seeking a theological rationale for my D.min project, I learned rudimentary lessons in how to do, and teach others to do, sound ministry and spiritual companionship in a multicultural, multifaith world. I determined to practice what Cracknell calls "radical openness." The way of "radical openness" was modeled by Jesus himself for us to imitate. It results in hospitality as warm and genuine as that Jesus extended to all persons. It is based, Cracknell says, on "affirmation of the dignity of all."[28] It puts in our hearts the "universal longing for, and seeking after, truth, peace and justice."[29]

What are some pathways to "radical openness" which are acts of spiritual companionship?

1. Encourage inclusive worship gatherings of patients, families and staff.
2. Invite dialogue with staff, patients, families and volunteers of other faith traditions in settings where there is no attempt to seek common ground, but instead to offer an open space to "pass over and come back."
3. Survey members of our community from other cultures and faith traditions about how we can more visibly welcome, include and offer spiritual companionship to them in the Baylor community.
4. Direct all patients, families, staff and volunteers to explore the rich resource of our Interfaith Garden of Prayer and raise it up as a symbol of inclusion and

[28] Cracknell, *In Good and Generous Faith,* 221.
[29] Ibid., 222.

living out the dream of Rev. George Truett, Baylor's founder, of becoming a place where all can come for healing.

5. Continue to teach the art of spiritual companionship that applies universally to all, regardless of faith or culture, to our staff.
6. Remind all chaplains of the Chaplains Code of Ethics (also attached) of the Association of Professional Chaplains, which requires us to work every single day with sensitivity and openness to support, listen and learn from those of other faith traditions than our own.
7. Personally pass over at every opportunity to learn more about other faith traditions and other cultures from conversations with the diverse people with whom I work.

I think that the ideology of inclusion will shadow me wherever I turn, cast a light on whatever I see. A quilter once said that to be a quilter, one has to learn to "Piece by yourself, quilt together." I link her wisdom to inclusive spiritual companionship. We piece our faith by ourselves from the information and inspiration we receive, but then we are called to piece our faith with those of others around the world, equally loved by God, to make a quilt of divine community where we are, to one another, spiritual companions.

CHAPTER 2: BUILDING A PROJECT TO NURTURE SPIRITUAL COMPANIONSHIP

With the certainty that I had a good concept for a D.Min project, but no idea how I would go about accomplishing the goal of nurturing spiritual companionship for our patients and families, I began to frame a proposal for the work. After many drafts and redirection from Howard Stone to consider this a multicultural ministry project rather than a pastoral care one, and thus to change to Kenneth Cracknell for mentoring and project advising, I outlined the one that begins the series of appendices to this paper which illustrate the ways and means that the project was completed. (D.Min Project Proposal, Appendix A)

I realized after an initial round of research and conversations with health care colleagues about the directive from JACHO to provide spiritual and emotional care to patients that I had a project that would benefit my organization at the same time it satisfied the D.Min project requirements. So I approached my supervisor at that time, Travis Maxwell, and my department director, Mark Grace, and asked for support for the time I would spend researching how to approach nurturing spiritual companionship within our institution. (Baylor University Medical Center Proposal, Appendix B)

Justification for requesting support was not only the JACHO requirements recently added to the daunting list of criteria for accreditation, but also pressure from

the American Nurses Credentialing Center (ANCC), which awards the coveted Magnet status to institutions with exemplary nursing care, to emphasize patients' spiritual and emotional care as key parts of their overall health care experience. The time, from an institutional perspective, was right for resources to be directed toward finding new avenues for bolstering spiritual and emotional care… care that had become a universal job requirement for health care workers. Chaplains are key spiritual caregivers, often leading the way by example and coaching. But they are few among the many, and the clarion call for spiritual companionship was now being directed to everyone.

I also harbored my own theory that patient satisfaction ratings so vital to retaining a competitive edge in a bustling market of health care providers would benefit from enhanced spiritual and emotional care, as well as employee satisfaction and job retention, all important potential positive side effects of the project that justified my appeal for support.

I pitched the proposal, and waited to hear back from my supervisor. I knew I would do the project with or without financial support because it had become my vision. More importantly, I coveted the institutional buy-in to the importance of the goal. I will never forget the morning I received the telephone call from Travis Maxwell, saying that our department director, Mark Grace, and John McWhorter, chief executive officer of Baylor University Medical Center, had approved 12 hours a week of my time to devote to this quest to find new ways to nurture patients emotional and spiritual care. At the time the call came on my cell phone, I was

standing outside the Rothko Chapel in Houston, just about to enter to meditate in the sacred space inside and pray for God's help on the work ahead, work that I hoped would unleash a new high of compassion and human kindness to our patients and families.

I looked around the interfaith chapel and saw, on each small bench set aside for prayer and quiet reflection, a sacred text from many of the major world religions. Other people of diverse cultures and faiths joined me in silence. I remembered how, standing where main hallways intersect two busy Baylor hospitals, I sensed being at the crossroads of the world. People of all nationalities, cultures and faiths come to Baylor, and they are beautiful to see, sometimes in native dress of other countries, often speaking in languages foreign to me. I prayed that this project would blanket them all with spiritual and emotional comfort and compassion at a difficult time.

I knew that Baylor University Medical Center has the capacity to provide amazing physical care; my own family members have been touched by miracles of healing there. And I knew there would be great potential to enhance spiritual care, and great openness from the staff to learn new spiritual care skills. In early reading for my work, I found this description of a hospital grounded in spiritual and emotional care of both those who come for healing and those who come to work there:

> A Healing Hospital is a place characterized by thousands of small and wonderful things and a few big ones. At the center is love. The Healing Hospital is a concept that, more than anything else, supports a strong culture of caring. It expresses the deep passion of both patients and caregivers. This is a passion in the human cry of the

> suffering patient. It is a cry for help, and for love. And it is also the silent call emanating from the eyes of caregivers who seek real support from leadership in their desire to respond to that human cry.[30]

I had total faith, as an employee of 15 years, that Baylor University Medical Center does not turn a deaf ear to those cries. When given the opportunity to help raise the bar on spiritual and emotional care, I was humbled and ecstatic. I knew we had the leadership that would make this project fly, when the right direction was found. I resonated with John Shea's observation that "In some faith-based health care organizations, spiritual sensitivity and spiritual knowledge are included in the criteria for leadership. Spiritual interest in the life of the organization becomes a structural commitment to the spiritual development of everyone from patient to employee."[31]

I knew we had that capability. The "yes" I received that August morning at the Rothko Chapel inspired me from that moment on. I strongly believe the theory Peter Senge and others put forth in the wonderful book, Presence*:* "The only change that will make a difference is the transformation of the human heart."[32] I knew we have an ample supply of kind hearts at Baylor Hospital. How to harness them for nurturing even more spiritual and emotional care was the question.

At this point in my life and in my career, I knew this was not a project I could do alone, nor would I want to try. To make even the smallest shift in enhancing

---

[30]Erie Chapman, *Radical Loving Care: Building the Healing Hospital in America* (Nashville:Baptist Healing Hospital Trust) , 16.

[31] Shea, 34.

[32] Peter Senge, C. Otto Scharmer, Joseph Jaworski, Betty Sue Flowers, *Presence* (New York: Doubleday, 2004), 66.

something as fundamental as spiritual care of patients required a culture prepared and open to the concept. It took buy-in from clinical departments, administrators, my team members in pastoral care, and many, many others.

Early in the work, Paul Boumbulian graciously volunteered to be my Community Project Advisor. He quickly become my teacher, coach, cheerleader, pipeline of contacts, library of resources, mentor and friend. Boumbulian is a passionate proponent of spiritual care in hospitals, a longtime health strategist, key builder of Parkland Hospital District's network of community clinics, former professor at The University of Texas Southwestern Medical School and national consultant for many other health care projects.

The long and winding road he traveled beside his beloved wife, Elizabeth, through her prolonged illness and eventual death created in him a passion for any work that improves spiritual and emotional care of patients. He welcomed the chance to help me move this project from concept to fruition. His first piece of advice was that I put together a multidisciplinary task force within BUMC to guide my work and create a base of accountability.

The task force would need to understand how the project fit with the business strategies of the hospital. A great boon was that CEO John McWhorter placed the project under the Spirit of Excellence Culture umbrella directed by Teresa Schardt, RN, MSN. Her basic commission for the Spirit of Excellence Culture was to enliven excellence in patient care and track patient satisfaction, giving reward and recognition when deserved and training and improvement opportunities for underachieving areas.

She enthusiastically and graciously took the project and I both under her wing and helped me compose a Spiritual Companionship Project Committee (Committee Roster, Appendix C). This group contracted to meet with me 30 minutes every month immediately following her overarching Spirit of Excellence Culture Leadership Team Meeting.

Time is the most scarce commodity available at Baylor, and these people are leaders, “movers and shakers” effecting positive changes in myriad ways. The discipline of meeting with them monthly and having a concise report that informed them, invited their input warmly, and kept the project on track was an excellent growth experience for me. Invariably there were necessary absences of some of the committee members, but the meeting notes were distributed faithfully by an invaluable administrative assistant, Lisa Hill. (Meeting Note Samples, Appendix D). We met faithfully and forged ahead toward the goal, gaining excitement and momentum as we went. The committee met monthly from Fall 2004 through our last meeting, a celebration luncheon, in June of 2006. Each member has been a wise counselor to me, a key voice in the project’s development, and a source of vision and energizing, fun collegiality.

CHAPTER 3: RESEARCHING BEST PRACTICES

The first and somewhat daunting task of my project was to research what was being done at hospitals in other parts of the country in the area of nurturing spiritual companionship. Unlike mortality rates or head counts of patients who acquire an infection while hospitalized, the practice of spiritual caregiving is nebulous and hard to document or measure.

It felt like what is described in *Presence*, where economist Brian Author said in his interview with the authors that creative projects, by nature, "encompassed suspension and redirection, but it also linked these to a different way in which action arises, through a process called 'a different sort of knowing.'" He continued:

> "The key is careful observation. In a sense, there's no decision making. What to do just becomes obvious. You can't rush it. Much of it depends on where you're coming from and who you are as a person. All you can do is position yourself according to your unfolding vision of what is coming. A totally different set of rules applies. You need to 'feel out' what to do. You hang back, you observe. You're more like a surfer or a really good race car driver. You don't act out of deduction, you act out of an inner feel, making sense as you go. You're not even thinking. You're at one with the situation." [33]

Arthur pointed out parallels in science as well, saying that "most scientists take existing frameworks and overlay them onto some situation," while "first-rate ones sit back and study the situation from many, many angles and then ask, 'What's fundamentally going on here?' My observation is that these outstanding people have

[33] Senge, *Presence,* 85.

no more intelligence than the 'good' scientists do, but they have this other ability, and that makes all the difference. The first type of understanding tends to be the standard cognitive kind that you can work with in your conscious mind. This inner knowing comes from here. (pointing to his heart) Every one of us has experienced this in different ways, consciously or unconsciously."[34]

Studying best practices in spiritual care definitely required a "different kind of knowing" from our entire spiritual companionship project committee. Through research, site visits, phone interviews, one personal experience of a hospitalization for Jonathan during that time and observing in one clinical area, I heard gifted, dedicated persons speak from the heart about what they were trying to do to enrich spiritual care of patients and families. A few voices suggested spiritual care for employees, too. The project committee learned with me and we collectively used our inner feelings as a guide to make sense of what we learned and to find our own path among those paths others showed us.

I was fortunate to be assisted in best practices research by the Marketing and Planning Leadership Council of The Advisory Board Company in Washington, D.C., a resource used at Baylor University Medical Center when benchmarking research on health care issues and opportunities is needed. The Advisory Board Company Inquiry Brief is included in full as Appendix E. The research company did their usual broad sweep of the country looking for spiritual care programs at hospitals. They

[34]Ibid., 85.

also provided contacts who were willing to talk to me further about what was in place in their organizations for fostering spiritual care.

While I did not find a model that seemed to fit Baylor for nurturing spiritual companionship in their report, I did learn several key factors to remember when pressing forward with the project:

1. Support by the institution's senior executives for building a culture of spiritual companionship is fundamental to success. Administrators need to be aware that this culture building process requires their involvement and support at every step for the idea of total patient care… mind, body and soul… to take hold.
2. Chaplains and pastoral care staff lead most of the programs encouraging spiritual care for patients, which could be a positive or a negative factor in influencing other employees to embrace the concept. Unlike the usual pattern of referring spiritual needs of patients to chaplains, the new JACHO standards require that *all* employees provide spiritual care. If chaplains teach the programs, it might be harder to break the established patterns and convince all employees of their accountability as spiritual companions.
3. Some hospitals in the group researched by the Advisory Board Company are seeing direct correlations with intensified efforts at spiritual care and increased patient satisfaction.
4. Sessions and in-services on spiritual care are often made mandatory to emphasize to employees that all staff members are responsible for tending to

the spiritual and emotional needs of patients. The in-services are tailored to teach different departments with various types of patients how they can practice spiritual care.

5. Training for nurses is often considered first priority because they often are first to assess the spiritual and emotional needs of patients.
6. Early on the distinction between spirituality and religion is made so that staff are not concerned that the training for spiritual care is an attempt to convert them from their own faith tradition.
7. Staff members are already involved in spiritual care and often pray with patients and participate in religious rituals or practices. They are attuned to spiritual and emotional needs and provide spiritual care along with the chaplains in times of crises or death.
8. Current patient survey instruments make it hard to track satisfaction of care provided for their spiritual needs.
9. Spiritual care initiatives are not limited to faith-based institutions. Non-sectarian hospitals are also offering spiritual care training to staff.
10. Training in spiritual companionship is often included in new employee orientation and in additional sessions that use videos, interactive teaching methods and power point presentations. These last from ½-1 hour.

Besides the research from the Advisory Board Company, which was helpful but didn't offer a model that I felt was worth replicating, I also visited many hospital websites where spiritual care programs or institutes for spiritual care are in place. I

interviewed several other key sources who are championing spiritual companionship in their organizations elsewhere in the U.S. by phone or in person while attending a conference on measuring spirituality at the Mayo Clinic in Rochester, Maryland.

One of those interviewed was Steve Ivy, former director of pastoral care at Parkland in Dallas and now senior vice president for values, ethics, social responsibility and pastoral services at Clarion Health System in Indianapolis, Indiana. Ivy introduced me to several ideas "outside the box" of the usual approaches I had been hearing about for teaching spiritual care. First, in one of the innovative programs at Clarion called The Gift of Caregiving, nurses, social workers and child life professionals lead a 2-day retreat for health care professionals. Soul-searching and self-care is the agenda, with a look at what brought the participant to health care, what keeps them there, and what threatens them with burnout most. Participation had been very high (3,000 attendees system wide at the time of the interview) in this program, which was not required nor used as remedial intervention, Ivy said.

The other interesting program he joint ventured developing with Clarion's chief nurse executive. Called "Sanctuary for Healing," the program offers different department managers the option to help staff members make their area more healing for work. Some of the staff-initiated changes included, so far, allocating a small area of the department for meditation space, or participating in team building or community building exercises. The plan for the "Sanctuary for Healing" is as individual as the work group making it.

Steve began redirecting my thinking toward spiritual companionship training that is focused on the caregivers, not only the patients and families. He introduced me to the theory that spiritual care cannot exist in a vacuum of self-care. I would hear much more on that theory with the two site visits that followed his interview. From his input, I knew to take a nursing manager along with me on the site visits so that whatever we saw at Houston's medical Mecca would be seen with clinical as well as pastoral eyes. He also echoed the advice from the National Advisory Board Company to make it clear that our training was spiritual, not religious, in nature. In his funny way, I still remember Ivy saying, "If employees confuse the two and think you are going to be teaching them about the Bible, they'll be offended, and you'll be dead in the water with this project before you even start."

I continued best practices research by observing staff at work on several clinical floors, seeing firsthand how spiritual companionship was being offered to our patients. I had a wonderful experience while watching employees working on a mobile mammography unit. I was encouraged at the obvious spiritual care in progress as they handled a steady stream of women patients in varying states of anxiety and stress. I saw them practice: courtesy, active listening, providing complete information on what to expect, humor, touches of kindness ("have a blessed day" was the sendoff message for each patient from the receptionist), and in several instances, the staff put the patient's needs first. I learned from that one observation experience how busy and pressed the staff are to engage in any kind of training, but how receptive they are to practice spiritual companionship, even when time is scarce.

The other units I was scheduled to visit and observe were derailed by life-threatening illness for my son, Jonathan, which required a week's hospitalization at Baylor. This hospitalization began his season of palliative and hospice care, and made me even more dedicated to the project for the sake of others who suffer illness and approach death in the hands of hospital staff. I observed plenty, from the vantage point of a patient's family member, including excellent spiritual and emotional care for both of us, for the most part. The week reinforced what I had seen in my one observational visit: the staff was ready, interested and the time was right to interject training that would nurture spiritual companionship.

A trip to Houston with Tricia Ault, a respected clinical nurse manager on a challenging floor populated primarily with patients with chronic lung disease, rounded out our best practices research. We visited Memorial Hermann Healthcare System where we met Tim Van Duivendyk, vice president of spiritual care & Louis Smith, Jr., executive director, Spiritual Leadership Institute. They had many interesting approaches to instilling spiritual care into the core values of their employees, including teaching modules on Cultural and Spiritual Sensitivity and Assessing and Attending to the Spiritual Needs of Patients. These were taught in auditoriums on the campuses of the system's hospitals with a mix of chaplains and representatives from clinical and business areas as faculty. Memorial also offered a Spiritual Wellness Center and Spiritual Leadership Institute where leadership training courses were offered on personal spiritual development and gaining deeper self-understanding. One interesting approach Memorial used was screening candidates for

employment with the Hartman Value Profile that indicated whether persons seeking employment had compatible values to those of the organization before they ever came to work.

The visit at Memorial Hermann was early on a beautiful Spring morning. Tricia and I left it inspired, but still searching for the right formula for enhancing spiritual care within the culture of Baylor University Medical Center. We met Rabbi Samuel Karff at the John P. McGovern, M.D. Center for Health, Humanities and the Human Spirit. We did not know that what we were about to find would give shape and form to our passion for spiritual care and become the heart of our project, providing us with materials to enrich spiritual companionship for our patients while simultaneously enriching the lives of a very dedicated and deserving group of employees at BUMC.

CHAPTER 4: CHOOSING SACRED VOCATION AS OUR PATH TO NURTURING SPIRITUAL COMPANIONSHIP

It did not take us long after meeting Rabbi Samuel Karff to know we had found an unusual person and a deep thinker. In his soft-spoken way, he told us about his vision for enhancing spiritual care in hospitals. It came from years of visiting members of his synagogue when in the hospital, and from his own time as a patient. He decided that it was the persons closest to the direct care of the patients who should be cultivated as spiritual companions…those women and men who changed the linens, brought the trays, gave the baths, positioned and repositioned weary, hurting bodies all day and all night, those who cared for body, mind and spirit most intimately. Rabbi Karff had the outline of the program he thought would help the direct patient caregivers in his coat pocket on index cards at the time of our meeting. He pulled it out, and described a six-week encounter that would, through group discussion, activities and self-enrichment exercises, help these caregivers to see themselves as healers in a sacred vocation of patient care rather than workers at a job.

Rabbi Karff described the experience he had facilitating such a group at the pilot site for his program, St. Luke's Episcopal Hospital. He told us how he made sure the Sacred Vocation program took place in a very nice atmosphere, with refreshments each week. The patient care assistants were welcomed each time with enthusiasm and respect. The circle of participants grew closer with each session, facilitated by Rabbi Karff where they were assured of total confidentiality. The series

of sessions ended with a graduation day, a happy occasion with special friends and family included.

It was not necessarily the content of the program that drew my colleague and I into the vision of Sam Karff, it was the intensity of the man and his desire to nurture spiritual care giving. His method seemed brilliant in its simplicity, and his idea to target those closest to the bedside first to seed a culture of spiritual companionship giving made more sense than any model we had discovered in all the other research. Tricia Ault and I only spent one hour with Rabbi Karff, but we left him knowing we had found what we were looking for. We could not wait to return to the project committee and begin gathering support to bring Sacred Vocation to Baylor.

I read *The Tipping Point*_ by Malcolm Gladwell early in my project research. I intuitively felt that Sacred Vocation had the potential to be a "tipping point" in our culture. Rabbi Karff was obviously one of Gladwell's "connectors," one who could "span many different worlds" because of "something intrinsic to their personality, some combination of curiosity, self-confidence, sociability, and energy.[35] He also had a heart for kindness and a compulsion for encouraging spiritual care of self and others.

But as we left his unique aura and headed back to Dallas, I worried that perhaps Sacred Vocation would not be enough of a "deliverable." After all, the project started with the goal of teaching everyone, in every job, the art of spiritual companionship. Would reaching only our patient care techs be too narrow a scope?

---

[35]Malcolm Gladwell, *The Tipping Point* (New York: Little, Brown & Company, 2002), 49.

But I remembered the rationale in *The Tipping Point* for tackling a small group to effect a big change. Gladwell writes:

> This is the first lesson of the Tipping Point. Starting epidemics requires concentrating resources on a few key areas. … A critic looking at these tightly focused, targeted interventions might dismiss them as Band-Aid solutions. But that phrase should not be considered a term of disparagement. The Band-Aid is an inexpensive, convenient, and remarkably versatile solution to an astonishing array of problems. In their history, Band-Aids have probably allowed millions of people to keep working or playing tennis or cooking or walking when they would otherwise have had to stop. The Band-Aid solution is actually the best kind of solution because it involves solving a problem with the minimum amount of effort and time and cost.[36]

I saw how this “band aid” approach of teaching spiritual care first to those most intimately involved and most accessible to the patients could be a case in point for Gladwell’s theories. He wrote that to find a tipping point takes nothing short of “reframing the way we think about the world.”[37] Isn’t that exactly what Rabbi Karff had done? And when Gladwell wrote, “What must underlie successful epidemics, in the end, is a bedrock belief that change is possible, that people can radically transform their behavior or beliefs in the face of the right kind of impetus,”[38] he captured the spirit of Rabbi Karff that had intrigued and excited my clinical partner and me so much about his program.

With those thoughts fueling the desire to bring Sacred Vocation to Baylor as the programmatic component of my D.Min. project, I co-authored with Tricia Ault

---

[36] Ibid., 256.
[37] Ibid., 257.
[38] Ibid., 238.

and Teresa Schardt the proposal that took the idea to CEO John McWhorter within a week of our visit with Rabbi Karff, included as Appendix F. Rabbi Karff came and visited with my project committee; my project advisor, Kenneth Cracknell, and McWhorter, and later in the afternoon described his program to all the nursing managers we could gather on relatively short notice. Our CEO said, "Go for it." All who heard Rabbi Karff's presentation were drawn into the concept and the promise it held for patients and staff to be the beneficiaries of a new day of spiritual and emotional care, led by the patient techs. The months of research and inquiry had come full circle. Sacred Vocation was chosen as our means to the end of nurturing spiritual companionship.

CHAPTER 5: IMPLEMENTING SACRED VOCATION

From the moment the proposal to implement Sacred Vocation was approved, positive energy and pure fun began, along with a ton of work. The Spiritual Companionship Project Committee became advisors on when (days of the week and times of the day) to offer the sessions to make them most user friendly and how to communicate about them to our patient care technicians (known as “patient techs” or simply “techs”). The committee identified four nursing units whose techs would be encouraged to take the training first, and four others whose techs would intentionally be asked to wait until the next six-week session so that the impact of the training on patient’s perceptions of spiritual and emotional provided by techs could be studied immediately after graduating the first class.

But before the first session began in September of 2005, there was important groundwork. To get a feel for the culture that the techs worked in, three of them were chosen for in-depth interviews about their work, their typical workday, their lives and their challenges. Nursing supervisors helped to select the three interviewees, specifically looking for a blend of high and mid-range performers of varying ages and tenure at Baylor (those selected had tenure ranging from 3 to 30 years). I spent delightful hours of visiting with three women, using as the basis of my interview questions supplied by the developers of the Sacred Vocation program. What I learned helped me, the other two facilitators and the program coordinators in Houston get

"inside the heads" of those who would be in our classes. Transcripts of the three interviews are included in Appendix G.

Finding the right additional facilitators was another important piece of preliminary work, work that was richly blessed. Paul Boumbulian, community advisor to the project, introduced me to Chick Deegan, an experienced nurse who had become a nurse educator and also was an experienced counselor. Chick is deeply committed to relationship-centered care and was eager to learn how to facilitate Sacred Vocation sessions.

I was searching for a prospect for the second facilitator who would bring diversity to our team, and I literally had a "God moment" while walking early one morning. I wanted facilitators who had been patient caregivers and who knew the intense labor of those who would be in our program. I had 25 years of experience as a caregiver for Jonathan, who was physically dependent on others for all of his personal care, feeding and mobility. Chick had her rich nursing background.

"Who could join us?" I mused as I walked. Suddenly, I heard from my divine source, "The answer is right in front of you." It took another circle around the park to figure it out. The answer was Denita Wade, a wonderful woman with a background in business, customer relations and group facilitation who had joined Jonathan's caregiver team along her mother. Denita is vibrant, approachable, and gifted in bonding with people. The trust she earns and interest she shows in each person encourages participation. She is also deeply committed to compassionate patient

care. We made a Sacred Vocation team together that was equipped, compatible, and eager for the task ahead.

After training with Rabbi Karff and Ben Amick, III, a former Harvard professor in sociology who became a co-developer of the Sacred Vocation program responsible for much of the business development and research attached to it, we could not wait for the sessions to begin. (Training cut a day short, I might add, by the approach of Hurricane Rita to Houston that prompted evacuation of the building in The Texas Medical Center where the training was taking place. Ben Amick demonstrated his own spiritual companionship that evening as Houston residents bailed out by hosting us, dining with us at one of the few restaurants open, and picking us up at 4:30 a.m. the next morning to chauffeur us to the airport using back roads whenever possible in order to get the first flight out. The training was continued at a later date in Dallas, far from the hurricane zone!)

In the month prior to rollout of Sacred Vocation, Teresa Schardt and I, along with our other two facilitators when they could join us, hosted 20 Orientation Sessions that spanned all shifts on a Wednesday and a Sunday. The flier that announced these sessions is Appendix H. The orientation sessions offered the techs a time to learn about the program, take a break from their work, and enjoy great refreshments and hospitality. The wording of the invitation to the orientation sessions began to set the tone of the program, totally affirming to techs:

> This Spirit of Excellence program aims to recognize you for working compassionately with patients and to enhance how you feel about your job. You will learn…

- That your job is a “sacred vocation”—you have the power and the opportunity to help brighten, heal and nurture the spirit of your patients.
- How meaningful you are to your patients.
- How to positively and sensitively connect with people while showing respect for their personal, religious or cultural backgrounds and choices.
- How to share your ideas about how Baylor can support your work as a sacred vocation.

Even before these well attended orientation sessions, a comprehensive communication effort coordinated by the BUMC Public Relations Department was blanketing the organization with news of Sacred Vocation. A managers’ email group, publications and brief presentations to management meetings, nursing leadership meetings, and administrative meetings as well as to the BUMC board, all were part of the rollout of the program. A second flier, announcing the exact times and dates of the sessions, included as Appendix I, was distributed at each orientation session. Copies were available to pick up on posters throughout the campus for several weeks prior to kickoff. Follow-up publicity in the Spirit of Excellence newsletters, seen in Appendix J, kept the momentum going as the Sacred Vocation sessions occurred from September 2005 through April 2006.

The first session of Phase I coincided with asking patients on our identified units (four with participating techs/ four with nonparticipating techs) how they perceived the spiritual and emotional care offered by their techs on the question shown in Appendix K, which was an add-on to the point of service questionnaire distributed to patients on the day of discharge. Another angle on measurement of the effectiveness of the program was the survey in Appendix L. Techs completed the

survey on their current job satisfaction and perception of themselves as spiritual caregivers on the second week of the program, and then they were asked to repeat the survey months after finishing Phase I of Sacred Vocation.

Painstakingly, the stage for Sacred Vocation was set. We offered five different rounds of Phase I, each with 7 class sections running at different times of day on different days of the week. The techs registered for the class section that would best fit their schedule, and they poured in. Before we finished the implementation, more than 200 techs graduated from the program. While paid for time spent in class, techs were encouraged to do the program on their off-duty time, not while at work, so as not to create patient care shortages and frustrated co-workers. This response was totally voluntary and somewhat amazing since participating took personal time away from their families, other activities, and, in some cases, much-needed sleep before their next shift. Many techs drove back in on their day off to take the classes.

There are 3 Phases in the Sacred Vocation program. It is easy to provide an overview of the material covered; much harder to capture the spirit of the techs attending and commitment to use the program as a life-enrichment experience. The outcome of every group was the enhancement of the techs' sense of work as a "Sacred Vocation" and of their calling as spiritual companions, not only to the patients and families, but also to one another.

The combined effect of the 3 phases was to help the techs find themselves and their calling in order to be healers to our patients and to one another. One theorist,

Stanford's Michael Ray, considers the shift in sense of self-central to creativity. To access deeper sources of creativity, he believes the key is two questions: "Who is my self?" And "What is my Work?" When we talk about "Self," said Ray, "we're talking about your high self, your divinity, your highest future potential. And by asking 'What is my work?,' we're asking what is the purpose of your existence or what are you meant to be."[39] Sacred Vocation invited the techs to explore this vital sense of self within the following framework of Phase I, II and III:

Phase I

The six 90- minute sessions in Phase I covered the following subjects:

Session 1: "Validating a Human Life"

The class looks at what gives meaning to their lives, and what their values are. They share their good attributes by telling what they hope co-workers say about them if asked how it is to work with them. They look at a fictional woman's life accomplishments, and evaluate them as to whether they should be included in her funeral eulogy. Then, they take quiet time and think about what they hope will be told about them at their own funeral years down the road… what they hope to accomplish in life, what they hope to be known for, how they hope to have made a difference. They are asked to think how work fits into their life plan, with the message that too much time is spent at work not to find reward and meaning there.

Session 2: "Discovering the capacity to heal"

---

[39]Senge, *Presence*, 101.

The class reconvenes and talks about "healing moments" they have experienced in the past week, both healing things they have done for patients, friends and family, and healing things people have done for them. We share times that we experience the good feeling of being where we are supposed to be, doing the work we are called to do. The idea of seeing themselves as "healers" in a Sacred Vocation is introduced in this session.

Session 3: "Discovering the capacity to harm"

The flip side of being a "healer" is being a "harmer." In this session, we candidly admit examples of times we have harmed rather than healed in our interactions with co-workers, patients and families. This session lends credibility to the whole program, by acknowledging that work has its frustrations and moments employees are not at their best. But it returns to positive energy by using case studies of patient care situations where harm had been done, and asking the techs what could be done differently to turn a harming circumstance into a more healing one. Both environmental obstacles to being a healer are examined and attitudinal ones. The session's activities create awareness in the techs that they have a choice of how to respond to negative situations and attitudes, and "No one can take away my power to heal," which is the powerful theme, repeated often during the whole program.

Session 4: Developing Sacred Vocation Coping Tips

Techs create role-plays of stressful and challenging situations they encounter at work. These can be quite funny, yet are candid and revealing about the challenges of dealing with nurses and co-workers; difficult patients and families, and heavy

workloads, especially in the event of staffing shortages. After the role plays, which sometimes prove cathartic and encouraging because they see others encountering the same challenges, the patient care techs work together to come up with "Coping tips" that can be applied in the daily challenges they face, a list that becomes one of the important takeaways of the program. A bucket of popcorn ready for a movie night with family and friends is awarded to each tech for their "blockbuster" performances in the role-plays. The bonding that has taken place in prior sessions is intensified with this fun but productive session.

Session 5: Developing Oath for Healing

The last session before graduation from the program is an exercise where the techs together draft their Sacred Vocation Oaths, commitments they want to make as to how they will care for patients, families and one another in the future. These are read in unison at graduation the following week in front of supervisors, managers, and family members who attend. After graduation, they are printed on a laminated badge, which techs wear behind their photo i.d.

Session 6:: Graduation! Techs celebrate their accomplishments of the past five weeks and the strides they have made in understanding the importance of their work as healers. Techs talk about the experience while enjoying a graduation cake and other special refreshments. They say their oath aloud in unison, and supervisors and managers compliment them publicly and affirm them as valued team members.

Phase II

The Sacred Vocation program seeks not only to affirm the techs and help them gain an identity as healers and spiritual companions, it also seeks to empower them to recommend changes in the workplace that will create an environment conducive to being healers. Phase II takes more work, more commitment. Techs who either volunteer or are recommended by the facilitators form a working group of 12-15 persons who represent the interests of all the techs in the organization. Over five weeks, they tackle the job of identifying positive changes that they feel need to be made. The content of the five sessions, which are held on paid time, cover:

Session 1: Identify work flow and work as sacred vocation.

Session 2: Identify work environment obstacles and facilitators for removing them

Session 3: Decide how the work environment can be changed to support work as Sacred Vocation

Session 4: Develop action plan recommendations

Session 5: Present action plan to management.

Phase III

Phase III teams techs with chaplains to sustain the momentum of their newfound status as healers and awareness of their role as spiritual companions. Chaplains consult techs about patients to whom they are referred, asking them what the family dynamics are like and for any helpful information on the patient's current status emotionally and physically. Chaplains can ask techs to give special attention to patients who are in particularly difficult circumstances, including those who have no

family or support system. Likewise, techs can consult chaplains about challenging patients or personal circumstances and seek personal pastoral support.

Follow-up social and continuing education activities, including Sacred Vocation "alumni" meetings and learning modules taken to each floor by tech leaders and chaplains for quick educational sessions offered in the break rooms, reinforce what the graduate learned and give them a chance to share experiences and support one another as they seek to live out their oaths.

Phase III also is a time to follow through and implement all the action items identified by the techs in Phase II. The goal of the action plan is to remove any organizational barrier to working as healers in a sacred vocation and to build new programs which help the techs find meaning in work and provide spiritual and emotional care to one another and to patients and families. Two examples from the initial Phase II recommendations being implemented currently in Phase III are the 1) Walk in My Shoes Program, where nurses and techs trade roles and observe each other's work for ½ day in order to foster understanding of their distinct but equally valuable contributions and 2) reinforcing communication between techs and nurses and techs with other techs and allied health professionals both during the shift and at shift change to be certain all important background information on patients is transmitted in a timely way that supports the highest quality of patient care.
These are only two examples of 14 recommendations approved for implementation from Phase II of Sacred Vocation (of 16 total suggestions) spilling over into Phase III, which has no foreseeable ending.

I believe I speak for all of us who facilitated the Sacred Vocation Program in saying that we learned far more from the techs than they from us. These men and women are the heroes of health care in our estimate, after hearing their stories about the nature of their demanding work. They are naturals at spiritual care… most of them feel a special calling and aptitude to the intimate bedside care they provide. They love the patients and the opportunity work affords them to build special relationships. Many of them recount with pride how patients come back to the unit with flowers or cards, or how sometimes current in- patients know when they will be at work next and ask for them by name.

In my reading, I found several insights that captured the sentiments shared by the techs during the implementation of Sacred Vocation. One of my favorite contemporary theologians, Henri Nouwen, said, "We are all healers who can reach out to offer health, and we all are patients in constant need of help. Only this realization can keep professionals from becoming distant technicians and those in need of care from feeling used or manipulated."[40] I sensed that our techs had long known this truth, and, in reaching out steadily to offer health, had avoided becoming anything like a "distant technician."

The techs experienced a time to be open to their own spirituality and to talk about how it impacts work. We were very careful to stay on the spiritual plane rather than delving into specific religious beliefs, and the techs seemed very comfortable with that boundary. They often mentioned prayer as a coping tool, for example, but

[40] Chapman, *Radical Loving Care,* 25.

not which church they attended or specific prayers they used. In their eagerness and openness to speaking of spiritual things, the techs verified the theory I read in Spirituality and Health Care:

> The inevitable flipside of dealing with the spiritual interests of the patient … is to focus on the spiritual interests of the caregivers themselves. Some spiritual teachers would contend that the desire to be open to the spiritual perceptions and questions of another somehow presupposes some conscious contact with one's own spiritual search. Perhaps this has always been part of the inner, motivational world of many caregivers. Now, however, many are asking that it come forward in an explicit way. If they pursue it, caregivers begin to walk a spiritual path, personally developing as they care for others.[41]

The excitement and support surrounding the implementation of Sacred Vocation Phase I and II over the course of 9 months in 2005, and the ongoing commitment by my department leadership and our CEO to keep the gains of the program alive in Phase III, tell me that I work for a unique and exemplary organization, one that "cares for its own," and lives out the ideals set forth here:

> If the health care organization is committed to delivering holistic care, a care that encompasses the physical, mental, social, and spiritual aspects of being human, then it also should be interested in the physical, mental, social and spiritual health of its employees. It would be contradictory to try to deliver spiritual care in a spiritually uncaring environment, to try to give to others what has not been given to you. Therefore, the organization as a whole must include the spiritual in how it attends to its employees if it hopes they will be spiritually sensitive to one another and to the various clientele they serve. William J. Bazan and Daniel Dwyer note that 'High quality services cannot be delivered by organizations or people who are not spiritually grounded…. Burnout distances caregivers from the recipients of their care, and the entire organization must be

[41] Shea, *Spirituality and Health Care*, 33.

> committed to employees' spiritual needs to assist in preventing those negative responses.' The organizational interest in the spiritual well-being of its employees is part of its mission of holistic care.
>
> In and of itself an organization cannot create people's spiritual beliefs and spiritual sensitivity. But it can be supportive of the resources that a person brings to work. It can cultivate and elicit the spiritual consciousness and motivation that is already there. The supposition is that people have an essential spiritual aspect and they are encouraged and satisfied when that side of them is recognized and invited into the workplace. An organization that is spiritually interested understands this deeper level of people, what Abraham Maslow called 'the farther reaches of human nature.' It searches out ways to tap into it.[42]

The implementation of Sacred Vocation at Baylor University Medical Center has every prospect of qualifying as one of Gladwell's tipping points. The raw material of spiritual companionship seems to be innate within the heart of a committed patient tech. Unleashing that force by encouraging the techs to use their unique skills at spiritual and emotional care and to recognize their singular importance in the patient's experience was the work of Sacred Vocation. Teaching the techs how to use powers within themselves to transform harmful situations into healing ones and empowering them to become change agents to create healthier work environments can tip our culture significantly toward greater spiritual care for patients and employees alike.

I left the Sacred Vocation implementation project a full believer in something I read in a fascinating book by organizational gurus Ian Mitroff and Elizabeth Denton,

---

[42] Ibid., 56.

a quote from one of many executives they interviewed regarding spirituality in the work place:

> "Perhaps the most telling reflection of all was the following: 'I believe that there is no alternative to organizations becoming more spiritual. The only organizations that will survive are those that have a deep value base. But values are not enough. It has to be something more universal. Most of corporate America doesn't realize it, but we are running out of gimmicks to motivate the work force. The only thing that will really motivate people is that which gives them deep meaning and purpose in their jobs and in their lives in general. This thing is not a gimmick. Whatever you call it, it is spiritual at its base.[43]

[43] Ian Mitroff, *A Spiritual Audit of Corporate America* (San Francisco: Jossey-Bass Publishers,1999), 52.

CHAPTER 6: EVALUATING PROJECT RESULTS

Did Sacred Vocation nurture spiritual companionship in a multicultural, multifaith health care setting? Varying indicators are assembled here to help answer the question and, in so doing, assess whether the goal of my d.min project was achieved. First, many comments of the techs who took Sacred Vocation are included in Appendix M. These comments were qualitative add-ons to a quantitative survey the techs completed on graduation day. The quantitative results showed that 100 percent of the techs found the sessions to be beneficial, and 100 percent would recommend the Sacred Vocation Program to a co-worker. Given that the content of the program was focused on teaching techs to be healers of spirit and body who saw work as a sacred calling, nurturing spiritual companionship seems a natural by-product.

Techs also demonstrated more awareness of their roles as spiritual companions in interviews for the Spirit of Excellence "Excellence in Action" newsletter. One tech, Gloria Bagsby, said "The classes were inspirational and opened my eyes to see patients' emotional and spiritual needs in a new light." Another tech, Carla Levels, said, "The Sacred Vocation Program is one of God's ways of reminding me of the importance of the work I do with patients, families and coworkers. Showing compassion is part of living out my faith." Tech Melissa Van Hecker added, "The training has helped me become a more understanding person. I think I

relate better to my patients and my coworkers. Along with the doctors and nurses, I see myself as a healer, as someone who patients can talk to and cry with."

The pride the techs took in their graduation certificates, shown in Appendix O, and the joy evident in all their graduation group photos, Appendix N, point to the effectiveness of the training in lifting the spirits of those providing the preponderance of personal care to our patients. The techs, when asked to identify a gift they would appreciate for graduation, said they would like a sweater with "Sacred Vocation Graduate" on the front and the Spirit of Excellence and Baylor logos on the back. These sweaters have become a mark of pride and a symbol of an employee devoted to spiritual companionship.

One of the strongest indicators that the project did nurture spiritual companionship was the work the techs did on composing their group's Coping Tips like the one in Appendix P and Sacred Vocation Oath like that found in Appendix Q. I believe only spiritual companions who have received nurture themselves could have crafted oaths including pledges to:

- Be a source of hope that heals the body and spirit
- Be honest and respectful of all
- Show empathy to patients and families
- Exercise patience as I work with patients and co-workers
- Take care of myself, so that I have what I need to care for others
- Enter through the doors with a prayer for my patients and coworkers

- Use my hands with tender compassion to heal and not to harm
- Respond in a timely manner and treat all patients equally
- Be friendly, gentle and kind
- Be empathetic, patient and understanding
- Listen for needs, feelings, hopes and fears
- Meet the patient where they are

Another important measure was the question asked of patients about their perception of how their techs provided emotional and spiritual care. There was a 7 percent increase in positive perceptions by patients of their own techs' ability to meet emotional and spiritual needs after participating in Phase I of Sacred Vocation.

Appendix R is the detailed report of the surveys of participating techs at the beginning of the program, then repeated after several months had passed. There were improvements in scores after the training in these vital areas: work satisfaction, affective commitment, meaning from work, intent to stay, communication and mental health.

Another positive evaluation for the Sacred Vocation implementation is the volume of participants who came from a broad spectrum of nursing units and found enough meaning in the sessions to continue attending through graduation. The roster of more than 200 attests to the relevance of the program in nurturing spiritual self-care and spiritual companionship. Graduates represented nearly every nursing unit at Baylor, showing the widespread appeal of the program.

The feedback I receive from the techs and, recently, from the chaplains who work side by side with them, tell me the D.Min. project is a success. I asked a tech recently what physical care she did that was also spiritual and gave her a chance to be a healer. Her answer touched me deeply: "Everything I do! Brushing their teeth, bathing them, turning them, helping them to the bathroom… all of these are spiritual acts too!" That response was perfectly in tune with what I envisioned could happen if spiritual companionship was nurtured. A chaplain told me, "I see the Sacred Vocation program working. I came around the corner and found two techs in a circle with a family praying over the sick loved one together. They welcomed me into their circle, and I was deeply moved."

After the implementation, a huge party was thrown for all 219 graduates and their special guests. There was jazz, and fun, and great food, and lots of celebrating and prize drawings. There was a time for testimonies from the techs, and a time for thank you and praise for them from administration and nursing. Other reflections of the success of the project's effort to nurture spiritual companionship came from three respected colleagues. Teresa Schardt, who was a wonderful proponent of the program and champion for the techs, wrote:

> "The purpose of my work is to raise patient, employee, and physician satisfaction through a service excellence culture. Patients expect us to be competent, to have the right tools to do our jobs well, and to have their condition improved when they leave the hospital. If that is our total focus, many patients will leave our hospital feeling that they could have received the same care and outcomes anywhere else. Our goal is to please our patients in body, mind, and spirit. So often it is the emotional and spiritual needs of the patient that bother them most while hospitalized, rather than their chief bodily ailment. Every staff

member needs to understand his/her role in providing for the holistic needs of each patient. Some staff members need development in this area while others have a natural affinity for spiritual assessment and deep, meaningful conversations. This program has accomplished that for us through a wonderful curriculum, excellent facilitators and coordination, administrative resources and support, and an audience that previously felt less valued by the professionals on their teams.

The Sacred Vocation program has had a strong impact on our culture and service excellence success since its implementation that began in September 2005. As a critical mass of our unlicensed assistive personnel (219 members) has recently completed the program, our patient satisfaction has increased across every service line.

Our techs have worked with a greater sense of purpose and pride since completing this valuable program. Many techs proudly wear their graduation present sweaters and respond to administrators on rounds more proactively than before this program. They want to give their input, greet us in hallways and meetings, and desire for us to round on their pleased patients. They have been very good to and for our patients and families, as well as the hospital as a whole.

Our president, John McWhorter, often remarks in numerous audiences, "Sacred Vocation© is one of the best investments we have made as a hospital in the last ten years!" Since beginning our service excellence culture transformation in August 2003, I can also say that the techs who work in their sacred vocation each day have done more for the emotional and spiritual support of our patients, families, and even co-workers than anything else we have implemented. Baylor is better for having found this profound way to improve job satisfaction of these valuable individuals and impact our relationships with our patients and families.

Whether our patients are born, recuperate, improve their health, or die here with dignity, it is satisfying to know that this very important part of our workforce is well equipped to minister to their deepest needs."

Chick Deegan, co-facilitator of Sacred Vocation, told of her experience with the groups and with the Sacred Vocation program:

> "The entire Sacred Vocation experience taught me many things...
>
> How the human experience ties us all together, and how we all want to make a positive difference in the world.
> How, in life and in organizations, we assign value to people/roles/classes based on a high low paradigm, and by so doing, limit their engagement, involvement, energy and ability to influence.
> How very little it takes, simply an invitation, to light the light within and wisdom and energy abound.
> The power of storytelling as a "measurement" tool.
>
> And, with the Phase II group, how they came together as individuals still questioning their ability to influence and find voice for their Sacred Vocation as healers and left a small community of powerful souls ready to make a difference...making their offer, not waiting to be asked.
>
> Finally, as part of the adopted family at BUMC, I was always assessing through my organizational development lens for alignment between values and actions...in strategy, tactics and leadership action. I have never experienced a more sincere and congruent community of individuals called to the mission of healing and the heart felt, spirit driven efforts that people go to help patients and families."

Finally, Tricia Ault, the R.N. from the Spiritual Companionship Project Committee who was with me the day we discovered Rabbi Karff and Sacred Vocation, remarked:

> "This project has been so exciting to be involved in. Ever since I first heard of Jennifer Rowley's vision of this idea it has raised so much genuine excitement from not only me but from others who have been involved in one way or another in the project or participants who have gone through the program.
>
> The results that I have seen on my unit have been very noticeable. Staff realize that by their actions they can harm or heal the patients. I receive more written and verbal comments from patients regarding the emotional aspect of support provided to them and the profound difference it has made to them. Staff also feels more comfortable praying with patients and talking openly about this. Before the

> program was in place, I don't believe that staff felt comfortable talking about praying with patients because it was something that was never openly discussed that's it's ok to do this. Now staff knows that it's ok. It's like they've been given permission and heard this is a great thing to be able to provide to patients that ask for it. The second piece to that last statement is this program has shown our techs that you can provide spiritual support to patient without feeling like you are forcing your religion or belief system on the patients. This has been extremely beneficial to techs and patients.
>
> The staff also feels the importance of their work. That what they do has an impact on patient's recovery. I have heard techs state that they feel better about themselves and what they do because of this program. It has rejuvenated some about coming to work.
>
> Overall, I believe this project/program has not only met but also exceeded our expectations. We continue to improve our daily process in order to continue to strive for excellence in all aspects of patient care.
>
> Jennifer has been instrumental in the success of this program. Without her effort, time, ideas and passion we would not be where we are today. And it can only get better from here."

These men and women who work as patient techs help me realize the power of potential, the impact a vision can have. Gladwell closes *The Tipping Point* acknowledging what I feel has happened through this project:

> "But if there is difficulty and volatility in the world of the Tipping Point, there is a large measure of hopefulness as well. …In the end, Tipping Points are a reaffirmation of the potential for change and the power of intelligent action. Look at the world around you. It may seem like an immovable, implacable place. It is not. With the slightest push—in just the right place—it can be tipped."[44]

[44] Gladwell, *TheTipping Point*, 259.

CHAPTER 7 : ONGOING IMPACT AND POTENTIAL OF SPIRITUAL COMPANIONSHIP PROJECT

The contemporary collect in the *Book of Common Prayer* for the day set apart to remember St. Luke reads: "Graciously continue in your church this love and power to heal…" I believe the prayer applies to hospitals too... our love and power to heal needs to continue to infinity. Though much work has been done in nurturing spiritual companionship so far at Baylor University Medical Center, the work will never end as long as one patient remains in the hospital's care.

The encouraging news is that resources are in place to continue the momentum of the Sacred Vocation program, and the commitment to enhance spiritual care far beyond the boundaries of that program runs deep. Some of the future plans for the Sacred Vocation graduates are:

To include the techs in times of worship such as the interfaith service for World Health Day as shown in Appendix S. Sacred Vocation graduates joined other clinical members in leading the prayers, and then were the ones who blessed the hands of co-workers.

To create a group of Sacred Vocation Alumni who plan get-togethers, help teach new learning modules on topics related to spiritual care to co-workers, share "healing moments" at regular staff meetings like the letter in Appendix V received recently by a graduate, and generally help keep a high profile on spiritual care initiatives

To offer the Phase I Sacred Vocation training several times during each year for new techs or techs who could not attend the sessions so far

To visit techs on the units during “tech rounds,” offering support and helping them continue to feel important and affirmed

To utilize chaplains and Clinical Pastoral Education residents assigned to each floor to support and seek pastoral care referrals from patient care techs

To offer Sacred Vocation Phase I to staff chaplains, with CEUs available from the Association of Professional Chaplains, so that they understand what the techs have experienced and know better how to support them.

To implement Sacred Vocation Phase II recommendations from techs for improvements in the broad categories of Communication, Teamwork, and Providing a Supportive Work Environment

To have an annual Sacred Vocation Celebration where all techs who have taken the program come for renewal of their Sacred Vocation vows and for recognition of their work as healers at Baylor

CONCLUSION

The past two years have nurtured spiritual companionship in ways beyond my imagination when this D.Min. project was conceived. The vision for what spiritual companionship can offer is explored in *Parting*, the earlier writing project on spiritual care of those near the end of life that provided inspiration for this one.

What we hope our techs have learned about the art of spiritual companionship is this:

> When you sign on to be a spiritual companion, you enter a two-way street. You invite intimacy, and you share from your own soul. You are a source of strength, but you look to your companion for inspiration and moments of strength as well.
>
> You open the window for peace to surround you and the one who is ill, and you feel its breeze on your face.
>
> You look for truth, for the expression of candid and deep feelings ranging from agony and anger to joy and acceptance, and find you must bare your feelings also.
>
> Both of you will grow. You will care for one another. And you both will find the shared journey to be a healing release and spiritual companionship to be a shelter in the cold night of illness.[45]

An apt reflection of what I have learned through undertaking the project is this:

> "'Bidden or not bidden, God is present.' These words, carved in Latin over the door to the office of philosopher and psychoanalyst Carl Jung, are as true or false in the workplace as they are anywhere else. If we don't believe them—really, functionally, in our gut—then the idea that work can be a source of spiritual insight, comfort, challenge and growth is absurd and a folly. If we do believe them, then the workplace becomes just one more place, one more opportunity, where the divine reality can be encountered in a tangible way.

---

[45] Holder, *Parting*, 3.

> Why would we want to look for God in our work? The simplest answer is that most of us spend so much of our time working that it would be a shame if we couldn't find God there. A more complex reason is that there is a creative energy in work that is somehow tied to God's creative energy. If we can understand and enter into that connection, perhaps we can use it to transform the workplace into something quite remarkable.[46]

I believe that the work of nurturing spiritual companionship in a hospital that embraces persons of every culture and every faith has immeasurable rewards for the spiritual health and job satisfaction of every employee. For all who take on this work, two of the most critical messages of Sacred Vocation are important to remember: 1.We are all healers at work in a Sacred Vocation and 2. No one can take away our power to heal. Letters like the one in Appendix T show how the graduates are impacting patients, families and one another.

As I finish this important work I chose as a focus, I return in my mind to the Rothko Chapel seen in Appendix U, where this whole D.Min. project took flight. In that place of peace I read the prayer for healing in a sacred Jewish text and wrote it down, remembering a time I once heard it sung by a cantor with a mystically beautiful voice. It addresses God in this way:

MI SHEBERACH, A Prayer for Healing

Mi Sheberach avoteinu
Mekor habrakha l'imoteinu
May the Source of strength
Who blessed the ones before us
Help us find the courage

---

[46]Gregory F.A. Pierce, *Spirituality at Work* (Chicago: Loyola Press,2001), xiii.

To make our lives a blessing.
And let us say: Amen.

Mi Sheberach imoteinu
Mekor habrakha l'avoteinu
Bless those in need of healing with *refuah shleima:*
The renewal of body.
The renewal of spirit,
And let us say: Amen

I will hope, and pray, that the work of nurturing spiritual companionship will know no end, and that as we practice the compassionate art of spiritual care and encourage it from others, we will "make our lives a blessing" and find our own renewal of body and spirit as the reward of healers in our own sacred vocation.

APPENDIX A

D.Min Project Proposal
Jennifer Holder Rowley, MPH, M.Div.
Brite Divinity School
Submitted to Kenneth Cracknell, PhD, Project Advisor
January 12, 2006

Project Name
Nurturing Spiritual Companionship in a Multicultural, Multifaith Health Care Setting

Project Description
To enhance spiritual and emotional care of patients, families and those who work with them in a multicultural, multifaith health care setting.

Project Goals
- To identify best practices in spiritual and emotional care at leading health care providers in the United States.
- To review current literature on the topic of spiritual and emotional care of patients and health care professionals in multicultural, multifaith health care settings.
- To identify and implement a program for health care professionals creating awareness of the vital role of spiritual and emotional care in the holistic care of patients, families and colleagues.
- To measure impact of the program on patient satisfaction scores and job satisfaction scores for employees providing the most intense level of direct patient care.

Project Resources
- Best practices research supplied by the National Health Care Advisory Board.
- Site visits and phone interviews of leading proponents of spiritual care.
- Current literature review in health care field on spiritual and emotional care offered to patients, families and employees.
- Mentoring and oversight by Spiritual Companionship Project Committee at Baylor University Medical Center, a multidisciplinary task force of the Spirit of Excellence including colleagues from Pastoral Care and Counseling.
- Funding to implement and measure impact of identified program at Baylor University Medical Center from Spirit of Excellence FY 2005 and 2006 budgets.
- Collaboration with Rabbi Samuel Karff and Ben Amick, Ph.D., innovators of the Sacred Vocation program created through The John P.McGovern, M.D. Center for Health, Humanities and the Human Spirit of the University of Texas Medical School in Houston.
- Ecumenical studies at Brite Divinity School with Professors Kenneth Cracknell and David Nelson, extending from Fall Semester 2005 through Spring Semester 2006.

Project Accountability
Doctoral student will seek counsel from D.Min project committee composed of Kenneth Cracknell, project advisor, Brian Feille and Edward McMahon. Paul Boumbulian serves

as community advisor for the project with depth of experience as a health care planner, strategist and inspired proponent of spiritual care. Clinical consultants to the project also include Teresa Schardt, M.S.N., and Robert Fine, M.D.

Doctoral student will communicate and meet regularly throughout Spring 2006 semester with D.Min project committee members, community advisor, project consultants and Spiritual Companionship Project Committee at Baylor University Medical Center.

First draft will be provided to all reviewers by April 10 to allow time to incorporate refinements and make needed revisions before required oral examination by the D.Min project committee preceding graduation in May 2006.

Project Choice Rationale

As a chaplain in a huge teaching hospital envisioned a century ago by founder Dr. George Truett, pastor of First Baptist Church Dallas, as a hospital where, he said, "persons of all faiths, and those of none, can come with equal confidence," I am deeply committed to encouraging spiritual and emotional care for our patients, their families, our employees and all who enter our doors. The need for spiritual care is universal when confronting illness or death. To enhance the ability of all health care professionals to offer sensitive spiritual and emotional care to patients, families and one another is the project I chose for my D.Min. work. It will remain a priority in my ministry for years to come.

I received institutional support to pursue this topic from my employer, Baylor University Medical Center, because their Spirit of Excellence initiative acknowledges the spiritual component of patient/family care at Baylor. Also, the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) acknowledges that patients' psychosocial, spiritual and cultural values affect how they respond to their care. JACHO emphasizes spirituality and emotional well being as important aspects of that care. A recent article in the Joint Commission Journal on Quality and Safety entitled 'Addressing Patients' Emotional and Spiritual Needs," states that a review of current literature "provides strong evidence that emotional and spiritual needs affect health outcomes and hospital financial outcomes… and overall patient satisfaction. Care for patients' emotional and spiritual needs can therefore be considered a component of overall health care quality." By choosing this topic of great interest to my organization and to other health care providers, I gained financial support for my work. The goal is that my work in this area can impact the quality of spiritual and emotional care offered to persons in great need at times of unusual vulnerability in life.

Project Evaluation

Evaluation sources to include:

- D.Min project committee, community advisor and consultants.
- Spiritual Companionship Project Committee of the Spirit of Excellence at Baylor University Medical Center.
- Patient Satisfaction Scores on identified units before and after spiritual care awareness program implementation.
- Employee satisfaction scores on same units before and after implementation.

APPENDIX B

Spiritual Care Project at Baylor University Medical Center

Project Focus:
Enhancing Spiritual Care of Patients and Families at Baylor University Medical Center

Project Description:
Based on academic research and qualitative research with patients and families at BUMC during FY 2004-2005, create a teaching module and simple handbook that that enables any BUMC staff member to provide sensitive spiritual care to "those of all faiths and those of none" as they minister to the physical needs of patients and families.

Rationale:

- The Spirit of Excellence initiative acknowledges the spiritual component of patient/family care at Baylor University Medical Center. This project would equip staff to provide spiritual care to patients of any faith or culture by teaching basic pastoral care skills that engage patients in meaningful spiritual conversations.

- JCAHO openly acknowledges that patients' "psychosocial, spiritual and cultural values affect how they respond to their care" and addresses spirituality and emotional well-being as important aspects of patient care. A recent article in the *Joint Commission Journal on Quality and Safety* entitled "Addressing Patients' Emotional and Spiritual Needs," states that a review of current literature "provides strong evidence that emotional and spiritual needs affect health outcomes and hospital financial outcomes…and overall patient satisfaction. Care for patients' emotional and spiritual needs can therefore be considered a component of overall health care quality." Chaplains in Baylor's Pastoral Care and Counseling Department are able teachers of the art of spiritual care and strongly believe that spiritual care, far exceeding the domain of chaplains, is a form of care all Baylor employees can offer.

- BUMC's current patient satisfaction survey asks patients to rate the "degree to which hospital staff addresses your spiritual and emotional needs." This project would enhance the ability of staff to address such needs, and potentially result in greater patient satisfaction with spiritual and emotional care. The survey offers one measure of the effectiveness of this project after implementation. In a dual benefit, meaningful spiritual encounters staff would have while providing spiritual care could have a positive effect on job satisfaction.

APPENDIX C

Spiritual Companionship Project Committee at
Baylor University Medical Center (BUMC)
Chairperson: Jennifer Rowley, M.Div., MPH

Members:
Tricia Ault, Clinical Manager, 8 Roberts
Teresa Schardt, Director, Spirit of Excellence Culture
Dora Bradley, Nursing Education Director
Dr. Robert Fine, Director of Clinical Ethics and Palliative Care
Joyce Grant, Clinical Manager, Breast Imaging Center
Marcella Owens, Clinical Manager, 2 Jonsson
Jeffery Place, Administrative Supervisor, Nursing Administration
Margaret Qualls, Human Resources
Denise Renfro, Guest Services
Randy Elms, Director, Volunteer Services
Tammie Dooley, Mobile Breast Imaging
Travis Maxwell, Pastoral Care, Oncology Chaplain
Jann Aldredge-Clanton, Oncology Chaplain, Interfaith Task Force and Healing Environment Project Leader
Mike Mullender, Manager, Pastoral Care
Remy Tolentino, Chief Nursing Officer

APPENDIX D

Spiritual Companionship Project Update: January, 2005

From Chaplain Jennifer Holder

I. Research

September 2004- May 2005

- ✓ Graduate Courses on Multicultural Ministry, Brite Divinity School
  Complete (Fall semester 2004)**:** Ecumenics, Mission and Interfaith Dialogue
  In Progress (Spring Semester 2005): Interreligious Dialogue: Jewish-Christian
- ✓ Mayo Seminar on Measuring Spiritual Care: November, 2004
- ✓ Research with project advisory committees at Baylor, Brite Divinity School (ongoing)
- ✓ Intensive Phone Interview with Steve Ivey, Senior Vice President for Values, Ethics, Social Responsibility and Pastoral Services, Clarion Health System, Indianapolis, Indiana
- ✓ Literature review (ongoing)

Upcoming Feb/March/April 2005

February:

- Observe on pilot units randomly during February to better understand target audience of teaching materials
- Engage Health Care Advisory board to survey industry for best practices in spiritual care of patients, families and staff
- Site visit to Houston Medical Center Complex
  Interview with Rabbi Sam Karff, leader of spiritual care initiative at St. Luke's Medical Center and Tim Van Divendyke, director of Memorial System's Institute for Spiritual Leadership

April/May:

Utilize focus groups to gain feedback on concept of spiritual companionship project and drafts of teaching module and spiritual companionship handbook before pilots begin on identified units

II. Create Teaching Module and Handbook for Spiritual Companionship

February/March 2005

Create draft of spiritual companionship handbook and teaching module with input from Spiritual Companionship Committee and D.Min Project Committee at Brite Divinity School

III. Pilot Spiritual Companionship Program

June 2005-December 2005

- Coordinate teaching of spiritual companionship module and provide handbooks in draft form to staff on identified pilot units
- Make needed editorial modifications to materials based on input during pilot project

APPENDIX D

IV. Measure, Report & Evaluate Results

New resource: Dora Bradley, Ph.D., R.N., new in Nursing Research and Education, from a Kansas Seventh Day Adventist Health System involved in an initiative with a kindred focus to ours. One of her chief areas of interest is measurement of spiritual/emotional satisfaction levels of patients, families and staff. Has agreed, enthusiastically, to join project team.

July-December 2005
Monthly reports at spiritual companionship project meetings from team leaders of participating pilot units using standardized reporting tool to be developed.

January 2006
Project summary and report of results of pilot to spiritual companionship project committee, Spirit of Excellence leadership team, Pastoral Care Department and others to be identified.

April 2006
Doctoral Project Paper on Spiritual Companionship Project submitted by May 2006 to committee at Brite Divinity School.

VI. Rollout Program to BUMC staff

Spring 2006

VII. Needed from Spiritual Companionship Project Task Force

1. Editorial input/feedback/ refinement of creative materials
2. Identify patients/families/staff for focus groups
3. Committee members to go on site visit to Houston with project leader
4. Project Task Force Roster!

APPENDIX D

Spiritual Companionship Project Update: April, 2005
Chaplain Jennifer Rowley, Project Leader

I. Research

After a site visit to Houston by Chaplain Jennifer Rowley and Tricia Ault, R.N., a presentation on the Sacred Vocations program by its developers, Rabbi Samuel Karff and Ben Amick, III, Ph.D., has been scheduled on April 19, 2005, 1-2:30 p.m. in Beasley Auditorium. The audience will include BUMC administrative leaders, the Spiritual Companionship Project Committee, Spirit of Excellence Leadership Team, Pastoral Care Chaplains and other invited guests.

The Sacred Vocations program has been piloted very successfully at St. Luke's Medical Center in Houston. It was developed by Rabbi Karff in his work with The John P. McGovern, M.D. Center for Health, Humanities and the Human Spirit at The University of Texas Medical School at Houston.

Key Components of the Sacred Vocations program include:

A. Work first with those most closely linked to patients (techs/aides) to help them discover a sense of sacred vocation in their work

B. Allow time on the job to participate in a series of groups (5 sessions at 1.5 hours/session) on the following topics:
   1. Building trust with patients and co-workers.
   2. Finding real meaning in work as part of the healing team.
   3. Healers can also harm… how do we avoid harming?
   4. Obstacles to being a healer and how to address them like: worries at home, conflict with co-workers, difficult patients and families, etc.
   5. Creating a "Hippocratic oath" for their work with patients

C. Follow training several months later with a renewal session of participants. Evaluate how Sacred Vocations program made a difference. Include sharing time and time for rededication.

II. After April 19 presentation, Spiritual Companionship Project Committee to formalize proposal on Sacred Vocations program and seek administrative decision on whether to adopt for use at BUMC and, possibly, later at other BHCS facilities.

III. Program implementation: July-December, 2006

IV. Measure, Report & Evaluate Results of Spiritual Companionship Program

A. Add spiritual/emotional care questions to point of service questionnaires on identified pilot units in May 2005 to obtain baseline scores on spiritual/emotional care offered patients and families.

B. Repeat survey on pilot units following Sacred Vocations (or alternative) program implementation, December 2005

C. Evaluate and report results, January/ February 2006

APPENDIX D

Spiritual Companionship Project Update: April, 2005
Chaplain Jennifer Rowley, Project Leader

I. Research

After a site visit to Houston by Chaplain Jennifer Rowley and Tricia Ault, R.N., a presentation on the Sacred Vocations program by its developers, Rabbi Samuel Karff and Ben Amick, III, Ph.D., has been scheduled on April 19, 2005, 1-2:30 p.m. in Beasley Auditorium. The audience will include BUMC administrative leaders, the Spiritual Companionship Project Committee, Spirit of Excellence Leadership Team, Pastoral Care Chaplains and other invited guests.

The Sacred Vocations program has been piloted very successfully at St. Luke's Medical Center in Houston. It was developed by Rabbi Karff in his work with The John P. McGovern, M.D. Center for Health, Humanities and the Human Spirit at The University of Texas Medical School at Houston.

Key Components of the Sacred Vocations program include:

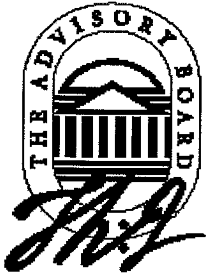
A. Work first with those most closely linked to patients (techs/aides) to help them discover a sense of sacred vocation in their work
B. Allow time on the job to participate in a series of groups (5 sessions at 1.5 hours/session) on the following topics:
    1. Building trust with patients and co-workers.
    2. Finding real meaning in work as part of the healing team.
    3. Healers can also harm… how do we avoid harming?
    4. Obstacles to being a healer and how to address them like: worries at home, conflict with co-workers, difficult patients and families, etc.
    5. Creating a "Hippocratic oath" for their work with patients
C. Follow training several months later with a renewal session of participants. Evaluate how Sacred Vocations program made a difference. Include sharing time and time for rededication.

II. After April 19 presentation, Spiritual Companionship Project Committee to formalize proposal on Sacred Vocations program and seek administrative decision on whether to adopt for use at BUMC and, possibly, later at other BHCS facilities.

III. Program implementation: July-December, 2006

IV. Measure, Report & Evaluate Results of Spiritual Companionship Program

A. Add spiritual/emotional care questions to point of service questionnaires on identified pilot units in May 2005 to obtain baseline scores on spiritual/emotional care offered patients and families.
B. Repeat survey on pilot units following Sacred Vocations (or alternative) program implementation, December 2005
C. Evaluate and report results, January/ February 2006



Advisory.com

Providing Pastoral Care Across the Hospital

Original Inquiry Brief • April 14, 2005

ASSOCIATE
Lauren Cozzolino

MANAGER
Lauren Lisher

RESEARCH IN BRIEF

The Joint Commission for the Accreditation of Hospital Organizations (JCAHO) and the American Nurses Credentialing Center (ANCC), which awards Magnet status, advocate that patients have a right to spiritual, emotional, and cultural care. Thus, administrators at many institutions are emphasizing that patients' spiritual and emotional care are important parts of their overall health care experience and are moving forward to more fully integrate a culture of spirituality throughout all aspects of hospital care. The type of comprehensive total body care that JCAHO and the ANCC emphasize is larger than the responsibilities of hospital chaplains, and calls for hospital staff members to integrate these qualities into the daily care that they provide to patients. Spiritual care training programs led by pastoral care department staff and supported by an institution's senior executives are an effective way for hospital administrators to more fully address the spiritual and emotional aspects of the patient care provided by all hospital employees. The following brief details how pastoral care administrators maintain a culture of spirituality at their institutions and train hospital employees to care for patients' spiritual and emotional needs.

MAJOR SECTIONS

I. Introduction and Observations

II. Profile: *Chaplains record outcomes of all patient visits to track and improve spiritual care*

III. Profile: *Spiritual care training sessions provided every six weeks, required of all staff*

IV. Profile: *Clinical approach to spiritual care training for nursing staff*

V. Profile: *Pastoral care training emphasizes differences between spirituality and religion*

THE ADVISORY BOARD COMPANY
WASHINGTON, D.C.

APPENDIX E

I. INTRODUCTION AND OBSERVATIONS

Hospital industry urges care for patients' spiritual and emotional needs

To achieve Joint Commission for the Accreditation of Hospital Organizations (JCAHO) and Magnet status, hospital administrators must address the spiritual, emotional, and cultural needs of patients. Both JCAHO and the American Nurses Credentialing Center (ANCC) standards advocate patients' spirituality and emotional well-being as significant aspects of overall health care. Many hospital administrators and pastoral care staff work together to integrate spiritual and emotional care into the overall care that patients receive during their inpatient stays. In some cases, they are reporting direct correlations with spiritual care services and increases in general patient satisfaction with the overall quality of care they receive. To fully provide for the total body care of patients, as described by JCAHO and ANCC standards, hospital administrators are realizing that spiritual care responsibilities must extend beyond the pastoral care department and become integrated into the daily care regimens of all hospital employees.

Thus, administrators are encouraging pastoral care staff to train hospital employees on how to recognize and provide for patients' spiritual needs. To effectively do this, hospital staff must first understand that they can be spiritual people by simply being compassionate and kind. Staff must also be well educated as to what the hospital chaplaincy represents and the spiritual and emotional services that it offers.

The following observations are based on interviews with pastoral care administrators at institutions that train staff members to integrate spiritual care into their regular care regimen:

Observation #1—Adminstrators and staff work together to provide total body care to all patients.

Administrators and pastoral care staff work together to promote the integration of spirituality throughout all aspects of the hospital and to create an environment of spiritual and emotional healing for patients. Administrators at the profiled institutions emphasize total patient care—caring for the mind, body, and soul of all patients. Hospital executives, staff members, and chaplains strive to make spiritual care a natural component of overall clinical care. Chaplains also make themselves easily accessible to all staff members and offer spiritual and emotional guidance and counseling. These services are not forced on personnel, but are instead made available if desired. By tending to the spiritual and emotional needs of all hospital employees, pastoral care staff are able to create a strong culture of spirituality and service at their institution.

Observation #2—Mandatory orientation sessions and department in-services allow for spiritual care training for all hospital employees.

By making spiritual care training a mandatory part of all new employees' orientations, pastoral care staff are able to ensure that all hospital staff members are aware of their responsibility to tend to the spiritual and emotional needs of patients. Employees are made aware of the purpose of the hospital's chaplaincy and the types of spiritual services that their institution provides. In-services, tailored specifically to the needs of different departments, enable staff members to receive training appropriate for their daily interactions with patients and reinforce the spiritual mission of the hospital. These in-services also give staff members an opportunity to speak more personally with and appreciate the hospital chaplains.

Observation #3—Pastoral care staff offer specific training sessions for nurses, as they are the often the first to assess patients' spiritual needs.

In most cases, nurses have the first opportunity to assess the spiritual and emotional states of patients. Therefore, chaplains provide specific training sessions for nursing staff to ensure that they are aware of symptoms that may indicate patients are in need of spiritual care. Nurses are also taught how to handle certain situations with patients and are encouraged to make referrals to chaplains and external support organizations as appropriate.

Observation #4—Staff taught the differences between spirituality and religion to avoid resistance to institutions' spiritual care programs.

By clearly differentiating between spirituality and religion, administrators are able to alleviate staff concern and resistance to participating in the institution's spiritual care mission. Administrators emphasize that staff are not expected to be religious or convert to the religious beliefs of administrators or hospital chaplains, but are expected to be sensitive to the spiritual and emotional needs of patients. Staff can be spiritual by being good listeners and by being compassionate, caring, and kind.

Observation #5—Staff respond positively to pastoral care initiatives and are sensitive to patients' spirituality.

Staff members are largely accepting of pastoral care services and are very attuned to the spiritual and emotional needs of their patients. It is not uncommon for physicians and nurses to pray with their patients and participate in religious rituals and sacraments. Nurses play an important role in working with the chaplaincy to guide help patients through the dying process.

Observation #6—Patient satisfaction feedback desired, but difficult to officially track.

Press Ganey surveys on patient satisfaction do not have questions specifically regarding satisfaction with care provided by pastoral care staff or fulfillment of spiritual needs. Thus, Press Ganey scores can only be used as a rough indicator of patient satisfaction with spiritual care services provided as they relate to the patients' impression of their overall inpatient stay. Administrators must therefore rely on internal methods, such as follow up phone calls or surveys conducted by their institution, to obtain a measurement of patient satisfaction with pastoral care.

The following sections of this report detail four administrators' views on strategies for integrating spirituality into total clinical care and methods for effectively training hospital staff to provide spiritual and emotional care for patients.

II. PROFILE: *Chaplains record outcomes of all patient visits to track and improve spiritual care*

Institution type:	600-bed, not-for-profit, teaching hospital located in the East
Source:	Director, Pastoral Care
Hospital religious affiliation:	• Non-sectarian
Staff members trained in spiritual care :	• New employees, nurses
Training methods:	• Department in-services • Volunteer training sessions • Nurse training sessions (expected 2005)

Despite the institution's non-religious affiliation, hospital administrators believe in and are fully committed to the hospital's spiritual care initiative. In 1995, hospital administrators prompted pastoral care department staff to launch a program to more fully integrate spiritual care into the overall clinical care of patients. Today, hospital staff members, with the support of the institution's senior executives and pastoral care administrators, strive to provide total person care—attending to the spiritual, physical, and emotional needs of all patients. Pastoral care staff members serve on numerous hospital committees and boards. A portion of all general hospital meetings are also dedicated to the discussion of pastoral care issues. Currently, pastoral care administrators are launching a training series specifically tailored to the needs of the nursing staff.

JCAHO accreditation, Magnet status secure positive relationship between administration and pastoral care department

Achievement of JCAHO accreditation and Magnet status necessitates that a hospital's staff provides patients with total body care and thus promotes not only patients' physical health but also their spiritual and emotional health. Great interdepartmental respect exists for the pastoral care staff's professionalism and the types of services that they provide. In addition, a section of all general hospital meetings are dedicated to discussion of the hospital's spiritual care initiative. Pastoral care administrators are very active in all aspects of hospital's operations. For example, pastoral care staff were asked for guidance by security and plant operations personnel on how to best create and effective emergency plan in response to a major crisis.

All chaplains are direct employees of the hospital

The pastoral care department is staffed by 15 full time equivalent (FTE) chaplains and approximately 125 to 150 volunteers. All chaplains are currently directly employed by the hospital. In the past, chaplains have been employed by external organizations, which led to dis-unification among pastoral care staff. Chaplains worked toward their individual goals and established personal agendas rather than collectively working together enhance the spiritual care mission of the institution.

Spiritual care services provided for both patients and hospital staff

The primary objective of pastoral care staff is to continually work toward the increased integration of spirituality throughout all aspects of the hospital. Chaplains reach out to all patients regardless of religious faiths and visit all patients after they are admitted. In total, chaplains minister to approximately 680 patients a day. During initial patient visits, chaplains assess patients' spiritual needs. However, patients are always given the option to opt out of pastoral care.

Spiritual services provided by the hospital's chaplaincy include the following:

- 24-hour television channel filled with music, meditations, and spiritual education
- Blessing of surgical suites
- Cultural awareness services for people of different ethnicities and religious backgrounds
- Daily mass (also broadcast to patients' rooms)
- Guided imagery
- Laying on of hands
- Memorial services for patients who die
- Music
- Prayer with patients
- Support for patients and families with death and the dying process
- Religious rituals and sacraments
- Training for future chaplains

In addition to spiritual care service provided to patients, chaplains provide spiritual and emotional support to hospital employees. Chaplains regularly conduct prayer services for staff and invite all staff members to participate in daily mass. Chaplains make themselves easily accessible for spiritual and emotional conversations and counseling.

Guided imagery services and laying on of hands are two of the pastoral care department's most popular services among both patients and staff. In guided imagery exercises, pastoral staff guide individuals through relaxation techniques and help them visualize what their disease looks like or possibly something as simple as what their favorite place looks like. This exercise significantly lowers stress levels. Currently, there are 24 staff members trained in the art of laying on of hands. Additional staff will undergo certification training later this spring.

Education on meaning of spirituality is chief priority in staff training

The first priority of pastoral care administrators is to educate staff on the difference between religion and spirituality. Spirituality has always been a core component of the hospital's mission and this is explained in detail to all staff members. Staff members do not have to be religious to be spiritual and are taught that they can minister to the spiritual needs of patients by being compassionate people. Furthermore, by clearly differentiating between spirituality and religion, administrators are able to avoid staff resistance to the institution's spiritual care initiative.

Chaplains provide tailored in-services for different hospital departments

An in-service is divided into two components: a PowerPoint presentation and a discussion. Chaplains try to impress upon staff members the importance of listening to patients and facilitating appropriate communication between clinical staff and patients.

Chaplains tailor in-services specifically to the departmental needs of hospital staff and universally emphasize that hospital employees need to be sensitive to the religious aspects of people's lives. For example, one of the in-services for nurses is devoted to discussion of death and the dying process. Nurses are trained to become involved early on in this process and to help patients as they progress through each stage of dying. Chaplains stress the importance of helping patients cope with death at the beginning of the dying process rather than waiting until the end.

Physicians and nurses sensitive to patients' spirituality, take part in prayer and rituals

Staff members are taught to look for signs indicating that patients may be in spiritual or emotional distress. Such signs may include the following:

- Anger
- Anxiety
- Loneliness
- Stress
- Suffering loss of loved one
- Withdrawal

Pastoral care administrators indicate that the majority of physicians and nurses are aware of the need for spirituality among patients, work to implement total person care at the hospital, and are in fact, becoming increasingly involved in the institution's spiritual care initiative. Nurses and physicians will often participate in the dying process and in religious rituals. In addition, many physicians will pray with their patients.

Launch of specific nurse training sessions scheduled for 2005

Plans to launch specific spiritual care training and orientation sessions for nurses await approval by the hospital's executive nursing committee. These sessions would specifically cater to each of the three nursing shifts to ensure around-the-clock care for patients' emotional and spiritual needs. In addition, pastoral care staff members aim to meet with all nurses as a regular component of their staff meetings.

Large volunteer base enables broader reach of pastoral care department

The pastoral care department's large volunteer base is generally older and has the desire to do something spiritually meaningful with their time. Pastoral care administrators require that all volunteers undergo 48 hours of training provided by pastoral care staff. This training consists of three classes held over the course of eight weeks and focuses specifically on the following topics:

- ✓ Hospital environment
- ✓ Infection prevention
- ✓ Listening techniques
- ✓ Meditation

Chaplains keep records of all patient visits to track patient satisfaction and fulfillment

Chaplains keep personal, handwritten records of the successes and failures of all visits with patients. Chaplains take this feedback and work with pastoral care staff to evaluate what they can improve on. In addition, pastoral care staff members conduct follow up phone conversations with patients after they leave the hospital and will make special visits to nursing homes and hospices. Chaplains have also experimented with sending patients comforting, spiritual literature.

There has been consideration of creating an evaluation to be given to patients before they leave the hospital; however, this has never been fully implemented because staff are never certain as to when patients will actually be discharged. Hospital executives use Press Ganey scores as a broad approximation of patient satisfaction with their overall inpatient stay and have generally received very positive results.

III. PROFILE: *Spiritual care training sessions provided every six weeks, required of all staff*

Institution type:	400-bed, not-for-profit, teaching hospital located in Midwest
Source:	Director, Pastoral Care
Hospital religious affiliation:	• Catholic
Staff members trained in spiritual care :	• Physicians, nurses, medical students, residents, managers, nursing counsel
Training methods:	• Regular training session every six weeks for all staff • Mandatory part of employee

The hospital mission is for its staff to be a means of touching and caring for patients in a "Christ-like" manner. Hospital administrators work to maintain an atmosphere of hospitality and healing that affirms the body, mind, and spirit of all patients regardless of religious affiliation. A commitment to providing spiritual and emotional care is a core part of the hospital mission and philosophy. Spiritual care at the hospital extends beyond hospital chaplains and is integrated into overall clinical care by all staff members.

Since January 2004, pastoral care department staff members have conducted regular sessions for staff members to educate them about the purpose of the pastoral care department, spiritual services offered by chaplains, basic Catholic values, and signs to look for that may indicate a patient is in need of spiritual care. The creation of these sessions was prompted by a lack of collaboration between chaplains and hospital staff on the integration of spiritual care throughout all areas of the hospital. Additionally, administrators believe high staff turnover necessitates frequent educational sessions to ensure that all staff members universally understand their duty to promote the pastoral care mission of the hospital.

Pastoral care staff includes Catholic and Protestant chaplains

Administrators in the hospital's pastoral care department work to build and maintain excellent relationships with religious leaders in the community from all religious denominations to ensure that all patients' religious needs are being met. The pastoral care department is staffed by four full time equivalent (FTE) chaplains. In addition to Catholic chaplains, the department maintains one full-time Protestant chaplain. On a part-time basis, staff includes sisters, ministers, and priests qualified to offer religious services. Pastoral care administrators regularly attend national pastoral care conferences.

High patient contact chief priority of chaplains

Hospital administrators emphasize and encourage the integration of spirituality and chaplaincy services into all aspects of clinical care. Chaplains serve patients and hospital staff members and provide the following spiritual care services:

- Baptisms in intensive care unit (ICU)
- Daily distribution of Holy Communion
- Daily mass in chapel (broadcast on closed-circuit television station so patients may participate from their inpatient rooms)
- Daily meditations
- Ethical guidance in end-of-life decisions
- Maintain a presence at outpatient and surgery centers
- Prayer services
- Sacrament of Anointing of the Sick (other sacraments available upon request)
- Routine visits to patients rooms
- Participate in all code blues and trauma calls

Chaplains strive to personally visit all patients admitted to the hospital and daily tend to approximately 300 patients on average. Chaplains make communion rounds alone twice daily to ensure that all patients' spiritual needs are being met. Upon leaving patients' rooms after an initial visit, chaplains are instructed to ask patients if they have any specific spiritual needs that they are concerned about or would like to be addressed. In addition, chaplains give patients a bookmark with a prayer or scripture verse and contact information for the chaplaincy offices so that patients are aware of the hospital's spiritual support services.

Additionally, the pastoral care department implements an end-of-life program to help patients and families cope with terminal illnesses or unfavorable diagnosis. All staff members are introduced to this program and familiarized with the two booklets that pastoral care staff members have prepared for families and patients regarding this topic. One booklet features AARP information on accepting a difficult prognosis and the second addresses coping with the process of dying and life after death.

Pastoral care department administrators are currently working to develop a cultural diversity and meditation center. The physical space is designed as a solarium with the intention of providing a healing environment for patients, visitors, and staff. Pastoral care administrators are on the hospital's board of cultural diversity and education and are continually working to recognize and meet the culturally diverse needs of patients.

All hospital staff members attend regular training sessions conducted by chaplains

Since January 2004, chaplains have conducted pastoral care educational sessions for all staff members. Separate sessions are conducted for the following personnel:

- Managers
- Medical students
- Nursing council members
- Nurses
- Physicians
- Residents

These sessions are conducted every six weeks to ensure that all new hospital employees are current with the institution's spiritual care services and to reinforce the spiritual care mission of the hospital. Sessions typically last a half hour in length and are orchestrated in a discussion format.

During these sessions, staff members are introduced to the pastoral care department's death and end-of-life program and receive hand-outs regarding the institution's spiritual service offerings. Hand-outs specifically outline the following information:

- ✓ Brief overview of Catholic values and sacraments
- ✓ Cultural and diversity values of institution
- ✓ Duty of all staff to provide for patients spiritual needs
- ✓ Explanation of purpose of pastoral care
- ✓ Services offered by chaplains

In addition, staff members are educated as to signs indicating that a patient may be in need of spiritual care. Upon recognition of these signs, staff members are instructed to make appropriate referrals to chaplains or other emotional support groups associated with the hospital. Such symptoms include, but are not limited to, the following:

- ☑ Anger
- ☑ Anxiety
- ☑ Death of loved one(s)
- ☑ Distress
- ☑ Grief
- ☑ Loneliness

APPENDIX E

Additionally, a portion of the orientation for all new employees is dedicated to pastoral care. Chaplains briefly meet with new employees and explain the spiritual services offered at the hospital and the purpose of the pastoral care department. However, these orientation meetings are not very detailed due to the expectation that employees will later attend one of the pastoral care department's formal training sessions.

Administration committed to spiritual care initiative, staff reacts positively

The institution's administration is fully committed to integrating a spiritual component into overall clinical care and provides the pastoral care department with all the necessary support to do so. Pastoral care administrators believe that a partnership with the hospital's administration enables chaplains to provide such a wide range of spiritual services to patients and staff. In addition, pastoral care administrators indicate that JACHO dedicates a section of its standards manual to the discussion of the responsibility of hospital's to provide for the spiritual, cultural, and emotional needs of patients. They believe that this standard may be a common ground for administrators and pastoral care providers at non-religiously affiliated institutions to begin working toward a comprehensive spiritual care initiative.

Employees are told upon hire that they will be working for a Catholic hospital and while are not required to be Catholic or religious, they are expected to uphold the spiritual mission of the institution. Pastoral care administrators have not encountered any employee resistance to the hospital's spiritual care program and indicate that staff members are very attuned to the spiritual mission of the hospital. Chaplains are constantly receiving referrals from physicians and nurses.

Patient satisfaction tracked by pastoral care department survey and Press Ganey scores

On behalf of the hospital's administration, pastoral care administrators conduct their own survey regarding patient satisfaction with their end-of-life program. These surveys are administered to the families of those patients who have passed away while under hospital care. On a 5 point scale (5 indicating the highest level of satisfaction), the pastoral care staff was awarded an average of 4.37 in 2004. Hospital administrators rely on Press Ganey scores to measure overall patient satisfaction with emotional and spiritual care. However, Press Ganey surveys do not have distinct categories for pastoral care offerings and therefore patient satisfaction with such services is categorized into Press Ganey survey scores on overall patient satisfaction with inpatient stay.

Publicity of institution's pastoral care department aids in spiritual education efforts

Pastoral care staff members have been interviewed and featured several times in the hospital's newsletter and in local community medical newsletters. This publicity serves as an additional tool for educating staff as to the purpose of the pastoral care department and the services it provides. It is also a method for making the local community aware of the spiritual mission of the hospital.

IV. PROFILE: *Clinical approach to spiritual care training for nursing staff*

Institution type:	300-bed, not-for-profit, teaching hospital located in East
Source:	Director, Pastoral Care
Hospital religious affiliation:	• Catholic
Staff members trained in spiritual care :	• New employees, nurses
Training methods:	• Mandatory part of employee orientation • Specific training sessions for nurses

Hospital administrators and the local Catholic Church work together to minister to the spiritual and emotional needs of patients. Church officials have supreme authority over all spiritual matters at the institution. However, senior executives are fully committed to the institution's spiritual care initiative and maintain an excellent relationship with Church officials. Hospital administrators encourage staff to take seriously the spiritual well-being of patients and therefore obligate all staff to undergo spiritual care training. Pastoral care department staff members teach spiritual care educational sessions during new employees' mandatory orientation and emphasize that the spiritual care of patients is the responsibility of all hospital employees. Additionally, chaplains provide continual in-services and a specific spiritual care training series for nurses. Content provided in these sessions is based on literature from the North American Nursing Diagnostic Association (NANDA). NANDA clinically addresses the diagnostic category of spiritual distress and discusses the nurturing of patients' spiritual components. By teaching staff the difference between spirituality and religion, administrators are able to manage any resistance to the institution's spiritual care initiative.

Chaplains achieve one contact with every admission 70 percent of the time

The goal of pastoral care staff members is to visit all admitted patients at least once during their inpatient stay. Chaplains indicate that on average, they are able to meet this goal 70 percent of the time. These basic visits allow chaplains to establish a line of communication with patients and to assess patients' spiritual and emotional needs. In addition, chaplains provide the following spiritual care services to both patients and staff:

- 24 hour a day availability for both patients and staff
- Anointing of the Sick
- Catholic sacraments
- Daily mass in the chapel (also broadcasted to people's rooms)
- Prayer requests
- Referrals to community churches and support groups
- Training center for chaplaincy
- Visitation to people of all faiths

Training emphasizes difference between spirituality and religion

The pastoral care department oversees a portion of the new employee orientation process. Pastoral care staff members present new employees with information regarding their expected roles in the spiritual care of patients. All hospital employees watch a video that emphasizes the spirituality of patients and discusses the difference between spirituality and religion. Spirituality is taught as a concept that extends far beyond the image of praying or attending church. Chaplains stress that staff members can be spiritual without being religious and that it is important for staff to project a spiritual image of themselves to patients. Staff members are not to be openly hostile to religion yet are to be careful not to be overly religious or preaching. The video component of the presentation is followed by group discussion about spiritual care services provided at the hospital. In some instances chaplains will uses case studies to highlight appropriate ways to spiritually care for patients. An example of such a case might be an 85 year old, dying Roman Catholic. In addition, staff members are briefly introduced to the Catholic sacraments offered by chaplains and are versed in the importance of being sensitive to patients' cultural needs as well. All staff members are given a brochure summarizing the key points of the presentation and are required to take a brief competency test demonstrating an understanding of the concepts presented.

These orientation sessions have been mandatory for all employees since 2001. The decision to launch these training sessions was motivated by the consensus between senior executives and pastoral care administrators that hospital staff members did not fully comprehend that caring for the spiritual needs of patients was not the sole job of chaplains but was instead the responsibility of everyone at the hospital. Chaplains also run occasional in-services to reinforce the material presented during orientation. These presentations take on more of a topical theme specific to the audience for which these services are being provided. For example, chaplains hosted a brown bag lunch and invited a rabbi to speak to staff regarding spiritual and cultural diversity.

Specific training sessions for nurses based on NANDA literature

NANDA classifies diagnostic categories for nursing and considers the spirituality of patients to be important enough to dedicate a diagnostic category to spiritual distress. NANDA clinically describes spiritual care and highlights ways in which nurses can nurture the spiritual components of patients' overall well being. This literature is often part of nurses' general education and therefore pastoral administrators prefer to used NANDA-based materials when training nurses in order to reach out to them in a clinical language that they have already been exposed to and understand.

Nurses are often the first staff members to spiritually assess patients. They are taught to look for symptoms such as anxiety, depression, loneliness, and a poor prognosis that may reflect patients' high spiritual distress levels. It is not uncommon for nurses to pray with patients. Nurses are instructed to refer critical spiritual and emotional points to chaplains. Training sessions include video presentations, discussion, and a small competency exam.

Staff enjoy working for an institution that promotes a spiritual component to clinical care

The emphasis given to differentiating spirituality from religion enables staff members who are not necessarily religious to interact with people of different faith levels. Staff members respond well to the fact that hospital administrators do not attempt to convert them to Catholicism or force them to personally believe in the faith of the institution. Staff members indicate that they enjoy working in an environment that promotes a spiritual dimension in medical care and like being encouraged to treat the body, soul, and mind of patients.

No formal measurement of patient satisfaction, previously used Press Ganey scores

In the past, administrators used Press Ganey scores to give an approximation as to the levels of patient satisfaction with the spiritual care services provided. However, the Press Ganey surveys only loosely address this subject and in many cases, patients tend to avoid these types of questions in a satisfaction survey because they on not comfortable answering them or are unsure as to how to answer them.

V. PROFILE: *Pastoral care training emphasizes differences between spirituality and religion*

Institution type:	200-bed, not-for-profit, teaching hospital located in Northwest
Source:	Staff Chaplain, Acting Head
Religious affiliation:	• Christian, Protestant
Staff members trained in spiritual care :	• New employees, nurses
Training methods:	• Mandatory part of employee orientation • Specific training sessions for nurses

Hospital administrators are fully supportive of the efforts of the institution's pastoral care department and promote the institution's commitment to be a "human expression of the healing ministry of Christ." A strong spiritual care initiative has always been a core component of the hospital's foundation. All staff members are trained to provide spiritual and emotional care to patients. Staff are taught that spirituality is an important part of patients' illnesses and is extremely important to their overall healing process. Pastoral care administrators believe in ongoing spiritual care education of hospital staff and work to maintain open channels of communication between staff members and chaplains. During the new employee orientation period, all hospital employees receive training in how to provide spiritual care to patients. In addition to this initial introduction to the pastoral care department, chaplains hold department in-services and nurse-specific training sessions.

Chaplains strive for culture of spirituality by providing services to patients and staff

Chaplains constantly strive to make spirituality a core component of the culture of the hospital by making themselves readily available to all hospital employees and by working towards the goal of visiting all patients admitted to the hospital. In addition, chaplains maintain an excellent relationship with senior executives and collaborate with hospital administrators as to how to improve upon and provide additional spiritual care services.

The following services are a part of the institution's spiritual care initiative for patients and hospital employees:

- Column in bimonthly newsletter
- Daily chapel prayer services
- Listening
- Making appropriate referrals
- Midweek meditations
- Prayer requests
- Religious song
- Support group services

Although the hospital has a Christian mission, chaplains provide services to people of all faiths and will refer patients to appropriate religious figures such as Catholic priests or Buddhist monks.

Staff undergo testing to demonstrate grasp of institution's spiritual care mission

During new employees' mandatory orientation process, staff members undergo training sessions on providing spiritual care to patients led by pastoral care administrators. Employees are presented with material regarding the spiritual mission of the hospital and are encouraged to be alert to the spiritual needs of patients. Staff members are versed in what pastoral care stands for and the types of services that the pastoral care staff provides. As part of the employee orientation process, staff members receive a blue book containing all pertinent hospital information for new employees. A portion of this blue book is dedicated to explaining the institution's spiritual care initiative and the spiritual services offered. Staff members proactively fill out parts of the blue book as they attend the various training sessions. At the end of orientation, staff members take a small examination testing their comprehension of the materials presented to them. Part of this examination tests an understanding of the hospital's spiritual care culture. This examination is turned in and is filed in employees' service records.

Chaplains also provide in-services tailored to departmental needs. These in-services are typically structured in a lecture and discussion format.

Nurses are trained to provide "whole person care"

Additionally, pastoral care administrators hold training sessions specifically for the nursing staff. Nurses make initial spiritual assessments of patients and are instructed to take note of the following symptoms:

- ✓ Anger
- ✓ Anxiety
- ✓ Fear
- ✓ Grief
- ✓ Isolation
- ✓ Loneliness
- ✓ Need for forgiveness
- ✓ Questions on meaning or value of life
- ✓ Questions regarding relationship with God
- ✓ Reconciliation
- ✓ Separation
- ✓ Struggling with purpose of disease or illness

Nurses are taught that patients can benefit from prayer or visits by chaplains and are instructed to make appropriate referrals to the pastoral care department. Pastoral care administrators believe that if nurses are conscientious and aware of patients' spiritual needs, they are more likely to facilitate direct involvement with chaplains. For example, a nurse contacted the pastoral care department because she was worried that her patient was becoming depressed and asked if a chaplain would pray with the patient.

Administrators upfront with employees about spiritual care obligations

One of the first things that is explained to new employees is the spiritual care duties that they are required to fulfill. The spiritual component of the hospital's mission statement is explained to potential candidates during the interview process. Employees are not required to change who they are or alter their religious beliefs; they are however, required to minister to the spiritual and emotional health of patients. Staff members are not expected to do something they are not comfortable with, but they are expected to be sensitive to the needs of patients and to make referrals to the pastoral care department when appropriate. Overall, there is a very high acceptance among staff for the integration of spiritual care into the process of total patient care.

Hospital's spiritual care services attract patients, results tracked through surveys

Pastoral care staff constantly receive feedback from patients on how much they appreciate the spiritual component of their inpatient stay and have received numerous letters from patients explaining that they seek treatment at this hospital because of its spiritual care services. Hospital administrators track patient satisfaction through annual surveys. These surveys have specific questions regarding the spiritual and emotional care that patients receive. Pastoral care staff members will also do their own follow up surveys with patients and ask about the quality of the care they received. In addition, hospital administrators also track employee satisfaction with spiritual care services. These surveys are conducted electronically via Internet.

Support of hospital administration key to successful integration of spiritual care

The senior administration has always embraced a spiritual culture and has exemplified this culture in their daily lives. Pastoral care staff stress that the importance of spiritual care has to be truly believed in and supported by the institution's senior executives. Without this backing, pastoral care staff members believe that it is difficult to truly integrate spirituality into all aspects of the hospital. Pastoral care administrators caution that administrators at institutions without a religious affiliation need to fully embrace the idea of spiritual care and not regard a spiritual care initiative as a business idea or a means to achieving a sought after accreditation.

APPENDIX E

Research Methodology

During the course of research, Original Inquiry staff searched the following resources to identify pertinent information:

- Advisory Board's internal and online (www.advisory.com) research libraries
- Factiva™, a Dow Jones and Reuters company
- Internet, via search engines and multiple websites, including the following:
  - ✓ American Association for Pastoral Counselors at www.aapc.org
  - ✓ Association for Clinical Pastoral Education at www.acpe.edu
  - ✓ Association of Professional Chaplains at www.healthcarechaplaincy.com

Based on leads generated from the sources above, researchers contacted administrators in pastoral care departments at institutions dedicated to the integration of spiritual care with overall clinical care.

Professional Services Note

The Advisory Board has worked to ensure the accuracy of the information it provides to its members. This project relies on data obtained from many sources, however, and the Advisory Board cannot guarantee the accuracy of the information or its analysis in all cases. Further, the Advisory Board is not engaged in rendering clinical, legal, accounting, or other professional services. Its projects should not be construed as professional advice on any particular set of facts or circumstances. Especially with respect to matters that involve clinical practice and direct patient treatment, members are advised to consult with their medical staffs and senior management, or other appropriate professionals, prior to implementing any changes based on this project. Neither the Advisory Board Company nor its programs are responsible for any claims or losses that may arise from any errors or omissions in their projects, whether caused by the Advisory Board Company or its sources. 1-FW709

© 2005 by the Advisory Board Company, 2445 M Street, N.W., Washington, DC 20037.
Any reproduction or retransmission, in whole or in part, is a violation of federal law and is strictly prohibited without the consent of the Advisory Board Company. This prohibition extends to sharing this publication with clients and/or affiliate companies. All rights reserved.

APPENDIX E

Ms. Ruth A. Kennedy
Director, Pastoral Care
Hackensack University Medical Center
30 Prospect Avenue
Hackensack, NJ 07601
201-996-2345

Section II

Hackensack University Medical Center is a 640-bed, non-sectarian, teaching hospital. The institution's pastoral care department was established to support the hospital's philosophy of total patient care. The pastoral care department is staffed with 15 full time equivalents (FTEs) and 125 to 150 volunteers. All chaplains are direct employees of the institution.

Pastoral care staff members work to increase the faith, values, understanding, and hope of patients and their families in times of difficulty or crisis. Specifically, chaplains guide patients and their families through the dying process and provide guided imagery, laying on of hands, music therapy, and daily prayer services. The large size of the department enables pastoral care staff to visit each of the institution's patients every day. In addition, pastoral care staff regularly communicate and interact with physicians and hospital employees to provide them with spiritual and emotional support services. Chaplains also work to meet the diverse cultural needs of patients and staff by creating a culture of tolerance and openness.

Chaplains provide in-service, spiritual care training sessions for hospital employees. These sessions are tailored specifically to target the needs of the staff members who are attending and are typically structured in a PowerPoint or overhead presentation format. Staff members are taught how to recognize and care for the spiritual and emotional needs of patients and are given relevant articles and handouts highlighting these topics. In addition, pastoral care staff require 48 hours of department training for all volunteers.

Each chaplain maintains a handwritten account of visits with patients. These records highlight the positive and negative aspects of chaplain/patient interactions and serve as a guide to help the pastoral care staff improve services to patients and measure overall levels of patient satisfaction.

Ms. Kennedy would be pleased to speak with you directly regarding the pastoral care program at Hackensack University Medical Center.

Sister Renee Zastoupil
Director, Pastoral Care
St. Alexius Medical Center
900 East Broadway
Bismarck, ND 58501
701-530-7000
rzastoupil@primecare.org

Section III

St. Alexius Medical Center is a 383-bed, not-for-profit, Catholic, teaching hospital that is sponsored by the Sisters of St. Benedict of Annunciation Priory and is dedicated to the healing ministry of Jesus Christ. Pastoral department staff members abide by the ethical and religious directives for Catholic health care.

Pastoral care staff play a very large role in the daily operations of the hospital. Chaplains are involved with all end of life decisions, called for all code blues and trauma codes, and are present at all outpatient and surgery centers. Chaplains also oversee a death and dying program designed to help patients and their families cope with the process of dying. The pastoral care department receives referrals from physicians, psychiatrists, surgeons, nurses, and managers. Additionally, chaplains provide spiritual and emotional support for all hospital staff.

In 2004, pastoral care staff began offering mandatory spiritual care training sessions for hospital employees because they felt there was a lack of collaboration between hospital employees and chaplains in carrying out the institution's spiritual mission. Staff members are given presentations and handouts explaining what the chaplaincy is and the individual roles that all hospital employees can play in addressing the spiritual and emotional needs of patients. Training sessions are given approximately every six months in order to reinforce the significance of patients' spiritual health and to accommodate a high rate of employee turnover.

Administrators explain to staff members upon hire the spiritual care duties that accompany working for a Catholic hospital. Administrators avoid staff resistance to such policies by explaining that employees are not expected to be Catholic or even religious, but are expected to attend to the spiritual needs of patients.

Sister Renee invites you to contact her directly with any further questions regarding the spiritual care program at St. Alexius Medical Center. She suggests that the best way to reach her is to speak with the hospital's operator and ask that she be paged.

Father Peter Beaulieu **Section IV**

Director, Pastoral Care
Worcester Medical Center
20 Worcester Center Boulevard
Worcester, MA 01608
508-363-6246

Worcester Medical Center is a 329-bed, not-for-profit, Catholic, teaching hospital that is directly affiliated with the local Catholic Church. Despite the hospital's strong religious affiliation, staff members serve the spiritual, emotional, and cultural needs of people of all faiths.

Pastoral care staff members continually emphasize that ministering to the spiritual health of patients is the responsibility of all employees, not just chaplains. Chaplains, supported by senior executives, impress upon hospital employees that the institution stands for a spiritual dimension in medical care and that all staff members should strive to provide care to the body, mind, and soul of patients. Chaplains offer daily masses, prayer services, religious sacraments and work to visit all patients at least once during their stay.

All hospital employees are required to attend a spiritual care training session as a part of their new employee education. Sessions include video presentations, lectures, and open discussions. Staff members are taught about the services that the pastoral care department offers and how to identify patients that are in need of spiritual care. In addition, chaplains conduct informal in-services specifically for nursing staff and other departments who may invite their teachings.

Staff members are clearly explained the difference between spirituality and religion and are reassured that hospital administrators have no intent to convert them to Catholicism or cause them to be more religious. In this manner, concerns or resistance to the hospital's spiritual care objectives are addressed before they become problematic.

Father Beaulieu would be pleased to speak with you directly regarding the pastoral care program at Worcester Medical Center.

Mr. Ray Ammon **Section V**

Staff Chaplain, Acting Head
Adventist Health-Northwest
10123 Southeast Market Street
Portland, OR 97216
503-251-6105
ammonra@ah.org

Adventist Health-Northwest is a 223-bed, not-for-profit, Christian, community hospital. Administrators and pastoral care staff strive to create a culture of service and spiritual healing for all patients. Hospital employees are encouraged to be a daily expression of the healing ministry of Christ.

Chaplains offer spiritual care services for both patients and staff by making themselves readily available for conversations, counseling, prayer, listening, and emotional support. Pastoral care staff members strive to create a culture of spirituality at the hospital by posting weekly meditations throughout the hospital building, offering daily prayer services, and making daily rounds to patients' rooms. Chaplains wish to be very visible in order to make patients and staff members feel as though they always have someone to turn to in times of need.

All hospital employees undergo spiritual care training as part of the new employee orientation process. During these sessions, staff members are taught about the hospital's spiritual care philosophy and purpose of the pastoral care department, and are instructed as to what signs to look for that may indicate a patient is in spiritual or emotional distress. Employees are given a booklet summarizing these topics and are asked to take a small examination to demonstrate their grasp of the hospital's spiritual care initiative. This examination is maintained and filed in employees' service records. Nurses are often the first hospital employees to interact with patients and therefore are the first staff members to assess patients' spiritual health. Chaplains hold special training sessions for nurses in order to better help them make accurate assessments of patients' spiritual and emotion well being.

Employees are expected to be sensitive to the spiritual and emotional needs of patients and such expectations are made clear upon hire. Administrators track patient satisfaction with the spiritual care component of their inpatient stay through annual hospital surveys and Press Ganey scores.

Mr. Ammon invites you to contact him directly with further questions regarding Adventist Health-Northwest's spiritual care program.

Research Methodology

During the course of research, Original Inquiry staff searched the following resources to identify pertinent information:

- Advisory Board's internal and online (www.advisory.com) research libraries
- Factiva™, a Dow Jones and Reuters company
- Internet, via search engines and multiple websites, including the following:
  - ✓ American Association for Pastoral Counselors at www.aapc.org
  - ✓ Association for Clinical Pastoral Education at www.acpe.edu
  - ✓ Association of Professional Chaplains at www.healthcarechaplaincy.com

Based on leads generated from the sources above, researchers contacted administrators in pastoral care departments at institutions where spiritual care is an important component of overall clinical care.

Professional Services Note

The Advisory Board has worked to ensure the accuracy of the information it provides to its members. This project relies on data obtained from many sources, however, and the Advisory Board cannot guarantee the accuracy of the information or its analysis in all cases. Further, the Advisory Board is not engaged in rendering clinical, legal, accounting, or other professional services. Its projects should not be construed as professional advice on any particular set of facts or circumstances. Especially with respect to matters that involve clinical practice and direct patient treatment, members are advised to consult with their medical staffs and senior management, or other appropriate professionals, prior to implementing any changes based on this project. Neither the Advisory Board Company nor its programs are responsible for any claims or losses that may arise from any errors or omissions in their projects, whether caused by the Advisory Board Company or its sources. 1-FW709

© 2005 by the Advisory Board Company, 2445 M Street, N.W., Washington, DC 20037.
Any reproduction or retransmission, in whole or in part, is a violation of federal law and is strictly prohibited without the consent of the Advisory Board Company. This prohibition extends to sharing this publication with clients and/or affiliate companies. All rights reserved.

APPENDIX F

Implementation Proposal for Sacred Vocation Project
at Baylor University Medical Center
Prepared by Chaplain Jennifer Rowley, Teresa Schardt, R.N. and Tricia Ault, R.N.
April 25, 2005

I. Project Description

Sacred Vocation is a project developed by Rabbi Samuel Karff of the John T. McGovern, M.D. Center for Health, Humanities and the Human Spirit and colleague Ben Amick, III, PhD. of the School of Public Health, both divisions of The University of Texas Medical School at Houston. The Sacred Vocation Project was piloted successfully at St. Luke's Episcopal Hospital and is supported by St. Luke's Episcopal Health Charities.

The aim of the Sacred Vocation Project is to enhance the spiritual and emotional care of patients by cultivating a sense of sacred vocation in those who work with them. This aim is accomplished by following these guiding principles:

Nurturing the spirit of patients by first nurturing the spirit of the employees/caregivers
Realizing that all employees have the power to heal and the power to harm
Discovering that the employee-as-healer self-identification helps give meaning and validation to that employees' life
Changing work to allow for meaningful experiences to occur

II. Sacred Vocation Project Phases

A. Phase I: Recognizing Work as Sacred Vocation

Patient Care Technicians and Patient Care Assistants, who spend the most time one-on-one in direct patient care, attend five 1.5 hour sessions and a graduation ceremony. This phase increases the worker's knowledge of work as sacred vocation and establishes the connection between work and spiritual identity and spiritual care of patients.

i) The five sessions cover:
Session 1: Validating a human life
Session 2: Discovering the capacity to heal
Session 3: Discovering the capacity to harm
Session 4: Developing Sacred Vocation Coping Tips
Session 5: Developing Oath for Healing
Graduation

B. Phase II: Reorganizing Work as Sacred Vocation

Smaller groups of Patient Care Technicians and Patient Care Assistants (focus groups) are invited to develop recommendations to management about changes in the work environment that could support work as sacred vocation.

i) The five sessions cover:
Session 1: Identify work flow and work as sacred vocation
Session 2: Identify work environment obstacles and facilitators for removing them

Session 3: Decide how the work environment can be changed to support work as Sacred Vocation
Session 4: Develop action plan recommendations
Session 5: Present to management

C. Phase III: Sacred Vocation Growth and Renewal

Groups of graduates meet periodically with staff chaplains to update and share experiences, to track the impact of the program in their lives and in the workplace, to support one another and to renew their oath.

III. Proposed Implementation Plan at Baylor University Medical Center

The Sacred Vocation Project can be implemented during FY '06 at Baylor University Medical Center in the following sequence of activities:

A. Summer, 2005 at Baylor University Medical Center

The project begins at BUMC with comprehensive communication to all staff, volunteers, donors, physicians and board members about the project, goals, how it operates, impact on our culture and how its effectiveness is measured. Particular emphasis is given to orienting nurse managers and staff nurses who support the participation of the Patient Care Technicians and Patient Care Assistants in Phase I sessions and graduation.

(During this period of time, baseline information is taken on patient satisfaction with current spiritual and emotional care from point of service patient satisfaction surveys and from the NRC patient surveys from identified pilot units and control units)

B. Fall/Winter FY '06

Three facilitators are trained in a three-day session in Houston with Rabbi Karff and Dr. Amick to lead the Phase I Patient Care Technicians and Patient Care Assistants sessions and graduation ceremony. As soon as possible following the training, groups of Patient Care Technicians and Assistants on the identified pilot units begin to meet. After the pilot units, train all Patient Care Technicians and Patient Care Assistants in Fall/Winter FY '06.

C. Spring/Summer FY '06

Phase II focus groups with a representative sampling of graduates of Sacred Vocation occur to seek ideas for positive changes in their work areas which can continue to foster a sense that work is sacred vocation and support excellence in spiritual and emotional care of self and others.

Measurements and reports of program effectiveness compiled and presented to BUMC leadership, nursing managers, employees, volunteers and boards.

Phase III Renewal groups of graduates begin meeting to update and share experiences, look at the effect of the changes made in the workplace, support one another and renew their Sacred Vocation oath.

IV. Required Resources for Sacred Vocation Project Implementation

Support for Patient Care to devote time off the floor during work shifts to attend Sacred Vocation sessions (1.5 hours weekly for five weeks plus graduation for participants in Phase I; additional time for those chosen to participate in Phase II)
Sacred Vocation Project Coordinator for FY '06 (8 hours weekly of Chaplain Jennifer Rowley's time with remaining 24 hours weekly allocated for palliative care & bereavement care coordination for a total of 32 hours to be included in the Pastoral Care Department Budget)
PR Communication Support for orienting BUMC to Sacred Vocation project
3 Facilitators (Chaplain Jennifer Rowley plus two non-BUMC employees to be identified) trained for three days in Houston and compensated as contractors to BUMC for each series of sessions facilitated
Administrative clerical support to coordinate meeting schedule/locations of groups of Patient Care Technicians and Patient Care Assistants
Market research support to measure program effectiveness qualitatively and quantitatively using patient surveys

V. Measurements of Sacred Vocation Project Impact

Added questions on spiritual and emotional care and support on point of service patient surveys on pilot and control units
NRC mailed patient follow up surveys looking at questions related to spiritual/emotional support
Sacred Vocation project participant feedback

VI. Expected Return on Investment in Sacred Vocation Project

A. The Joint Commission for the Accreditation of Hospital Organizations (JCAHO) and the American Nurses Credentialing Center (ANCC), which awards Magnet status, advocate that patients have a right to spiritual, emotional and cultural care. The national trend in health care is to emphasize that patients' spiritual and emotional care are important parts of their overall health care experience. This care is the responsibility of all employees, not only those in chaplaincy.

B. The Sacred Vocation Project has the potential of enhancing the spiritual and emotional health of Patient Care Technicians and Patient Care Assistants, and in turn, enhancing the spiritual and emotional support they can offer patients. Patient satisfaction as well as employee satisfaction and retention are expected benefits of implementation of the Sacred Vocation Project.

C. In the pilot of the program at St. Luke's Medical Center in Houston, participant feedback was extremely positive. Comments like these from two participants show the potential impact of the Sacred Vocation Project:

"This project has opened my eyes and heart to be a different person, communicate, understand and to be more open and honest to others."

"…We were able to find out things that were never spoken or verbalized before and I feel that this makes for a better working environment as coworkers and friends. That in turn allows us as individuals to be able to turn around and be able to look at our patients more as human beings and not just another patient, and be able to provide them with the service and support that they need and want."

VII. Potential for Sacred Vocation Project to extend to other BHCS facilities.

A. The Sacred Vocation Project has the potential to be used throughout the Baylor Health Care System based on positive outcomes and project evaluation at Baylor University Medical Center. Resources would be allocated by individual facilities of BHCS to underwrite program implementation costs at that facility. The suggested vehicle for dissemination in BHCS would be the Service Excellence Council.

APPENDIX G

1 **Tape 1A - Interview**

2

3	**Interviewer:**	How long have you been at Baylor?
4	**Tech:**	[inaudible]
5	**Interviewer:**	Okay, and how long have you been a real technician – patient care technician?
6		How long have you been that?
7	**Tech:**	Three years.
8	**Interviewer:**	Three years. So, this was your first position at Baylor – that you came to?
9	**Tech:**	Um-hum
10	**Interviewer:**	Cool. Okay, what led you to become a patient care technician?
11	**Tech:**	Well, I'm a – a certified medical assistant. So, when I got hired on at Baylor I
12		thought the medical assistant in a [inaudible] unit care – unit tech at that time
13		pretty much was doing the same thing… [Interrupted by interviewer]
14	**Interviewer:**	Was that – was that true? Did you find they were similar?
15	**Tech:**	A little bit similar. Um, I didn't get to do any blood draws or things like that –
16		that I had my medical assistant… [Interrupted by interviewer]
17	**Interviewer:**	A medical assistant sounds neat. Where would you do that roll? Where…
18	**Tech:**	Um, doctor's offices, some hospitals, and uh, doctor's office. I would work in a
19		doc – doctor's office before I came here – so…
20	**Interviewer:**	Um-kay. Well, you came and you stayed…
21	**Tech:**	Yep [laughter]
22	**Interviewer:**	There must be something worth – wha – what is keeping you in this particular
23		job?
24	**Tech:**	Actually, the schedule. The schedule is working out with me going to school.
25	**Interviewer:**	Oh, you're going to school? I see, working towards what?
26	**Tech:**	Well, I was working toward physical tech. So, I think next year I'll probably get
27		into the program – of physical tech. Hopefully, again.
28	**Interviewer:**	That's exciting.
29	**Tech:**	Yeah.
30	**Interviewer:**	Is that here at Baylor?
31	**Tech:**	No.
32	**Interviewer:**	[inaudible] somewhere else.

33	**Tech:**	Yeah.
34	**Interviewer:**	Okay, so you're going to school by day and you're working from seven to seven
35		a.m.? Did we wake you up today when we called?
36	**Tech:**	Yeah [laughter]
37	**Interview:**	Sorry, oh my gosh…[laughter]. I was like, "Yeah. It's the first thing you do is
38		clarify whether it's one on one because, you know, all the day people don't ever
39		think about it as – as being – oh, I felt so bad.
40	**Tech:**	Oh, no. She said, "Well, uh…[inaudible] [laughter]
41	**Interviewer:**	Well, we're on the same page now. Um, when you were a kid what did you
42		imagine yourself doing?
43	**Tech:**	Working in the medical field.
44	**Interviewer:**	Really?
45	**Tech:**	Yes.
46	**Interviewer:**	How did that – how did – how do you think that came about as your own
47		ambition, or your dream?
48	**Tech:**	Mm, I don't know. I guess just helping people. I love to help people and take
49		care of people so that just kinda spilled into high school and I did nurse assistant,
50		worked – you know – part time and then went to school for nurse assistant and
51		from there on just kinda stayed in it.
52	**Interviewer:**	Well, okay. Um, do you see yourself doing this kind of job for a long time or
53		leading to another type of job? You've sort of answered that. Would the surgical
54		tech be your main goal, or would you – do you think you'd try that for a while,
55		or…?
56	**Tech:**	I'd try it for a while and then I'd do something else. You know, relating to that
57		field.
58	**Interviewer:**	Um-kay. I'm just, in my mind, thinking, "people and surgery," I guess you do –
59		guess you do work with people who – before they go under and as they come out.
60		You're so warm, I wonder, [inaudible] I – I hope I get to keep up with your career
61		[laughter] – with what happens next. Um, can you describe for me a workday you
62		had last week? Not – not necessarily a good day or a bad day just a workday.

63	**Tech:**	Mm. Let's see. We come in – we come in about seven. Between seven and see
64		the last at twelve – it's pretty busy. Pretty steady. Uh, the patients are still up and
65		going, and then about twelve they usually start to settle down for the night. So
66		between twelve and – twelve and four we kinda get a rest period. We have
67		[inaudible] a call in through the night and then at four we start getting busy again.
68		[inaudible]
69	**Interviewer:**	So you do those every four hours, or…?
70	**Tech:**	With some patients – every four hours. We'll start doing that between four and –
71		until time to home – we're pretty steady busy again.
72	**Interviewer:**	So a typical day for you, you don't go home and go to sleep do you?
73	**Tech:**	Mm—mm. I go to school [laughter] well, now I don't have to go to school. I'm
74		kinda resting in between because the program was so filled up. They want me to
75		wait until October to come back, uh, to re-apply again.
76	**Interviewer:**	Um, okay. So you have to rush at first then you have a little bit of a slow period,
77		and then you get really really busy again. Okay, let's see if, um – what are the
78		most important things that you do?
79	**Tech:**	Um, mainly patient care. That's pretty much the most important thing.
80	**Interviewer:**	Do you feel like you're team up there works well together in support. You know,
81		do you feel support in your job?
82	**Tech:**	Yes.
83	**Interviewer:**	Okay, do you – do you have your own list of things to do, or do you do what
84		people ask you to do specifically? Do you work with the RN telling you or
85		advising you, or do you go by the patient chart to know what to do, or…?
86	**Tech:**	Uh, actually they – they give us – um – information on the patient and what all the
87		patient requires.
88	**Interviewer:**	At the beginning of the shift….
89	**Tech:**	Yeah, and then the RN comes through if something else is needed then she'll ask.
90	**Interviewer:**	She'll come tell – she'll come ask you personally?
91	**Tech:**	Yeah.
92	**Interviewer:**	Okay. Yeah, most things do come up during the night. Don't they.
93	**Tech:**	[inaudible] [laughter] Yeah.

94 **Interviewer:** Yeah. Um, what part of your workday do you feel most needed?
95 **Tech:** Mmm. That would be the seven to twelve…
96 **Interviewer:** Seven to twelve peak [laughter] I'm gettin' smart [laughter]. Okay, um, because
97 it is so much to do as you change the shift. Okay. I'm sure people'll get – their
98 company leaves and their ready to go – get more comfortable and cleaned up and,
99 yeah, I remember what it was like. What part of the workday is the most
100 meaningful to you? Like on this typical day you described.
101 **Tech:** Uh…
102 **Interviewer:** What do you enjoy the most?
103 **Tech:** Um, I think between four and time to go home. That way the patients are just
104 waking up and – "well how was your night?" and just asking how things went,
105 you know. You kinda know how it went, but just to get their point of view – just
106 kinda know how – your job – well, how you did. How smoothly it went, or how
107 not [laughter] smoothly.
108 **Interviewer:** [laughter] …nightmare.
109 **Tech:** Exactly.
110 **Interviewer:** And then you're ready to give that report.
111 **Tech:** Mmm-mm.
112 **Interviewer:** Do ya'll all sit around a big table and the techs and assistants report and dialogue
113 with the nurses?
114 **Tech:** Yeah.
115 **Interviewer:** …at the end of the shift and the beginning of the new people coming on.
116 **Tech:** Mmm, we do the checks together and then the nurses will give back the report –
117 sometimes they'll give us a report after everything was done – after all the
118 reporting is done.
119 **Interviewer:** So, do you pretty much tag-team with the same people most mornings. Ya'll
120 know each other real well?
121 **Tech:** Oh, yeah. [inaudible] [laughter]
122 **Interviewer:** Um, could you describe for me one of – a time during the day when you felt
123 proud of the work you were doing.
124 **Tech:** Uh, time of the day?

125 **Interviewer:** Well, just a time during the day that you felt really proud of the work you were
126 doing sometime last week.
127 **Tech:** Ummm, that would be the time when, uh, the patient – she was acting – uh,
128 actually, it was the family. The patient wasn't doing so good. So I was in and out
129 of the room most the night – and the family, they were just really appreciative –
130 of the work, you know, of me coming in and checking on them and the patient.
131 That – at times like that – makes you really appreciate what your doing.
132 **Interviewer:** The more challenging the patient the maybe the more – even though it's hard
133 work it's real – sounds like it would be very rewarding.
134 **Tech:** Yeah.
135 **Interviewer:** I know what a comfort it was for me during the night to see the same person all
136 night long. I thought that was – I felt for people that had the twelve-hour shift,
137 but it sure was nice to go through the whole night with one person. I've got – you
138 talk a lot during the night…
139 **Tech:** That's true. When I work eleven to seven I would get the comment, "Boy, ya'll
140 sure change a lot – uh, I don't think I see the same person all the time." So when
141 I work from seven to seven it wasn't so bad. It was like, "Oh, you coming on
142 now?" you know, "I'll be looking for you yesterday."
143 **Interviewer:** Yeah, 'cause their awake when you see people.
144 **Tech:** Exactly, exactly.
145 **Interviewer:** That's nice. That is nice. Um, okay. Here's one that is really interesting.
146 Describe a workday where you wished you'd stayed home.
147 **Tech:** [giggle]…
148 **Interviewer:** Please start at the beginning of the day an – and we're looking at kind of
149 frustrations an – you know – things that may show up – time to go in again. Wha
150 – what are some of those?
151 **Tech:** Ummm, oh those would be the times as soon as you walk in their calling you for
152 something [giggle] and then when you leave their still calling you for something
153 [laughter]…
154 **Interviewer:** So, it never lets up.
155 **Tech:** It never lets up. That would be one of those times.

156 **Interviewer:** Yeah, you don't have time to get your bearings.

157 **Tech:** Exactly.

158 **Interviewer:** Sometimes do you have to start right in without report?

159 **Tech:** Uh ha.

160 **Interviewer:** Really?

161 **Tech:** Yeah. [inaudible] 'Cause the techs – you – that had the patient before you is – is
162 busy with that patient or busy doing something else and they call you for
163 something. So, you kinda get – kinda get – you know, sidetracked.

164 **Interviewer:** How many patients do you take care of, typically?

165 **Tech:** Uh, tonight we're doing 13 a piece.

166 **Interviewer:** Thirteen? You've got to be kidding?

167 **Tech:** No-o-o.

168 **Interviewer:** These – these people that took care of me made me feel like there were maybe
169 three others they were looking after.

170 **Tech:** Really?

171 **Interviewer:** Yeah.

172 **Tech:** Oh, that's good [laughter].

173 **Interviewer:** Yeah. Thirteen. Okay. What helped you get through that day – that you kinda
174 wished you'd stayed home?

175 **Tech:** Oh, I don't know. Just a – just waiting until lunchtime to take a break.

176 **Interviewer:** Mm-mm. Do ya'll get to take a break?

177 **Tech:** Oh, we definitely try to make sure we take a break.

178 **Interviewer:** Oh, you've got to.

179 **Tech:** Exactly.

180 **Interviewer:** Twelve hours.

181 **Tech:** Mm-mm.

182 **Interviewer:** Do you take an hour?

183 **Tech:** Mm-mm…

184 **Interviewer:** Do you try to do an hour?

185 **Tech:** …try to do an hour and so…

186 **Interviewer:** What do you do during lunch?

187	**Tech:**	Um-mm. Usually we'll sit and in the staffing lounge. Something like that.
188	**Interviewer:**	You don't really get too far away.
189	**Tech:**	No.
190	**Interviewer:**	Do you bring something from home?
191	**Tech:**	Mm-mm.
192	**Interviewer:**	Okay. There's not much here that's not pretty expensive, is there?
193	**Tech:**	Oh, my goodness… [laughter]
194	**Interviewer:**	Yeah. I know. When I'm here as a chaplain…[inaudible]
195	**Tech:**	Oh, it's ridiculous.
196	**Interviewer:**	Um, okay. Let's see. Do you count on your co-workers, or what oth – when
197		you're having a rough day who do you feel like you can reach out to?
198	**Tech:**	Definitely count on the co-workers and the nurses. So, you know, running around
199		having a rough day and their calling your name and that's when you ask, you
200		know, "Can you please take that for me?" or the nurses would hesitate to tend to
201		their patients when their busy.
202	**Interviewer:**	So you feel like you can raise your hand for help?
203	**Tech:**	Oh, yeah.
204	**Interviewer:**	Okay. Well that – that does help. Do you have any, um, do you have – do you
205		use spirituality as a tool?
206	**Tech:**	Um, some cases. Some cases where the family members or the patient is not
207		doing so good, or their dying, or things like that.
208	**Interviewer:**	How do you express that – to them, or with them?
209	**Tech:**	Mmm. I try to provide some kind of comfort to them, you know, uh – it just
210		depends on – on their condition or what they ask – what they ask me, or just
211		listening. Just listening.
212	**Interviewer:**	That's the best gift of all – a nice touch, you know, 'cause those things out there
213		that are so comforting. Ummm. Let's see, I think this is kinda – kinda redundant,
214		but the roughest part of the roughest day is…? Fill in the blank.
215	**Tech:**	Ummm.
216	**Interviewer:**	What makes it the roughest day that you wished you'd stayed home, the very
217		roughest part?

218	**Tech:**	Oh, when you have patients not appreciate anything you do. Oh, man. They feel
219		like their the only ones here and that they should be tended to the only one – as
220		the only one. That's the roughest. And then they just disregard you and, you
221		know, "Well, we're here to pay your salary." You know, I've heard that before.
222	**Interviewer:**	Really?
223	**Tech:**	Yes. I mean, we – the patients have gotten so disrespectful. You know, as the
224		patient, you know, having that kind of care – it's – it's like, why even bother?
225		You know, they won't – [inaudible]
226	**Interviewer:**	They probably feel like that toward all the staff, or do you feel like…
227	**Tech:**	All the staff. 'Cause I get a report from the other techs and they tell me the same
228		things. You know, "This patient…," you know, "This patient is rude and …"
229		You know, wants you to do everything for 'em and…
230	**Interviewer:**	So, it's pretty consistent.
231	**Tech:**	Yeah.
232	**Interviewer:**	They even – do they treat the nurses and other staff, and the respiratory therapist?
233	**Tech:**	Yeah.
234	**Interviewer:**	So, people are pretty consistent in their personalities.
235	**Tech:**	Oh, yeah. Oh, yeah.
236	**Interviewer:**	Okay. Do ya'll ever work together? I mean do you just laugh it off, or I'm – I'm
237		curious about what do ya'll do with [laughter] a patient like that.
238	**Tech:**	Well, hopefully they'll be leaving soon [laughter]
239	**Interviewer:**	Pray together that they get well [laughter]
240	**Tech:**	Yeah. That they leave soon [laughter][inaudible]
241	**Interviewer:**	All right. Well, this is another – uh – take on the same questions, but – stress.
242		You know, stress is different than tough. So, what – what – uh – stressful
243		workday – what adds to the stress of the work that you do?
244	**Tech:**	Mmmm.
245	**Interviewer:**	Difficult patients…
246	**Tech:**	Difficult patients.
247	**Interviewer:**	…and coming in to stuff already popping all around you that…

248 **Tech:** Oh, they have – give you a list of things that you have to have done through the
249 night. Uh, things that you have to do through the night, and on top of having, you
250 know, your regular stuff to do.
251 **Interviewer:** Where do those lists come from? What – what are they…
252 **Tech:** They come form the supervisors and someone like that, you know, having stuff to
253 do…
254 **Interviewer:** More – just extra things for those patients, or just around the unit?
255 **Tech:** The unit, or um, the learning network – things like that.
256 **Interviewer:** Oh, my goodness. That Simon Says…[laughter]
257 **Tech:** Yeah – yeah.
258 **Interviewer:** Where do ya'll even sit down to do that kind of stuff?
259 **Tech:** Uh, we'll try to go at the computer – um – at one of the workstations in between
260 patient calls.
261 **Interviewer:** Oh, man. You can't even concentrate.
262 **Tech:** Oh no.
263 **Interviewer:** Yeah. I do that stuff too and it's – it's hard to…
264 **Tech:** Especially when HIPPA came around. All that stuff you had to do.
265 **Interviewer:** That does add to the stress, doesn't it?
266 **Tech:** Uh-uh.
267 **Interviewer:** Is there anything – um – we'll get into this more, I think, the next interview, but
268 do you carry things in from home that cause stress, you know…?
269 **Tech:** Oh, I try not to. I usually go – you separate job and home. So, when you leave
270 your job, you leave your stress at the job, and then when you leave home, you
271 leave everything stressful at home.
272 **Interviewer:** Mm-mm. That's a good boundary, you know? You're – you're young, but
273 you're…[inaudible] [laughter]
274 **Tech:** [laughter]…learned it early [laughter]
275 **Interviewer:** Yeah. Yeah, that is good. So, 'cause it just – keeps kinda eating on you, doesn't
276 it?
277 **Tech:** Yeah.

278 **Interviewer:** Umm, when you feel stressed, what helps you with like – how do you get through
279 Simon Says or Baylor Learning Network assignments with all that hubbub around
280 you? How do you do it?
281 **Tech:** Umm, take one day at a time. I tell you – sometimes you don't finish it all. So,
282 you kinda chop it up and then ask the other co-workers, "Have you done this?"
283 and "Let's do it together." Sometimes we'll do it together as a group, you know,
284 to make it easier.
285 **Interviewer:** So, ya'll just kind of get it up on one screen and then everybody [inaudible]. That
286 does make it a lot better.
287 **Tech:** Yeah.
288 **Interviewer:** Yeah. So, it sounds to me like you're describing a lot of teamwork to get you
289 through and boundaries – healthy boundaries, and – are there – is there anything
290 else that co – coping skills for Shauntina that you've learned?
291 **Tech:** Mmmm. I've – teamwork up – um – this kind of – um, job – being – kind of at a
292 loss. 'Cause you cannot do all that by yourself. I went to other floors that there
293 was not teamwork.
294 **Interviewer:** Really?
295 **Tech:** Yes, you were pretty much at a loss. Lost the whole night.
296 **Interviewer:** Okay. If -- if you were in a – if you were in a position to – to be a team leader,
297 and I think you are a leader up there, how do you cope without teamwork. What
298 would you do to cope without that? What do you think the difference is between
299 your floor and other floors?
300 **Tech:** Mmmm. Communication.
301 **Interviewer:** Oh, really?
302 **Tech:** Oh, definitely. Other floors – they don't even get reports from other techs during
303 the morning time, or any thing like that. So…
304 **Interviewer:** How could they know…?
305 **Tech:** I know, I know, and – so our floor usually do – since everybody know each other,
306 we do our reports with each other. So, in order to communicate and know what
307 the patients need, you…
308 **Interviewer:** You've gotta.

309	**Tech:**	You've got to.
310	**Interviewer:**	I don't know how you could do it any other way 'cause you'd be walking in cold
311		on the situation.
312	**Tech:**	Yes. And some nurses, they've got it set up where you put everything up on a
313		board and you barely speak to the nurse at night, so…I don't know.
314	**Interviewer:**	Okay. Well, so that would be your – your top thing that you would implement –
315		is – te – communication to support teamwork.
316	**Tech:**	Uh-hu.
317	**Interviewer:**	Okay. Great. Um, let's see. Can you tell me about the best day you've had
318		recently at work?
319	**Tech:**	Oh, the best day was – um – wasn't so much a quiet day. The patients were nice.
320		They weren't too – too rowdy – um [laughter]
321	**Interviewer:**	Yeah. They weren't un – they weren't unappreciative?
322	**Tech:**	Weren't unappreciative. I think that makes the night. When the patients
323		appreciate what you – what you do, so…
324	**Interviewer:**	So, that was a good – the best day?
325	**Tech:**	That was a good day. Oh, yeah.
326	**Interviewer:**	All right. Do you get attached to some of your patients?
327	**Tech:**	Yeah.
328	**Interviewer:**	That must be nice – driving back there the next night. Tell me about your
329		schedule. You didn't really tell me how – are you on five days and off fi – or –
330		uh, when you work seven to seven…?
331	**Tech:**	Three seven.
332	**Interviewer:**	Three seven? Okay. Okay. So, you're on three days and off three days? Is that
333		right?
334	**Tech:**	On – on three and off four.
335	**Interviewer:**	Off four. Okay. That's – um – thirty-six long hours though. Okay. Um, what is
336		the nicest thing that's happened to you at work? An example of some –
337		something nice. Either some patient interaction, or co – co-worker interaction?
338	**Tech:**	Ummm. They buy lunch for everyone at night [laughter] …so he ordered pizza
339		[laughter]

340	**Interviewer:**	Well, that's nice.
341	**Tech:**	Oh, it was. It was. He's a recurrent patient so, he was in – he was in a good
342		mood and he – in a good mood that night and just ordered lunch for everyone.
343	**Interviewer:**	Marvelous. Yeah. It's gratitude isn't it?
344	**Tech:**	Um-mm.
345	**Interviewer:**	Okay. That makes for a great day.
346	**Tech:**	Oh, yeah. When our co-workers – we get together and have our little lunch.
347		That's good [chuckle] it breaks up the monotony.
348	**Interviewer:**	Yeah. And those luncheons are a deep night then. So, ya'll potluck?
349	**Tech:**	Yeah.
350	**Interviewer:**	Okay. Like – like who will instigate that? Will somebody just come up with an
351		idea? Mexican or something, or…
352	**Tech:**	Oh, yeah. Anybody can instigate it though [laughter] we try to do that [laughter]
353	**Interviewer:**	How often do you do that?
354	**Tech:**	Oh, not too often. We used to do it a lot, but we don't do it too often anymore.
355	**Interviewer:**	But it's fun. Yeah. I've been around at some of the Christmas parties and they are
356		fun.
357	**Tech:**	Oh, yeah.
358	**Interviewer:**	You know, I was going to ask you – what – what do – what do ya'll do to take a
359		break? Do you socialize outside work ever, or do you just…
360	**Tech:**	Oo-o-o, the way our schedules are we really – um – don't socialize too much
361		outside of work.
362	**Interviewer:**	[inaudible] [laughter]
363	**Tech:**	[laughter]
364	**[end]**	

APPENDIX G

1 **Tape 2B – Interview**

2 **Interviewer:** Have you had any thoughts our questions from last time, or something you
3 thought about that you'd wished you said and didn't, or…

4 **Tech:** Uh – not particularly. It's just that – uh – I thought that, you know, after we met
5 the other day – last week – last Thursday, it was like – it became a little bit more
6 exciting to me, and – uh – I thought, "Oh, I think we gonna like this." You know,
7 and it's good, we all gettin' together, you know, and expressin' ourselves. 'Cause
8 I always thought that – uh – uh – the techs were kind of – not overlooked, but not
9 looked into deep enough. So, how much we – uh – really [tape slips] for the
10 patients, you know what I'm sayin'. So, that's why – that's why. We did it for
11 management, you know, on our floor and that's about as far as it goes. A
12 questionnaire, or some paperwork, but we've never had the opportunity to just
13 really express ourselves like we doin' now [laughter].

14 **Interviewer:** This one starts with an interesting question. Tell me about when Baylor changed
15 things recently when… [tape skipped].

16 **Tech:** Something that changed? Let's see [tape skipped]

17 **Interviewer:** [tape skipped] brought down on you [tape skipped] We're going to do things
18 different [tape skipped]

19 **Tech:** [tape skipped] Oh, when they, probably, some years ago when they started adding
20 jobs to us [tape skipped] function. Like – uh – uh – we used to could – they were
21 sending all of us to class to learn how to even insert Foleys, or do simple dressing
22 changes – uh – but several other things I don't remember. We – on 2J, we never
23 really got to go. I think they cancelled the whole thing or something happened to
24 where they [tape skipped] took that out. And – uh – like, we never did those
25 classes. And we were suppose to get this rate hike, you know, behind it all.

26 **Interviewer:** What do think made them stop?

27 **Tech:** Uh – if something happened with the – now I heard it was something on 9Roberts,
28 or something, one of the techs was doin' a dressing change, but it was the wrong –
29 it was a sterile dressing change, which we cannot do, and I think something
30 happened with the patient. That was just, you know, talk, but – uh – it wasn't fair
31 for us.

32 **Interviewer:** Well, [tape skipped] had come in.
33 **Tech:** Well, you know, it was – I don't understand why a person would even do a
34 dressing change like that anyway, when you know you not 'suppose to do that.
35 And even if a nurse – a lot of the techs, if a nurse ask 'em to do something, they
36 just do it, without no questions.
37 **Interviewer:** What about the idea, though, of adding more [tape skipped] How did you – how
38 did you feel about that idea?
39 **Tech:** To me – it was – to me it was okay. And – uh – people like me that been here a
40 long time, and it was, like, simple to us because of the fact that we'd been here so
41 long and have seen it so much. So, wasn't like we needed very much education to
42 do it anyway, you know, but – uh – I didn't mind it because they told us we were
43 getting a pay hike, behind that, you know. They would add more functions and
44 they would increase our salary and all that, you know. That was a good thing,
45 but, you know, we were…
46 **Interviewer:** When it didn't happen, how did you feel then?
47 **Tech:** I was kinda hurt behind it 'cause I was really hurt because we didn't even get to
48 go to class, you know. And I think most floors went, except 2J, maybe one or two
49 others, but some of 'em had already got the pay hike, but we didn't. But they had
50 cancelled all that out and we were doin' – uh – I think they stopped – they
51 stopped us from doin' enemas -- all that because of a lot of the problems, so. I
52 feel like…
53 **Interviewer:** And it never really [inaudible]
54 **Tech:** Yeah. I never did particularly like it because you got your – it's a lot more than
55 just the feel of it. You know what I'm sayin'? We – they have to educate you.
56 Your know what I'm sayin'? You got to do more than just insert a Foley. Okay,
57 you got to go get education – educated about where they going, and why this, and
58 why that, and this area. I mean just the whole education of it, not just inserting a
59 Foley. Anybody can do that. I have – my husband, which he's deceased now, but
60 I inserted Foleys in him at home, you know. So, that was nothing new to me
61 either. You know what I'm sayin'. So – uh – we have to understand the reason

62 and – and get educated more so than just somebody showin' you how to do
63 something. I felt like that was left out a lot, you know.
64 **Interviewer:** How did it effect the rest of the staff to have somethin' kinda dangled out and
65 then taken away?
66 **Tech:** It – it bothered some of us, but some of us it didn't. Uh – the newer ones, it didn't
67 bother them at all, you know. But the ones that has been there for a while and
68 have been through a lot with Baylor, it kinda – they have the same opinion as I
69 did.
70 **Interviewer:** [tape skipped] That change involved job duties and procedures [tape skipped]
71 Well, hey it didn't involve benefits. So, okay. Um – here we're back to one that
72 we kinda discussed last time, but I think the [tape skipped] inspiration that made
73 you feel good about what you did at work [tape skipped]
74 **Tech:** I think the fact that I – I'm [tape skipped] [laughter] off the lot, you know. And a
75 lot of times the patients – we have a guy from New Orleans, and – up on the floor
76 – and – uh – so he told me this morning. You know, I was in there talkin', mostly
77 listenin' and goin' on, and [tape skipped] we started laughing about somethin' and
78 he said, "You know what, Ms. [inaudible]" He said, "I ain't laughed since I
79 [laughter] [inaudible] He said, "Are you crazy?" I said, "What?" He said, "You
80 just make may day." You know, I said, "Oh, okay." That just made my day, you
81 know. I told him, I said, "Look, I like to talk, so just tell me to shut-up and get
82 out your room." [laughter] He said, "Oh, I'm not goin' to tell you that. I'm
83 gonna tell you to sit down." [laughter] He was havin' a few problems. He can't
84 find his sister, and –uh – she's 71 [taped skipped] but he still was able to laugh
85 about other things. That made me feel good. That was the thing. I felt really
86 appreciated. Especially, when he said he hadn't laughed in four or five days, or
87 smiled or nothin'.
88 **Interviewer:** Well, this is a kind of personal one, and you just pick the tough time in your life
89 and how you dealt with [tape skipped].
90 **Tech:** The toughest time, I believe, in my life was when I lost my husband. Because it –
91 I had a nine-year old child at the time, and – uh – work. I was tryin' to figure out
92 how I was goin' to move on with it. It's easy to say what you want to do, but the

93 reality is not, or you may go around people and you, "Oh, I'm fine." And, you
94 know, "I just have to move on." But deep down inside that is not what you feelin',
95 you know. And my manager at the time was, Greta – Pardue, and she would – uh
96 – she told me, "Well, Jesse, you just stay off as long as you can – as long as you
97 want." And I'd call – I think after a week and half and I said, "No, I gots to come
98 back to work." Because I knew what it was doin' in that – constantly in the
99 house. If I'm in the house, I wanted to stay in the house, you know, and that was
100 just really, really makin' me feel worse and worse and worse. So, I needed to go
101 back to work and start functionin', and maybe that would help me to get partially
102 back to normal. It won't get me back to normal, but partially get back there, and
103 it actually did. Because I told 'em, "When I come back to work don't ask me – I
104 didn't want nobody to ask me a lot of questions. Because, I'm a loudmouth and I
105 giggle, but I'm also very sensitive. I cry real easy, and so, I don't want to talk
106 about it. If I want to talk about it I start talkin' 'bout it [laughter]. Just let me be,
107 just don't ask me nothin', you know. After a week or so I was, you know, I could
108 talk about it, you know, but right then I couldn't. I just needed to – that's just me,
109 period. I have to move around and do things. It makes me feel better.

110 **Interviewer:** At that tough time where did you find your strength?

111 **Tech:** In prayer. And I constantly did that. I would go in the bathroom and pray
112 [inaudible] breakdown [giggle] You got to hang in – I know you there with me
113 [chuckle] 'cause, you know, I can't do this, you know. And I would just – prayer
114 and reading the bible. [Tape skipped] people in general. I work with such good
115 people. And my family, we're very close. And at the time, you know, I had
116 daughters – they full grown and [tape skipped] The only thing that worried me
117 was that little nine-year old, but then I thought about it – my oldest daughter –
118 'cause I had him when I was 36. So, my oldest daughter was 16, 17 years old
119 when I had him. She said, "You don't have nothin' to worry about. Most people
120 think I'm his mommy anyway [laughter]. 'Cause she always had him. You
121 know, I have a daughter two year younger than her then I had another one two
122 years younger, you know, they just took over. He's still spoiled – 22 years old.
123 So, I guess that's the toughest time for me.

124 **Interviewer:** [tape skipping] and we get tough times [tape skipped] if you were [tape skipped]
125 close by, far away.
126 **Tech:** Well, I felt like he was – like that. I felt like he was right there. During the time –
127 'cause I took care of my husband at home. I didn't want my oldest daughter – uh
128 – she was pregnant at the time, and she didn't work. So, they were living in an
129 apartment, so her and her husband and one child, just [tape skipped] with me.
130 And she took care – she was there during the day and I picked up – uh – in the
131 evenin', and so – um, you know, I was like, workin' and, you know, tired when I
132 get off here and go home and I would have to take care of him. He would't let
133 nobody bathe him, but me. He wouldn't let nobody do nothing. And even if he's
134 in the hospital and they would call me, or tell me, "Can you please come out here
135 'cause we can't do nothin' with this man [laugher]. He was six feet three, a big
136 man, and they couldn't hardly handle him. So, and – uh – he just wanted me
137 there.
138 **Interviewer:** Well, it sounded like you had family coverage.
139 **Tech:** Oh, yeah. Because we were 24 hours in the hospital, and my sister-in-law – they
140 would relieve me, like, on the weekends, and – uh – something like that. Yeah, I
141 knew He was there, but I question because I should have been tired and wore out,
142 and I would have to get him medicine around the clock. I would have to get up at
143 three o'clock in the morning, five o'clock in the morning and he had a tube in his
144 stomach so I would have to [tape skipped] I don't know how I made it. And even
145 when he passed away – uh – I had to call my mother because I didn't feel like I
146 was – felt like I was suppose to, you know. So, a friend of my mother's, he told
147 me, he said, "You know why you feelin' 'okay' so-to-speak?" or, "You don't feel
148 like you wanna cry every second?" He said, "Because that's the good Lord
149 working on you. You are relieved from that, and you did everything you could
150 for your husband, and the Lord was with you then and He still gonna be with you"
151 [laughter]. You know, I see some women that be just torn all to pieces – torn all
152 apart and don't know what they doin' and cry all the time. I wasn't doin' that and
153 I couldn't figure that out for nothin'. And that's what my mother – I mean her
154 friend – that's what it is. And my mother kept sayin', "He aint' never gonna

155 overload ya honey. He know exactly what you can take and what you can't. So,
156 my mother used to tell me – all those long years when I was a kid, "He ain't never
157 late, baby." [laughter]
158 **Interviewer:** All right, now. How does religion and spirituality affect the work that you do?
159 That was a perfect example, by the way.
160 **Tech:** Sometimes I can – if you talkin' to patients, or dealing with patients, but you can't
161 help but think about God. You know what I'm sayin'? Because [laughter] you
162 can't help but think about it. Sometimes a patient will start talkin' about God, or
163 Jesus Christ and then it like, "hang in there honey, just don't lose the faith." You
164 know what I'm sayin'? It comes up, you know, and I said, "Sometimes, you
165 know…" and I just keep the faith, for whatever it's worth. That's as far as I get.
166 But it comes into play a lot because it pops on my mind even when I'm dealing
167 with patients, or bathe them, or see how bad off they are, or patients comin ' in
168 from the nursing home with sores and [tape skipped]. You ain't have to think.
169 You ain't have to think about God then.
170 **Interviewer:** Do you remember one time when you were touched by an angel or an experience
171 [tape skipped] any time [laughter]
172 **Tech:** I do kinda remember, and I think it was because – we had a patient and nobody on
173 that floor could deal with that patient. They fought a lot, they was silent, they
174 would spit on you, and then for some reason I passed by the room, and the patient
175 – I never looked at the patient – I walked in front of him [laughter] This patient
176 said, "Ms Jesse." And I looked at the patient and I – there's so many people that
177 come through that I – he think I just probably forgot. And, "How you doin'?"
178 And I went in there and I just started talkin' to the patient, you know. And, "I'm
179 so glad you here 'cause these people just they not treatin' me right, they not doin'
180 this, they not listenin' to me, they not doin' nothin' that I ask 'em to do. It's
181 takin' them too long, and I'm hurtin', and this and that." On and on and on, you
182 know. So, I went in there and just started talkin' to the patient, you know, and I
183 did kinda remember who – remember who he was. And the nurse said, "You
184 mean he ain't through that tray at you?" [laughter] And I'm like, maybe it's the

185 way I [inaudible] But it calmed him down. Maybe God sent me to his room. But
186 it calmed him down. The only problems I had was [inaudible] [laughter].
187 **Interviewer:** Would you say [tape skipped] do they tell you what if feels like to be them? Do
188 they describe their hurtin' and …?
189 **Tech:** Yeah, they do. They describe themselves. Well, they – they just. Some – most
190 of 'em just loose all everything. They have [tape skipped]. "I lived my life. It
191 might not have been okay, but I did what I wanted to do, and" [laughter] I mean,
192 we're so much different. And a lot of it is – afterward a lot of 'em said they lived
193 the life they wanted, and I said, "Well, that's good." Made you happy[inaudible]
194 you should be happy, you know what I'm sayin'? We have choices. If it wasn't
195 in the direction of God, whatever direction you were goin' in that made you
196 happy, I'm all for it. I tell them a lot of times, I am a Christian. I will say that,
197 and – uh – I don't knock people that aren't.
198 **Interviewer:** That's right, but you're there for them too.
199 **Tech:** That's my choice. Whatever you do, I would never try to – uh – put on you or
200 nothing'. I won't even mention it, you know, if that's not what you want to hear.
201 A lot of times we just start talkin', and if a person starts cursin' or talk vulgar, or –
202 and stuff like that – they would start respectin' you and not curse and start –
203 because they know you a Christian. We get a lot of patients like that. They are so
204 bad [chuckle]. When they find out – uh – what your beliefs are they will start
205 respectin' me. It's that light shinin'. And you can't tell me they don't see it,
206 because it shows. [inaudible] We did. We, as a group of people – I've had
207 patients that were [tape skipped] as a group. A lot of the nurses, we go in – hold
208 hands, everybody, and pray with them because he asked for it, you know what
209 I'm - and we go do it with the whole crowd. We have Janie and [inaudible] – uh
210 – some of the people that have been there a long [tape skipped] Greta was our
211 manager then – uh – [tape skipped] [laughter].
212 **Interviewer:** And what was their response?
213 **Tech:** And – uh – the patient? And they would just be so thankful, like they know, and
214 the peace – you can see it in [tape skipped] 'cause they really wanted to do that

215 because they have been told, have some knowledge of [tape skipped] nothin' the
216 doctors can do. They need to heal and pray, all the time.
217 **Interviewer:** There are people who are cured, but not healed.
218 **Tech:** [laughter] I'd rather be healed [laughter]. [inaudible]
219 **Interviewer:** It sounds like, you know, I'm learning that different units have people that are
220 right there ready to pray and some people are not so comfortable with it, but it's
221 not that people [tape skipped] you're comfortable when patients need you.
222 **Tech:** We go to, for personal reasons, Jamie – uh – our social worker – our retreats, it's
223 about four or five people [laughter].
224 **Interviewer:** Okay, do you remember a time when you feel like you contributed to a certain
225 person [tape skipped] not the guy who was combative, but is there another story?
226 **Tech:** Well, yeah. A lot of patients asks you, "Will you please pray with me?" Holding
227 their hands I say, "Would you hold my hands and pray with me, please?" And
228 with – I'll do it. [tape skipped] If they ask me, I'll do it.
229 **Interviewer:** [tape skipped]as a partner in the healing process.
230 **Tech:** Well, just, you know, just talkin' with the patient. They know – everybody know
231 everybody's character and characteristics, and Oprah – Oprah has a certain point.
232 That we know who to go to for – okay, the truth has her certain points – strong
233 points. I have my strong points, you know, and that's talkin' people down. It's
234 like a calmin' effect, you know. And – uh – each person has a certain strength
235 that we already know who to go to [tape skipped].
236 **Interviewer:** You needed to come back after the loss of your husband because this is
237 affirmation that your life will [tape skipped] You still have a lot to give and I'll
238 use [tape skipped] after the loss of my little boy. And ya'll are helping. I've
239 heard something from each different person that I'll take with me. Any other
240 examples of the way your [tape skipped] suggesting that you think you bring to
241 this.
242 **Tech:** Well, I guess, most people are bitter people. When I get to the point when that
243 patient [tape skipped] I just smile at them. One patient told me one time, "Oh,
244 you have the prettiest white teeth." I wanted to [inaudible] [laughter] He said,
245 "That smile on your face is worth a million dollars, woman." And he said, "That

246 smile is worth a million dollar, you just don't know." So, when I get them to
247 smile I feel like, okay, "I got you now" [laughter] Everybody know me because I
248 hum, and – uh – so, we had a little contest goin' around the floor of certain
249 characters by each person. Oh come on now, they goin' say "hum." Everybody
250 knows that's Jesse 'cause I hum, and Marcellas say, "Jesse, when you at that desk,
251 don't start that hummin'" [laughter]. Anyway, a patient [inaudible] I not aware of
252 it, I just do it. So, I was in a patient's room and I was getting' on his nerves, and I
253 didn't know I was hummin'. He say, "I wish you'd quit that so-and-so hummin'.
254 It just drives me crazy." I go, "Sir, I'm sorry, I didn't know I was hummin'," you
255 know. "Whatever that song is, I wish you'd stop when you come in here." I said,
256 "Yes, sir, I will try." And so, every time I go in the room I'd have it on my mind,
257 you know, "Don't hum." And so, about a week later, you know that patient came
258 back to me and apologized to me, and told me he was sorry, that he felt so bad,
259 you know. And he said, "I felt like, maybe you were hummin' for me to make me
260 [tape skipped]…and I just really bit your head off, and I'm so sorry." You know,
261 and – uh – [inaudible]. A lot of the patients know me because they always askin',
262 "What song you hummin'" And they know me by that because I'm a hummer,
263 but I usually don't know I'm hummin'. It just, I – it's not a particular thing. It
264 just kinda a hummin'. My Momma said it comes from my great-grandmother.
265 She did that, and that is the way she dealt with stress. They always tell me,
266 "That's how you get away from stress. It may be your stress relief or something."
267 And then I – sometimes it scared me 'cause I guess I didn't know I was hummin'.
268 **Interviewer:** Alright. Now here's one that'll make you think, and this is the last one – um –
269 except to just ask you if there is anything you want to add. What do you [tape
270 skipped] think people'll be saying about you [tape skipped].
271 **Tech:** That they remember me for nothin' but good – about Ms. Jesse and – uh – what I
272 contributed to their lives – the role model I played for a lot of kids. We have a lot
273 of kid, well to me kids, workin' here [tape skipped] they are kids to me. All of
274 those guys, they'll come, "Good morning, Ms Jesse." Uh – they know that they
275 can depend on me to help them and uh – without question, and I'm the only thing
276 up there [laughter] And they'll come and they'll like [inaudible] and they all

277 speak to me and hug me every mornin', you know. And so, and I teach them how
278 to transport a patient from the bed to – the right way if they doin' it wrong. Stuff
279 like that, and they appreciate that. So, if I – what I contributed to – uh – my
280 patients or my job here at Baylor. I've never been a person that – I'm not that
281 way, you know [tape skipped] I know everybody don't like me [laughter] but I –
282 you know what I'm sayin'. I don't think anybody hate me. They may envy me
283 because, and I think that's because some people may wish they had my character
284 or something, but mostly to that, for what I've done in the years for my patients,
285 for my floor and for other people and their lives, and whatever. 'Cause a lot of
286 times we – we – we have to – somebody has a issue, and it could be a child, you
287 know, and if we contribute little thoughts because we are older – some of us are
288 older and we've already raised children. So, we kinda like take the younger ones
289 and chastise them a little bit [chuckle], "You let her do what?" [laughter] "No,
290 sweetie, you need to stop that right now, or they gonna be runnin' the house,
291 okay?" That kind of thing. And it's for the good we – I've done in people's lives.
292 And – uh – work I've contributed. [tape skipped] It makes me feel even good
293 now, talkin' because a lot of times we talk, but we don't feel like we're being
294 heard. You know what I'm sayin'? [chuckle] And – uh – I always felt like
295 talkin' care of a patient [tape skipped] got more than passing his pill, or givin'
296 him a shot, [tape skipped] a whole lot of time, patience and a smile. And
297 sometimes that's better than a shot of morphine. You understand me? And I have
298 seen that in the 21 years. I have talked to patients and forgot they asked for a pain
299 pill. You understand? So, you – I know it's the truth, you know. And – uh --
300 you know, I feel good inside just bringin some of the things out that you asked
301 me. You know what I'm sayin'? So, I know this'll be a really good thing.
302 [laughter] And the others, 'cause if it open me up it'll open them up too [tape
303 skipped]
304 **[end]**
305
306
307

308

309

APPENDIX G

1 **<u>Tape 2A – Interview</u>**

2 **Interviewer:** How long have you been at Baylor?

3 **Tech:** Twenty-one years.

4 **Interviewer:** Okay. And how long have you been – you're a patient care assistant technician –
5 patient care assistant?

6 **Tech:** Yeah, patient care assistant.

7 **Interviewer:** How long have you been that?

8 **Tech:** Uh, well that's what I started.

9 **Interviewer:** That – that – you are what you began as? Twenty-one years, that's fantastic. My
10 other interviewee was more of a new employee, but this is perfect. We're getting
11 a wide range. What led you to become a patient care assistant?

12 **Tech:** Well – uh – I guess this about 21-22 years ago and I thought about going into the
13 career of nursing, but I couldn't at the time. I was raising four kids by myself and
14 – uh – this and that, so I said, "Well, I'll just start out here and maybe I can…"
15 [laughter] you know, "…eventually go into nursing," and then I was divorced and
16 then I re-married during that time. So, the husband I re-married was pretty much,
17 you know, taking good care of us. So, I never did, you know, feel like I needed to
18 move in it further.

19 **Interviewer:** Oh, that's good. So you're still – he's still in – the whole life is still with him
20 together with him and everything…

21 **Tech:** Uh, no. He passed away.

22 **Interviewer:** I'm sorry. Sounds like he was very wonderful…

23 **Tech:** Oh, he was very nice. Yeah, he passed away, but – uh – we're still – I'm still in a
24 pretty good shape, and I just never did pursue anything different and – uh – kids
25 going to college and I worked trying to get them through college [laughter].
26 That's what I'm really working for, but then…and then too I was – uh – I didn't
27 need to reti – I didn't wanna retire. I was in my 40's. Forty-one, forty-two,
28 something like that. It was too early for me and I'm not the "sit down" type
29 person. So, I just kept going, and – uh – but then the crew I work with are
30 fantastic people. Most of us have been working together for fifteen to twenty-
31 somethin' years that I've known 'em. And we've all been workin' together.

32 **Interviewer:** On 2J?

33 **Tech:** On 2J, and that's half of the staff. We've all worked together a long time.

34 **Interviewer:** That seems like that would feel great.

35 **Tech:** So, yeah, we're more like family. Mm-mm.

36 **Interviewer:** Maybe that's why the acuity level of the patients is, you know, is – if you've got a
37 team to support you and keep [inaudible] you know that you can call on to give
38 you a hand.

39 **Tech:** Oh, yeah, and – uh – we all know each other. We've been through personal
40 times, tragedies, happiness, you know, whatever. So, it makes…

41 **Interviewer:** That makes job important.

42 **Tech:** Yeah, it makes a big difference, and – uh – we all stick together, try to help one
43 another. I'll be way over on the other hall and like they – one of the male nurses,
44 I've been working with him for sixteen years, he'd come way over on the other
45 side, 'cause he know me, but then that other girls are kinda new, but then David
46 know me [laughter] that feel pretty good, you know, and then there I go, you
47 know.

48 **Interviewer:** You're all over the place.

49 **Tech:** Yes, so if, you know, he know I need help he right there for me.

50 **Interviewer:** Tell me, if – so, you were drawn to nursing, and – and just became what you did.
51 What was it about nursing? What is it about patient care?

52 **Tech:** I think that's just one of my characteristics, I guess. So-to-speak, you know. I
53 like people, I like [inaudible], and – uh – and I really feel I'm a soulful person as
54 far as people, you know. I'm sensitive. I will cry in a minute [laughter]. Then I
55 [inaudible] [laughter] too bad. You know, I'll go in the bathroom and do it
56 maybe, but you know, but I like helping people, you know, and – uh –

57 **Interviewer:** Well, that's good.

58 **Tech:** Yeah, I like to smile, and some of the patients will, "Now what in the world do
59 you have to smile about at 6:30 in the morning?" [laughter] "I heard you…you're
60 the first thing I hear every morning is you." [laughter]

61 **Interviewer:** That's good, that's good. Well, you obviously enjoy your work a lot.

62 **Tech:** Yes. I do enjoy it, you know, and – uh – it's not like – uh – something that stays
63 the same all the time, you know, we see 'em come in really, really sick and in
64 pain. We've seen 'em come in that they've given up on 'em and they walk out of
65 here. That's satisfying.
66 **Interviewer:** I'll bet so. When you were a little kid what did you – when you were a kid what
67 did you dream of growing up to be?
68 **Tech:** When I was a kid? Mm-mm. I think when I was a kid I was going to be a
69 teacher, and – uh – and I wanted to teach little kids. Children. I have five
70 children and seven grandchildren [laughter].
71 **Interviewer:** Do you think you'll retire in this job?
72 **Tech:** Yes. I know I will. Mm-mm.
73 **Interviewer:** That's kind of a satisfying feeling too.
74 **Tech:** Mmm. Yes, it is. It is very satisfying.
75 **Interviewer:** And twenty-one years.
76 **Tech:** Twenty-one years.
77 **Interviewer:** All right. Tell me about a workday you had last week, and what we're trying to
78 see is, what – what is it like to do your job? A workday last week – um – and I'm
79 going to ask you a few other questions, like when did you fell most needed?
80 What was the most meaningful to you? Uh – a time during the day that you felt
81 proud, but if you can pick a day from last week, or even this week, we'll roll into
82 this week and just kind of tell me what was the most important things you feel
83 like you were called to do? Or, what's a day like for you?
84 **Tech:** Uh – yeah – well, it was last week. Well, I think it was Friday, and – um – we
85 have – what we do – we have patients, and we get so attached to some patients, or
86 they know us, and – and it's like they call on us by name, you know. And so, this
87 one particular patient – uh – couldn't – they just like, nobody would deal with this
88 patient, but [inaudible] [laughter] you know, everybody else either afraid of him
89 or this or that and it's like, I mean, "You go in there – ya'll just be talkin," but
90 I've learned that – uh – in all these years, even if – when you get on the – I call it
91 "gettin' on the patient level" you know, and it's like, if it's a black – one of us –
92 and he's like the ghetto type, you know – uh – I mean, I was raised to where it

93		wasn't in the ghetto, but I know ghetto, so you get on that level, you know, and
94		you talk the way he talks [laughter]'cause I do understand 'em, and then you talk
95		the way they talk and see, that way you can – uh – get together with the patient
96		and the patient starts – uh – trusting you, you know, and – uh – confiding in you
97		and that's the difference. And it could be Mexican, you know – uh – Philippino,
98		or whatever – same – same thing, and – uh – yeah, he was – he was – had a
99		personal problem which he wanted his wife to come up and she didn't come, and
100		– uh – so he was telling me about all what he'd done or he'd tried to do the best
101		he could do and this is what he gets in return and all this, "When I'm sick, I need
102		her and she's not there for me." And all – and he needed to talk. So, I just
103		listened. You know, I don't ever – uh – give my opinion too much about – and I
104		tell them I will listen at you, but I can't tell you what to do [laughter].
105	**Interviewer:**	Maybe they find their own answer.
106	**Tech:**	Right, and if they talk enough they actually do, you know. And so when he left
107		he got discharged and he wrote the sweetest note concerned, you know, me. And
108		it's not that – he said, "It's not that I'm just pickin' people. It's just that she was
109		special in her own way, even though she was just sittin' there listenin," you know,
110		but then a lot of people – that's all they need, just somebody to talk to anyway.
111	**Interviewer:**	So, like on an average day, you're taking care of how many people.
112	**Tech:**	Eight. I have eight patients.
113	**Interviewer:**	And you still find time to listen.
114	**Tech:**	Oh, yeah. Mm-mm. I still find time to go in there and – uh – we have Ms. Guy,
115		she's a stroke patient, and – uh – I go in there so often and tell her the – uh –
116		wave, "Let's see what you can do with that hand, or smile." You know, and she
117		started waving her hand yesterday, she started waving her hand. But, you know,
118		you just – me – I just – that's just me. I just like going in there by the rooms
119		talkin' and I said, "See, this is why I can't get nothin' done." [laughter] That was
120		rewarding for me last year, and basically we go – it's something every day, every
121		day, you know…

122 **Interviewer:** How do ya'll communicate as a team? How do you get the information of who
123 your – who your patients are? Do you have the same rooms, or is every day a
124 new day?
125 **Tech:** Every week we rotate. It's like, you either one through eight, nine through 16, 17
126 to 24, 25 to 32, and we rotate. Like, I'm nine through 16. So I'm with a different
127 patient, and – uh – staff, but we always get reports from the previous techs, or the
128 nurses, if it's something important.
129 **Interviewer:** Seems like when I go back there – it seems like this great big conference room.
130 Everybody's talking to everybody all the way around…
131 **Tech:** Oh, yeah. Oh, yeah, and – uh – yeah. We always get report, and – uh – even –
132 uh, you know, little bitty things that they need to know except [inaudible]
133 [laughter]
134 **Interviewer:** Well, tell me. Is the listening where you feel most needed, or there other work
135 that you do where you feel the most needed.
136 **Tech:** Uh, no. Listenin' is not – that's just part of me – and just – I do that actually
137 after, you know. 'Cause when you in the hospital – okay you sick and you can't –
138 at some point in time you not gonna be able to do what you do normally when
139 you not sick. And, it like – uh – some of the patients – they'll say, "God, I
140 haven't had a bath in three days." Well it's no problem. We gonna get in that tub
141 one way or the other. And then you figure out a way to get them in that tub and,
142 you know, we get out and they sweatin' and I'm wet [laughter], but it get done.
143 You know what I'm saying. And – uh – I think I – helpin' people – uh – in that
144 kinda way – it is more rewarding. Listenin' is just something harder. Just helpin'
145 people that need help.
146 **Interviewer:** All right. What's your favorite part of your workday?
147 **Tech:** The favorite part of my workday? Uh – I think it's – um, basically when I get to
148 talk to somebody. When you finish up. When you got to get support.
149 **Interviewer:** Okay, we're going to flip a little bit, and describe a workday when you just
150 wished you had stayed home, you know?
151 **Tech:** Yeah. Well, I've had those too, and it's when – God every – seems like every
152 patient has a drama, problems, you know. Are they goin' here, are they goin'

153 there, it's – we also a diabetic floor. Okay, we have patients that come in with a
154 problem that that. So, they DKA, which is – we have to take blood sugars every
155 hour, and I've had to take three patients every hour. And then you have your
156 others. Then all your patients are bed-ridden so you have to do complete bed
157 baths [laughter], turn every two hours, you know, and that's – uh…then I don't
158 wish I'd stayed at home, but I'd be wishing three o'clock need to hurry up and get
159 here. So, I could hurry up and go…[laughter]
160 **Interviewer:** So, really it's the workload, not the people you work with, but the workload that
161 gets to be frustrating.
162 **Tech:** Oh, yeah. The workload. Yes, yeah.
163 **Interviewer:** What helps you get through that kind of workday?
164 **Tech:** It's the teamwork. We have a – oh Lordy, yeah. We have a – we have a good
165 working relationship with everybody, everybody. Yep, even the manager, yeah.
166 Marcella will get in there and – and yeah, she get in there and turn them patients,
167 bathe them, whatever – it don't make no difference. She right in there with us.
168 'Cause acuity is high. So, it – uh…
169 **Interviewer:** And she's found time to work on this committee all year, and I don't know how
170 she – I just take 30 minutes a month [inaudible] commitment, and I don't think
171 she's missed a single meeting. She's really – she's really committed.
172 **Tech:** Yes, she is. She's a fantastic woman.
173 **Interviewer:** You have – um – do you have faith resources that you use at work, or is that sort
174 of something you – not resources, but do you use – do you use prayer, or…?
175 **Tech:** Yeah. Oh, yeah. On my way to work every morning I pray coming in and if I
176 feel the need I will go in the bathroom or something and just pray. You know,
177 when I'm gettin' too hyper, frustrated, or gettin' really, really tired or something,
178 and – uh, 'cause you not gonna be 100% every day. Somebody may make you
179 upset. You know, you may get upset about something, or whatever, and then I
180 gotta go [laughter] I go in this bathroom in a minute, you know. And – uh – to try
181 to get some release so-to-speak, and it helps.
182 **Interviewer:** Whatever your – whatever your religion is it's got to help to go to the divine
183 power that we believe [inaudible]. What else can we do?

184 **Tech:** And I go in there, yes, "Hey, Lord…[laughter] I got to tell ya [laughter]"
185 [inaudible]
186 **Interviewer:** I had [inaudible] that God just got bored when we don't come to Him because he
187 wants to hear from us. We are His creatures, you know. Okay. Well, um, let's –
188 this is sort of the same – what's stress to you? What makes the stress? Is it the
189 same things that you were talking about if the patient load is too much to do?
190 **Tech:** If the patient load is too much to do. Yeah. The stress comes from – you don't –
191 you know, you – you don't – you don't really have time to break, you know. And
192 sometimes we will eat and run, you know. Because if you don't [laughter] you
193 would never get out, you know, you'd never finish up. And – uh, that brings –
194 takes your stress level up too. It do mine because I have to eat. You know what
195 I'm saying. I'm so used to it. My body is used to it – of certain things, and then –
196 uh, but – uh, or sometimes I will take a minute or so and go outside and – uh –
197 just deep breath or something and that'll relieve it.
198 **Interviewer:** Well, let's see. There's one more…when you're stressed out you re – retreat to
199 the bathroom to pray. The toughest part of stress, where does stress collect in
200 your. Like, you know, I feel it in…
201 **Tech:** Yeah. It's in my – right here in my shoulders, and I know, you know, when I –
202 'cause they [inaudible] it doesn't hurt bad, bad I know when it's gettin' tight.
203 Mm-mm, mm-mm.
204 **Interviewer:** What do you – what do you think of as ways you do – care for yourself? What
205 are – what are some of the things you do in self-care? Maybe not just here, but
206 when you go home. You have a – you do have a stressful job. How do you take
207 care of yourself?
208 **Tech:** Well, okay. I'm – I'm already – uh – a goin' person, okay, and I think that that
209 came from my mother [chuckle], and – uh – so, it's like when my typical day –
210 when I leave work I go home, I – uh – take my bath. I'll take [inaudible] I take a
211 bath 'cause I needs everything to soak [laughter] you know, I need to soak and
212 that relaxes me, you know, and then I'll go in there and turn on – I love cookin'
213 shows, HGTV, I love flowers, I have grownin' – I'm grownin' tomatoes…[fades

214 out] and I go outside, me and my little doggie, we go outside and we get in that
215 yard and do something. And it makes me feel like a totally different person.
216 **Interviewer:** That's what I needed to know. I mean, I know you had to do something.
217 **Tech:** Uh-hu [laughter] right, and – and I say, "Maybe that's what we doin' up in
218 Heaven is – is spreadin' flowers, but I love that, gardening.
219 **Interviewer:** Gardening and a little 'ole pet. I have a dog [fades] she's a precious little thing…
220 **Tech:** Um-mm. And she's not old 'cause she – 'cause – and she sat at the back and she
221 be like, "What are you waitin' on? Come on." You know [laughter]…She know
222 her routine. She know the routine and everything [laughter].
223 **Interviewer:** Well can you – we're almost through with this part. We have just a few more
224 questions. What's the best day you've had recently at work? The best day and
225 the nicest thing that happened that day, you know, that kind of thing. Was it that
226 patient you told me about earlier, or – that wrote the note, or…
227 **Tech:** Yes – uh – it was – every so often – um – the [inaudible] he comes on the floor
228 and walks and they visit a couple of patients or whatever.
229 **Interviewer:** John? Uh, Mr. McWhorter?
230 **Tech:** Yeah, and – uh – so, he wrote me a letter, you know, to my house and told me that
231 – uh – he had talked to one of my patients and they had really, really gave me an
232 overwhelmin' positive – uh – you know, what they said about me was
233 overwhelmin', very positive, and they love you to death and they recommended
234 you highly. They was just, you know. And so, he wrote me a letter and told me,
235 you know, that he appreciate what I do, you know, and all this and – uh – and I
236 thought that was really, really – it just made my day. And sometimes, you know,
237 I think the same day, you know – we don't have certain jobs on the floor, we
238 work together so it's like we got two or three [inaudible]. If I'm in the
239 refrigerator and I see something, I'm gonna clean it out, you know what I'm
240 sayin'. So, that particular day I just cleaned the refrigerator out and did
241 something, you know. And so, Marcellas, she came to me. She said, "Come
242 here, I got something for ya." And she gave me two movie tickets [chuckle]. She
243 said because, you know, you take it upon yourself...", you know, other [inaudible]
244 do "…take it upon yourself, you know, just to do that, you know." And – uh – I

245 said, “We all family.” Now if I’m at home and my refrigerator is dirty, I’m gonna
246 clean it, so.
247 **Interviewer:** Okay. Um – let’s see. You’ve already done this. You described what you do
248 before and after work on a typical day. What do you do before? You come on at
249 sunrise?
250 **Tech:** Yeah. I get up – uh – around five o’clock in the morning, and I get up that early
251 ‘cause I like to watch the news and drink a cup of coffee [chuckle]. And I want to
252 have time to get ready to go to work. ‘Cause I don’t want to be stressed because I
253 have to drive from Lancaster to here – Gaston – and I don’t wanna be rushin’. So,
254 I like my day to go as smooth as possible. So, that – that what I do in the morning
255 soon as I get up – uh – five o’clock and I get – sit there ‘til about five-thirty.
256 Then I start gettin’ ready a little bit here and there and I leave – usually leave at
257 about six or five after six. I have plenty time to go slow [laughter] ‘cause I hate
258 stress [laughter].
259 **Interviewer:** Well, that good, and you’ve told me what you’ll do when you leave work today,
260 probably go home and garden and see that puppy…
261 **Tech:** Hot as it is I’ll be out there – uh – doin’ something. Mm-mm.
262 **Interviewer:** What’s your doggie’s name?
263 **Tech:** We call him Red. He’s a miniature Doberman.
264 **Interviewer:** Oh, my. How beautiful. I’ll bet he gorgeous.
265 **Tech:** Yes, he is. Looks like a [inaudible] and he acts – the mentally is the same as a big
266 dog, and he’s very protective, you know, and I – he could hear a pin fall, you
267 know, and he’s always on guard. Just like they are, and – uh – and I told my older
268 son. I told him, “That’s my alarm system.” I don’t need to pay nobody for no
269 alarm system. ‘Cause if somebody’s goin’ down the sidewalk, I’m takin’ about in
270 the street, he’s right at that door. Just like at attention, and if they start comin’
271 towards the sidewalk he start barkin’. It’s like, “Where do you think you goin’?”
272 **Interviewer:** Well, tell me about a time when your work interfered with life outside work.
273 **Tech:** Interfered with it?
274 **Interviewer:** Yeah. Your work and personal life [coughing] work got in the way of something
275 you wanted to do. You generally work seven to three, Monday through Friday?

276 **Tech:** Mm-mm. The only time it interferes, I would say, is – is when – uh – I can't get
277 off [chuckle] to do what I want to do. I may wanna go out of town or it may have
278 come up – something may have come up, you know, and I wanted to go and I
279 couldn't go, you know, 'cause I couldn't find coverage or something like that, but
280 as far as gettin' in the way – because I, you know, I separate all 'em. So, it didn't
281 – my work is never in the way of my personal life. Now, where I have really
282 something goin' on Marcella, she's already told us, she said, "I don't care
283 sickness comes, somebody call, you got to go. 'Cause I know I would be headed
284 toward the elevator [chuckle] and ya'll better be headed toward it too." You
285 know. So, -- uh – that's the understandin' so, we don't, you know, she's
286 understandin' person so I don't have a problem there. So, it's just, you know,
287 everybody – somebody come up and say, "We goin' – we goin' to Houston this
288 week – weekend." You know, and – uh – I'm fifty-eight years old so I have a lot
289 of friends that are already retired. So, they kinda like move around a little bit and
290 so, they was like, "Well, I'm goin' down – we goin' be down there Wednesday,
291 Thursday, and Friday." I can't get off [laughter].

292 **Interviewer:** Tell me how coverage works for ya'll. Where do you get your coverage?

293 **Tech:** We – uh – we have PRNs that – we have a couple of 'em. And we put in – we
294 put in if we know we goin' be off like next month, sometime. Well, we have like,
295 Henry'll put the schedule out. We have a book we write in, and so, every month,
296 if you want to be off sometime, we just write it in. Okay, but if he pokes that
297 schedule and you haven't written anything in it then you have to find coverage,
298 but if you've already put it in, you gonna get it.

299 **Interviewer:** Okay. One last question for this – this session, and we have one more session that
300 has even more interesting questions. We've talked about your work for the last
301 30-40 minutes. Is there something else you want to share with me about your
302 work and what it means to you?

303 **Tech:** Well, it's – it's not really about my work. It's – it's – uh – it's like, you know, we
304 as Techs – uh – patient care assistants – we do a lot, you know, it's all under
305 nursing and my thing is if it's under nursing like the nurses, you know, true they
306 went to school and got educated to do what they do and – uh – and – but we

307 workin' side by side with 'em and all of it is patient care to me, you know what
308 I'm sayin'? So, it's the only thing is that sometimes bothers me it's not
309 [inaudible] I think it's just administration. They will – when they give the nurses
310 raises they don't consider us enough, you know. And – uh – because of the fact
311 that we – uh – we right there with 'em, the nurses, and a lot of times we are with
312 the patient more that they are too. And – uh – it's like they don't make us feel
313 important enough. You know what I'm saying? That kinda thing. Other than
314 that, then too, you know, they talk about budget and stuff too, but in the back of
315 my mind I don't feel that that's what it is, you know. And we did get a raise a
316 couple of years ago, but it took us two years [chuckle], but we were promised
317 another one 'cause they got a raise, but then the supervisors and the techs didn't
318 get raises, and they said probably come later, maybe, you know. But then I feel
319 like, if you gone over all do something like that you should take it all the way
320 through. You should let the whole team benefit and not just part of it. Otherwise,
321 you know, I love Baylor. I've been here a lot of years, so…[fades out]
322 **[end]**

APPENDIX G

1 **Tape 3B – Interview**

2 **Interviewer:** All right, um did you have any questions or comments after last time?

3 **Tech:** No. no.

4 **Interviewer:** Okay, all right. Well, we will go on. Today's interview we questions you may
5 consider more personal. Our goal is to work with the staff to identify how to
6 improve the work environment. Ways to improve the job. That's part of what we
7 do. [tape skipped] We want to look at with you something that's been changed in
8 the past, about one time when something Baylor did changed things around here.

9 **Tech:** [tape skipped] the whole Baylor facility participated in [tape skipped] like, we had
10 changed, tried to improve like on – um – teamwork [tape skipped] like with
11 partnership counsel meeting, the talk with – uh – like whoever was [inaudible]
12 feedback from the staff we had team leaders. Like, I'm a team leader and then we
13 have – I have five people under me who I report and let them go out and ask
14 suggestions and let them know, so, that part of the group will come back and
15 discuss on the feedback – output from – what was discussed – what need to be
16 discussed in our meeting. [inaudible] not there's just one [inaudible] whoever the
17 members are in the group 'cause we workin' like – um – like um – [inaudible]
18 control, we have the [inaudible] control sit in, the one from housekeepin' sit in,
19 respiratory – uh – physical therapy – uh [tape skipped] nurs – nursing. We have
20 nursing sit in, and like – some doctors sit in discussin' on what, you know, what
21 issues there is to discuss. We discuss different protocols. How can we improve.
22 Different areas that need what suggestions [tape skipped] to make. To make it
23 easier for us to work together when work on 15Roberts or make Baylor a home.
24 Make it good so everybody want to come to work everyday.

25 **Interviewer:** Okay, how often does that meet?

26 **Tech:** We meet once a month on Thursdays.

27 **Interviewer:** And you're the elected rep for the techs on your floor, for the day shift?

28 **Tech:** Day shift. We have tech from three to eleven and we have nurses on like four and
29 ten and we have…

30 **Interviewer:** They all come to the same monthly partnership?

31 **Tech:** Come to the same monthly meeting. I also have people that under representatives
32 that's under me, but I'm also the [inaudible].
33 **Interviewer:** So, you have five techs that tell you ideas [inaudible].
34 **Tech:** I have nurses and techs.
35 **Interviewer:** That you are the final on information to the counsel forum?
36 **Tech:** Uh-uh. So, they report to me anything that needs to go on with that [inaudible].
37 **Interviewer:** So, those ideas go to Mela?
38 **Tech:** Mela sits in on the meeting. Like, and – we – after group decide on what is good
39 – what we discuss in the meeting is confidential among us in the group. So, we
40 discuss on what can do to make it better for everybody, and Mela sits in and let us
41 know what's goin' on – what – you know – and then she have feedback from stuff
42 that we done done, and stuff that's goin' on on the floor to let us know what needs
43 improvement, or what has been done, like changes and stuff. We have [tape
44 skipped] So, from there, from the [inaudible] came up with partnership. It helps
45 sometimes. As a group we – you know – and our partnership we come up with
46 different ideas. So, like we came up with like – uh – it's lucky [inaudible] so we
47 ask, like for the members and the staff to contribute five dollars each month – to
48 contribute for like if somebody get ill, when somebody dies, for the birthdays.
49 So, it won't have to come out of pocket. Everybody don't wanna give or
50 contribute so we just have a pot that we just put in five dollars [inaudible] For the
51 day shift I hold the money. Uh – like the treasurer for the day shift. When
52 occasions come up we have the money so we don't have to go around and pass a
53 card out and make contributions for it. So, we already have the money, like that.
54 So, that's one of the suggestions. We just have little odds and ends things that we
55 do.
56 **Interviewer:** How did that effect the staff? You're on the partnership counsel. How do you
57 think the idea of the partnership counsel has effected the staff?
58 **Tech:** It hasn't because most of the staff is from people like TVA days or three to
59 eleven. It's – it's all within the staff of the floor on 15Roberts, so somebody from
60 each shift in – in – in the staff is representative of who they feedback to, or who
61 they have people that's under them and they like – issues of [inaudible] concern,

62 and so we bring somebody like from [inaudible] and physical therapy how they
63 [inaudible] 'cause they work on our floor with all the patients. So, it just a
64 feedback.
65 **Interviewer:** Okay. Do you think the staff feels like their represented with their ideas?
66 **Tech:** Yeah, we bring in – some of the things that we have that they came up with
67 [inaudible] Like the break time. How some people don't wanna – uh – relieve
68 you while you take break. You can't sit down to eat your food at break time
69 without somebody hollerin' so, we came up with a meal sign-in and that allow –
70 you have to have [inaudible]. So, you truly get a break and it's the same with
71 nurses. That's when it – it's the same with nurses. Whoever you on break it's
72 same house same rules. You cover for each other. You have to sign in and out.
73 So, that's one of the things that the – that's come out, no receiver for break time
74 without somebody callin', "I'm sorry they just went in there." Sometimes we
75 have a day where the floor be so hectic where you just can't – you don't – you
76 know this other person so tired 'cause they been humpin' all day where I could
77 say where I sat down from watchin' my own patients 'cause I may have a good
78 group of patients [inaudible] make sure they don't need something before I left to
79 eat, and I tell them goin' to eat and I be back in 30 minutes so whatever you
80 needsI can take care of you then.
81 **Interviewer:** This question [tape skipped] does not involve benefits. It did involve working
82 closer on job duties, rules and procedures, right? Okay. Let's go back to this
83 kind of question. Can you describe something that made you feel good about
84 what you do at work? Maybe related to the partnership [tape skipped]
85 **Tech:** Just knowin' that my patient is satisfied, seein' that smile on their face to let me
86 know that I have done the best that I can do to satisfy them and make sure they
87 comfortable and make them smile. And they say, "Thank you, and I appreciate
88 you." Sometimes that's mostly what we be wanting to hear when we don't get it
89 from your supervisor or your clinical manager or nurse that you working with.
90 [tape skipped] Know that you done did the best that ;you can do, but they still
91 wanna find something.

92 **Interviewer:** Do you remember a tough time in your life and how [tape skipped] fortify you in
93 [tape skipped].
94 **Tech:** [tape skipped] my divorce. That was just like the hardest time ever 'cause I feel
95 like takin' – movin' away from Dallas. Just movin' as far over. I was hurt [tape
96 skipped] and didn't know what to do, but I just didn't wanna – you feel like I
97 wanted to live and be around in the area, so I just wanted to just up and move and
98 that's all. [tape skipped] I had found a house, I had – my mood is – I had made
99 up my mind, and then, you know, about leaving. But, you know, lots of friends
100 and co-workers and then you have someone that supports you and talk to you like
101 how they know that you goin' through a hard time and – divorce is very hard. It's
102 very stressful, especially – you know, I don't really think that it effected my kids
103 a whole lot, but it effected me to where I couldn't eat, I couldn't sleep. I was like
104 in a daze. I come to work just to come to work – not – just to do my job, you
105 know, any little thing could tick me off because of the stress of what I was going
106 through [tape skipped] My mom, I don't know what it is, but my mom just – uh –
107 that I don't agree with and [inaudible] I feel like I'm the mom over her and she's
108 the child because that somethings you do is just – act like she's just the child and
109 I'm the mother and I have to take with my hours to come to her rescue to rescue
110 her out and it get very stressful and tired when she know better and she
111 [inaudible] I don't care how much I spoke to her or I talked with her about it, it
112 don't – it hasn't worked. It didn't help. And I talked to my sister and I said like I
113 thought she gonna make – I was havin' a nervous breakdown from her.
114 **Interviewer:** How long ago was the divorce?
115 **Tech:** Uh…[tape skipped] my co-workers and friends, my sister. Uh – just the talkin'
116 and someone to just listen to me and just, you know. I really didn't need no
117 advice because I knew I had to move out and I knew that we were separated. I
118 was just in the denial part. Just in the denial part of it all. So, they comfort – just
119 lendin' a listenin' ear, just to get you outta the house just to get you out and keep
120 your mind occupied and you won't have to dwell on this right here. Supported
121 friends, my sister [tape skipped] I am very religious and very spiritual. I read the
122 bible and I prayed on it and – I just prayed on it and I asked the Lord to give the

123 strength and the character to move on with my life and don't look back on what –
124 what was in the past. If it was meant for us to be together and meant for us to –
125 uh – for us to go through this – you know and – it wasn't -- I know if it wasn't for
126 this we'd still be together. So, you know, you know what's best for me and
127 what's best for him because you know all things before we even know – know
128 what's goin' on within our own life and our own self. God is strength – uh – and
129 I have people that will pray for me and constant [inaudible].
130 **Interviewer:** Sometimes we don't know what's around the corner and we think it's as dark as
131 night and then there is something that's so joyful.
132 **Tech:** I made a statement, I like, "I don't think I wanna be doin' such, such, such for you
133 [inaudible]
134 **Interviewer:** How does religion and spirituality [tape skipped]
135 **Tech:** You never know what someone is going through until you walk in their room.
136 You could have a person that's sick and they don't wanna be bothered, but you
137 say a kind gesture like, "my thoughts and prayers are with you" or "May God
138 strengthen you and make you better." Any little thing like that can lift a person
139 up. You never know what someone's going through so any little kind comment
140 or gesture [tape skipped] happy and put a smile on their faces, and with the family
141 members also.
142 **Interviewer:** [tape skipped] something around one of your patients?
143 **Tech:** I can't really recall. I know here's a lot of my patients – uh – that ask me to pray
144 for them, you know, just to pray for them because they goin' for a procedure or
145 don't think they be doin' good and they ask me to pray for 'em or I say, "Let me
146 pray for you. Maybe it'll help you feel better or uplift you some."
147 **Interviewer:** When you're praying do you feel the Spirit?
148 **Tech:** I feel it all around me. And sometimes when you just get to talkin' about the Lord
149 and the many versus [tape skipped] and we know that bad things are goin' to
150 happen and it's happened for a reason. We don't know why or what the reason is.
151 It just brings tears to my eyes because that's tears of joy and tears of sadness
152 because He know what He doin'. It's hard to accept things – for us to accept
153 things for – for numbers of reasons [tape skipped] We know that one day we all

154 goin' have to die 'cause this just a temporary home. Number one, this is not a
155 permanent [inaudible] for us. So, we know that everyone has to die, so – and you
156 – can't never [inaudible] yourself for it. So, you – but you know it.
157 **Interviewer:** [tape skipped] patient talked to you about what it [tape skipped]
158 **Tech:** I never had a patient to – um – talk to me – talk to me about [inaudible] I can tell
159 you from personal experience from my mom. She has emphysema and she has
160 asthma and she – uh – gaspin' for air to breathe – she – uh – says it's scary. So,
161 I'm thinkin' like she's dead to me already because she's trying to gasp for some
162 air and ain't nothin' comin' – 'cause everything is closed and she can't get it. The
163 patient's just tell me about the pain that they in or something like that, but for my
164 mom tellin' me that she can't breathe and it's scary and she feels like she's
165 already dead because of that right there. I have to tell her to breathe or calm her
166 down so she can catch her breath or whatever. We came too close too many times
167 when she couldn't breath, you know, and she'd be right there at the doctor's
168 office and she done get really sick and they had to stick that tube down her open
169 her lungs up and drain fluid from her. That's a lot of [tape skipped] You know
170 what? Because when my grandmother died I wasn't right there and they called
171 me from work and she died at 1:15. I left work and I went by my house to pick
172 up my uncle [inaudible] I helped – 'cause she died in her house and they takin'
173 her body to Greenville, Texas, so I helped them lift her up, wrap her and take her
174 out [inaudible] I guess all the time in the hospital and seein' what it feel like and
175 when I be with my mom I be so calm to where I know how it is. I just be so calm.
176 It don't overreact 'cause I still helpin' all the time. So, this is why I'm glad I am
177 in the nursin' field, so a lot of stuff that happens and takes place and go on – I can
178 [inaudible] even though it's my own family and someone close to me. I know
179 how to deal with it other than not being able to deal with it. When my – uh –
180 sister – sister-in-law passed, she passed here at Baylor, and then my sister's
181 husband passed here at Baylor, but they brothers and sisters. I called for the
182 chaplain to pray for the family. I read the scripture – I did more for them than the
183 Chaplain. He looked like what I'm gonna say? What to do? So, I was readin'
184 scriptures and I was prayin' for them and I did everything. Like to minister them

185 and sooth them and make them feel good and they like, "What is he here for? He
186 didn't do anything – just look." 'Cause I did it all. So, then when my sister
187 husband died last October, he died on my birthday – uh – we go up here on the
188 fourth floor on ICU. I was cryin' but [inaudible] soothin' them, making 'em –
189 reassure them that the Lord know what's He doin' and everything gonna be
190 alright. He' just takin' His child home. And I cried, but I stayed calm. 'Cause I
191 be around it a lot here at work and it makes it easy for me to deal with when it
192 comes personal or family member or something. My grandmother [inaudible] a
193 long talk, me making her smile. "The Lord has seen me through. I have many
194 blessing. I seen my kids all grown." You know, she was ready. She didn't have
195 any regrets. Whatever things she did do wrong, she pray about it and ask the Lord
196 to forgive her.
197 **Interviewer:** I see how you contributed to her spiritual healing are there times you [tape
198 skipped]
199 **Tech:** All the time. Not everyone can be a nurse. Not everyone can be a doctor, or a PA
200 or a [tape skipped] inner strength and clean somebody else's bottom, or bathe
201 them. So, it takes a lot within to do that because this is a hard job and everybody
202 ain't as strong to do this. It's like you say, "I couldn't have the job that you do. I
203 couldn't sit there and watch somebody die like you do, I couldn't – after we done
204 bathe the patient I done seen the patient just die after we done bathe them. They
205 couldn't do [tape skipped] and clean poop of somebody else and then with the
206 confusion and Alzheimer's and the AIDS and the cancer and the heart attack and
207 the stroke and all of that. They couldn't deal with that. It's the inner strength that
208 the person have in order to do this. So that's very spiritual.
209 **Interviewer:** Well, I'm hearing you say you do see yourself as a healer.
210 **Tech:** Yeah.
211 **Interviewer:** How does that make you feel?
212 **Tech:** I feel good all over. 'Cept I feel I done touch the lives and the lives done touch
213 me.
214 **Interviewer:** How does being a healer, how does that make you [tape skipped]?

215	**Tech:**	Sometimes it has it's high points with any job and low points. Sometimes I go
216		around like, "I'm blessed" because I know there's many times when I know I can
217		still [inaudible] and I got another opportunity to still be here. So, I know that I am
218		blessed and this is my calling to be with – to touch other people's lives – to be
219		able to [inaudible] them to do whatever they need to do [tape skipped]
220	**Interviewer:**	What would you want people to say about you if they were talking about…
221	**Tech:**	I would want them to remember all the good things that I did and the bad – all the
222		good stuff with the bad. I mean like, sometimes when I get frustrated and may
223		snap at a patient, or made a comment about a patient that did this and did that and
224		then I turn around and do something good for the patient, and the patient was very
225		satisfied with me and they end up writing me a Five-Star Spirit, or nominating me
226		for a Spirit of Excellence or something. It came back around and they end up
227		appreciating me even more because you got on the same level they was on, even
228		though you not suppose to – it was meant to be that way, but you got down with
229		them and on the level they were and you kill 'em with your kindness – you
230		overwhelm them with your kindness and they just took everything. Just – uh –
231		[tape skipped] certain things I don't fool with. I don't talk about other peoples
232		and behind their backs, or [inaudible]. Just remember me for what I was and for
233		what I did. [inaudible]
234	**Interviewer:**	[tape skipped] I have one more question [tape skipped]
235	**Tech:**	I enjoyed our little sessions that we had – the first one and the second one because
236		it makes you be aware and learn more about the person – the individual person
237		[tape skipped] try to judge the person by lookin' at 'em and you really don't know
238		the person on the inside of 'em. So, by getting' to talk to me for a couple of days
239		you know how I really am on the inside and I am sensitive and I will cry, and that
240		I'm not so bad after all – by just lookin' at me you thought, "Oo-oo, she –
241		attitude" 'cause they can always judge, but they don't know the person on the
242		inside.
243	**Interviewer:**	At our orientation, did you hear any [tape skipped]
244	**Tech:**	I enjoyed the whole program. You did good about introducing the program and
245		Teresa did good by tellin' some details about what needs to be done and how the

246 program is set up so everything was good. But I would like to see – one of my
247 nurses tonight, on our floor, she would like – uh – like once a week on our floor –
248 whatever Chaplain was on duty for our floor for that week [inaudible] to come in
249 a pray with our staff. Like once a week, pray with our staff. It would make us
250 feel a whole lot better and it'll life some burden off of us if we goin' through
251 some stuff or the patient done got on your nerves, you know. It'll bring us a little
252 closer together.
253 **Interviewer:** Would that be posted on the board, or would you just want him to circle around
254 and say, "I'm here, we're going to gather in the break room for prayer." How
255 would that be – easiest to do?
256 **Tech:** She said if we see him up there [inaudible] well we could have a little poster sign
257 or something up there about once a week – a pray session for five or ten minutes
258 where he would pray for the whole staff and he pray for us as one [tape skipped]
259 **[end]**
260
261
262

APPENDIX H

All BUMC Patient Care Techs & Patient Care Assistants Should Attend a

Sacred Vocation

Kick-off Event!

Wednesday, August 31 or Sunday, Sept. 11
Folsom Room - 17 Roberts Hospital

Attend the 30-minute session of your choice:
7 a.m. ▪ 8 a.m. ▪ 9 a.m. ▪ 10 a.m. ▪ 11 a.m. ▪ noon
1 p.m. ▪ 2 p.m. ▪ 3 p.m. ▪ 4 p.m. ▪ 5 p.m. ▪ 6 p.m. ▪ 7 p.m.

Patient care techs and assistants will be paid for time spent at the 30-minute event and should "wave"/clock in and out! Refreshments will be served.

Sacred Vocation© is a new enrichment program for all patient care techs and patient care assistants who are employees of Baylor University Medical Center (BUMC). This Spirit of Excellence program aims to recognize you for working compassionately with patients and to enhance how you feel about your job. You will learn…

- That your job is a "sacred vocation" – you have the power and the opportunity to help brighten, heal and nurture the spirit of your patients.
- How meaningful you are to your patients.
- How to positively and sensitively connect with people while showing respect for their personal, religious or cultural backgrounds and choices.
- How to share your ideas about how Baylor can support your work as a sacred vocation.

APPENDIX I

Sacred Vocation

Objectives of the Sacred Vocation© program:

1. Nurture the spirit of patients by first nurturing the spirit of the employee/caregiver.
2. Realize that all employees have the power to heal and the power to harm.
3. Discover that the employee-as-healer self-identification helps give meaning and validation to the employee's life.
4. Change work to allow for meaningful experiences to occur.
5. Provide development and demonstrate value of our techs.

SACRED VOCATION TRAINING SESSIONS (Paid Time)

Use This to Self Enroll **now** on BLN: BUMC Sacred Vocation-

Select One Session Below at a Consistent Day/Time:

Session One: 2005

Begins the week of September 25 and ends on the week of October 30

Session Two: 2005

Begins the week of November 6 and ends on the week of December 18
(No classes the week of Thanksgiving)

Session Three: 2006

Begins the week of January 9 and ends on the week of February 13

Session Four: 2006

Begins the week of February 20 and ends on the week of March 27

Session Five: 2006

Begins the week of April 3 and ends on the week of May 8

Each Training Session is 1 ½ hours in length;
One day per week for Six weeks. Class size: minimum of 8

Wednesdays:
3:30 PM to 5:00 PM – (Longhorn Room Truett Basement)
9:00 PM to 10:30 PM – (Longhorn Room Truett Basement)

Thursdays:
7:30AM to 9:00AM – (Bluebonnet Room Truett Basement)
11:30 AM to 1:00 PM (Longhorn Room Truett Basement)
1:00 PM to 2:30 PM (Wildflower Room Truett Basement)

Sundays:
2:30 AM to 4:00 AM (Longhorn Room Truett Basement)
2:30 PM to 4:00 PM (Longhorn Room Truett Basement)

Spirit of Excellence
BAYLOR UNIVERSITY MEDICAL CENTER AT DALLAS

Excellence in Action

JUNE 2006

The Spirit of Excellence (SoE) newsletter serves to spotlight employees, teams and initiatives helping make Baylor University Medical Center at Dallas (BUMC) world famous for its customer service.

ED: Satisfaction on the Rise!

Patient satisfaction scores are indicating success for BUMC's emergency department (ED). Our Level 1 trauma center has made many positive changes to improve patients' perceptions of their care, including:

- Clinical coordinators and physicians leading specific efforts
- Renewed SoE focus
- Senior leadership visibility and involvement
- Reception area/concierge services
- Improved triage process/staffing
- Greater use and staffing of ED Fast Track area
- Service recovery
- Random discharge phone calls within 24 to 48 hours
- Increased employee recognition
- Key words at key times
- Standards of Performance
- Nursing business cards
- Wallet-size medication cards for patients
- Dedicated parking spaces

These improvements show the personal commitment of Baylor's ED employees, emergency medical physicians on staff, guest relations staff and our many allied health employees. Thank you for making a difference for our patients!

***Teresa Schardt**, SoE director*

I am pleased to share this valuable input from the Studer Group meetings. Our senior leaders are determined to address these issues in BUMC's journey toward clinical, operational and service excellence.

***John McWhorter**, BUMC President*

Enhanced Excellence Culture

For the past two and a half years, BUMC's journey toward clinical, operational and service excellence has involved a more formal, determined approach to enhance patient and employee satisfaction. We have enjoyed many successes by focusing on measurements, best practices and reward and recognition.

Our approach follows a model started by Quint Studer, a former hospital chief executive officer who teaches hospital leaders nationwide how to improve satisfaction by focusing on the right things. Recently, the Baylor Health Care System Board of Trustees and senior leadership engaged Mr. Studer's consulting firm to help us build on our successes and move us to a higher level of excellence. To achieve this level, BUMC will focus on:

- People Management
- Leader Accountability
- Leadership Development

Thank you to the many role models who embrace our culture of excellence. I look forward to this next phase of our journey! – ***John McWhorter**, BUMC president*

BUMC's Current Strengths

In April, more than 90 BUMC leaders and staff members attended the Studer Group site assessment meetings. They identified Baylor's current strengths to be:

People – 84% favorable commitment by employees; greater than 80% physician satisfaction; staff turnover rate is two and one-half times lower than national average

Service (as measured by patient satisfaction scores) – varies by quarter but definite improvement noted in most departments since the January 2006 town hall meetings on information and emotional support

BUMC's strengths include pride in Baylor's care team, like these members pictured at the April President's Recognition Reception. BUMC honors employees for their service excellence to patients, visitors, co-workers and physicians.

Pride in Baylor and Care Team – interaction between and within departments/units; employees value co-workers; quality of medical staff and physicians easy to work with; visibility of executives to managers; communication through town hall meetings and president's monthly newsletter to managers for staff updates

Ideas for Service Excellence Improvement

To achieve Baylor's vision to be trusted as the best place to give and receive safe, quality, and compassionate health care, BUMC's workforce and the Studer Group consultants identified these opportunities for improvement:

- Senior leader/manager visibility to front line staff
- Wayfinding to make large campus easier to navigate for guests
- Communications related to new initiatives and between departments
- Benefits package
- Incentives for retention, not just recruitment
- More timely and consistent employee reward and recognition
- Improved patient and employee transport systems
- Patient satisfaction measurement tool clarification
- No parking fee for patients *(fee is routine for large hospitals in Metroplex)*
- Communication of available guest amenities *(new patient services guides placed in all inpatient rooms in early May)*

APPENDIX J

Recognizing Excellence at BUMC

SoE's Reward and Recognition Team honors departments and individuals who demonstrate service excellence at BUMC.

Spirit Stick Winners

These departments won the quarterly Spirit Stick Award for showing visible enthusiasm for service excellence through service-minded conversations and actions.

Spring 2006

Inpatient: 7 Roberts
Outpatient: Martha Foster Lung Care Center
Ancillary: Medical Physics and Radiation Safety
Support: Epidemiology

Tops in Willingness to Recommend

Four outstanding BUMC departments earned top scores in patient satisfaction for the fourth quarter of calendar year 2005. They received the highest rating for the patient loyalty indicator "Willingness to Recommend" on the National Research Corporation (NRC)/Picker Group survey. Each quarter, Baylor leaders serve and provide meals or gift cards to the winning units in honor and celebration of their accomplishment. Congratulations to these winners:

7 Roberts
10 Roberts
4 Jonsson
2 West Truett

The team on 7 Roberts show off their Spirit Stick Award and "We're TOPS in Willingness to Recommend" banner. Great Job!

Wow! Access Services won the Soaring to New Heights Trophy for both February and March.

GI Services employees smile big after winning the Best Satisfaction Trophy in February.

Monthly Satisfaction Trophy Winners

Congratulations to these latest winners of the Best Satisfaction Trophy and Soaring to New Heights Trophy! The monthly trophies go to departments achieving the highest patient satisfaction scores and to those with the most improved scores (greater than one percent). Scores indicate 12-week "excellent" averages from surveys conducted before and after patient discharge.

Best Satisfaction Trophy (*highest scores*):

Inpatient: *February* – New Family Center/L&D; *March* – 3 North CCU; *April* – 4 Truett ICU; *May* – New Family Center/L&D

Outpatient: *February* – Gastrointestinal Services; *March and April* – Lung Care Center; *May* – Center for Pain Management (Dallas)

Ancillary: *February to May* – Physical Medicine & Rehabilitation

Support: *February to May* – Pastoral Care

Soaring to New Heights Trophy (*most improved scores*):

Inpatient: *February* – Antepartum (20.5-point increase); *March* – Bone Marrow Transplant Unit (13.6-point increase); *April* – 4 West Roberts ICU (12.9-point increase); *May* – BMTU (8.3-point increase)

Outpatient: *February* – ED Fast Track (17-point increase); *March* – 2 West Truett (1.1-point increase); *April* – A.M. Admit (13.8-point increase); *May* – Center for Pain Management (Dallas) (6.1-point increase)

Ancillary: *February* – Environmental Services (3.6-point increase); *March to May* – no winners

Support: *February* – Access Services (13.7-point increase); *March* – Access Services (3.7-point increase); *April* – Pastoral Care (1.09-point increase); *May* – Pastoral Care (9.2-point increase)

APPENDIX J

Sacred Vocation Phase 2: Action Plan Approved

Congratulations and thanks to the members of the Sacred Vocation Phase 2 team! The 11 patient care assistants and techs (PCAs/PCTs) spent five weeks evaluating barriers and enablers to performing their jobs as a sacred vocation or calling. On March 6, they presented an action plan to improve their environment to BUMC senior management and the spiritual companionship team. After careful consideration, management approved 14 of the 16 action plan recommendations and applauded the team's insightful work.

"Yes" to Action Plan

Communication:

- Access to Voice Care in all units for patient updates.
- During shift change report, RNs and techs communicate about patients with special needs or who had issues on previous shift.
- All staff accountable for communication behaviors as stated in Core Competencies (communicate openly, listen to understand, keep others informed, encourage adaptability/flexibility, respond in timely manner).
- Regular communication of Sacred Vocation work through established communication channels.
- When organizational changes are announced, tell why and how they relate to Baylor's mission, vision and values.
- Use Partnership Councils to disseminate to everyone the "why" for organizational changes.

Teamwork:

- Implement "Walk in My Shoes" (shadowing) program in units.
- Patient care is everyone's responsibility: No one lets call lights go unanswered or patient needs unmet.
- Secretaries ask for call light response for normal tech requests to available tech first, and then to RN.
- Communication training (includes feedback and coaching) for all unit level staff.

Supportive Work Environment:

- Select and evaluate individuals in all unit leadership positions by ability to live Baylor values (Integrity, Servanthood, Quality, Innovation and Stewardship).
- Unit leadership seeks constructive feedback from staff through annual surveys.
- Begin a Sacred Vocation/Living the Values recognition award for PCAs/PCTs.
- Develop a Tech Float Pool to avoid short staffing.

Sacred Vocation Phase 2 team representatives include: (sitting, left to right) ***Gloria Bagsby****, BMTU;* ***Melissa Van Hecker****, 3 Hoblitzelle;* ***Ida Loum****, 7 Jonsson;* ***Victoria Debusk****, 7 Roberts; (standing, left to right)* ***Andrea Jones****, 12 Roberts;* ***Lafeada Jones****, 16 Roberts;* ***Rowena Cajucom****, PACU;* ***Chick Deegan****, Phase 2 facilitator;* ***Candice Woods****, 2 Jonsson;* ***Carla Levels****, 6 Roberts;* ***Barbara Gayton****, 12 Roberts; and (not pictured)* ***Brenda Benson****, 7 Roberts.*

"No" to Action Plan

- The proposal for PCAs/PCTs to receive an "on call" rate was declined; however, administration supports improved staffing by expanding the Supplemental Tech Pool to better meet needs on various shifts. Also, clinical managers have re-evaluated direct bedside staffing for RNs and PCAs/PCTs to ensure appropriate numbers of replacement FTEs are hired. Currently, only adult Intensive Care Unit (ICU) RNs take call as a requirement of their position to support timely ICU admissions.
- Because Sacred Vocation training is targeted to PCAs/PCTs, the proposal to train all staff was tabled. Future sessions will be offered to both new and current techs and assistants who missed the first round.

Sacred Vocation Phase 3

Is there a Sacred Vocation Phase 3? Yes! And BUMC Pastoral Care chaplains will lead the way, says Chaplain and Sacred Vocation Facilitator **Jennifer Rowley**. "For Phase 3, chaplains will continue training techs and affirming them as spiritual caregivers. We will look to them as partners in our patients' spiritual care," she says. For questions about Phase 3, contact Chaplain **Jennifer Rowley** at 2-4835.

APPENDIX J

Automatic Doors

New automatic doors make entering the elevator banks in Parking Level 1 and 2 of Wadley/Barnett Towers much easier for visitors and employees. Great team win for SoE Outpatient Team!

After-Hours Delivery Appreciated!

Pharmacist **Ping Du** says he was just doing his job. But a liver transplant patient thought his hand-delivering medication to the Twice Blessed House after hours and on a holiday was above the call of duty. Due to a mix-up, her husband's prescriptions were not called into the pharmacy before New Year's. When the wife realized the mistake, she called the transplant coordinator who in turn called Ping Du in the pharmacy. The pharmacy was closed, but Ping filled the prescription and personally delivered the patient's medicine. **Mike Sanborn**, director of pharmacy services, says Ping always focuses on customer service. Nice work, Ping!

On the Calendar

June

- Sacred Vocation graduates celebration
- Town hall meetings
- "Service to the Stars" appreciation for weeknight employees
- President's Recognition Reception
- Increased rounding by leadership

July

- Enjoy your summer!

August

- Leadership Development Institute (LDI)
- President's Recognition Reception

September

- Town hall meetings

Please post this "Excellence in Action" newsletter for BUMC employees in your area

Direct questions about the Spirit of Excellence to Teresa Schardt at 2-1670

Team "Wins" Making a Difference

Employee teams make a difference in patient and employee satisfaction at BUMC. Here are some recent team "wins" or successes. Ideas? Contact the leader for the appropriate team.

Leadership Development Institute Team:

WIN: Held the first combined Leadership Development Institute (LDI) for BUMC and BHCS leaders/managers May 22. The LDI focused on the Studer Group "Must Haves" and "Nine Principles." The participants looked at how to apply these successful processes throughout Baylor. **LEADERS: Marta Tingdale**, pulmonary; **Glenn Hill**, ARAMARK nutrition services; **Teresa Schardt**, SoE; **Lisa Hill**, administration.

Outpatient Team:

WIN: Formed new team and are beginning to train outpatient departments in the five fundamentals of excellent service: AIDET. Previous Outpatient Team wins recently achieved include the automatic doors in the Barnett/Wadley Towers underground parking areas and improved signage at Ruth Collins Diabetes Center. **LEADERS: Elaine Neufeld**, Outpatient Clinic; **Matt Schweyer**, Center for Hyberbaric Medicine.

Service Recovery Team:

WIN: Held individual department service recovery training sessions with the Emergency Department and 6 Truett. The team reviewed the red service recovery manual located with all managers, how to log on to myBaylor.com home page using their network log-in, and reviewed how to complete the online service recovery form and save it. The team reviewed how individual staff members can give out service recovery. **LEADERS: Gracie Vilson**, Guest Relations; **Yolanda Smith**, Trammell Crow engineering services.

Modeling BUMC's new patient gowns are (left to right): **Carrie Johnson**, Weight Loss Surgery Program, bariatric patient gown; **Don Allen**, Radiology, radiology/IV gown; **Linda Plank**, BUMC administration, standard gown; and **Olha Prijic**, New Family Center, maternity/nursing gown.

New Patient Gowns

BUMC's new patient gowns arrived May 1! They're larger, longer, and more comfortable (thicker thread count) than the current gowns. The new size accommodates today's average-sized adult and are patient-friendly for radiology, maternity and bariatric patients. The new gowns are a "win" for enhancing patient satisfaction for the SoE Inpatient Team. A special thanks to **Linda Plank**, BUMC administration, for being the champion for this important BHCS project and calling distributors/manufacturers sometimes weekly.

SoE Best Practices: New Family Center, GI Services

When it comes to best SoE practices at BUMC, take a look at what makes the New Family Center and Gastrointestinal (GI) Services successful.

New Family Center

Two years ago, the New Family Center's satisfaction scores hovered in the 70% range. Today, the unit's scores consistently rank in the 90% range. New Family Center Clinical Manager and RN **Olha Prijic**'s explanation for the 20 point increase: "We have hardwired Spirit of Excellence behaviors in our everyday work." Rounding, recognition, service recovery, telephone standards, pain clocks and thank you notes just begin their list of SoE initiatives. She says, "Rounding is expected work for our supervisors because they know it's one of the best ways to find out how well our unit is doing." The rounding spills over to positive recognition for the staff. Olha sends thank you notes weekly to employees who patients identify as making a difference.

GI Services

GI Services once struggled with high staff turnover and low physician satisfaction. Today, both measurements have dramatically improved. Administrative Director **Karey Simmer**, RN, credits a Spirit of Excellence mindset for the department's success. "Employees are staying because they see the impact they're making in patient care and, in turn, physicians see how well their patients are cared for and feel good about referring patients here," she explains. GI Services' employees discuss Spirit of Excellence behaviors and approaches in their weekly staff meetings. They watch videos and even role play patient care interactions to help, as Karey describes, "make patients real and not a procedure." They add fun to their everyday work with periodic "just because" parties, birthday board announcements and employee contests.

To learn more, contact **Olha Prijic**, at 2-7670 and **Karey Simmer** at 2-7370.

APPENDIX J

Excellence In Action is a quarterly publication produced by the Spirit of Excellence office and BUMC marketing/public relations. Printed copies are delivered with the *Baylor News – Dallas Campus* by interoffice mail to Baylor supervisors and managers. An online version is posted on myBaylor.com. To submit news items for consideration, contact Teresa Schardt at 2-1670 or Carolyn Adelman at 2-2116.

Graduates Speak Out about Sacred Vocation© Training

Lessons Learned

More than 145 patient care technicians and assistants have graduated from the first three sessions of Sacred Vocation© training classes. Two more, six-week sessions will take place this Spring. The goal of the employee enrichment training is to increase understanding of the vital role techs and assistants play in the healing process of patients. A few graduates share below what they learned.

"The classes were inspirational and opened my eyes to see patients' emotional and spiritual needs in a new light. It has helped me get back to being a team player."
***Gloria Bagsby**, BMTU*

"The Sacred Vocation program is one of God's ways of reminding me of the importance of the work I do with patients, families and coworkers. Showing compassion is part of living out my faith."
***Carla Levels**, 6 Roberts*

"The training has helped me become a more understanding person. I think I relate better to patients and my coworkers. Along with the doctors and nurses, I see myself as a healer, as someone who patients can talk to and cry with."
***Melissa Van Hecker**, 3 Hoblitzelle*

"The training showed me how to talk to patients and help them feel more comfortable as well as talk to family members who are concerned."
***Andrea Jones**, 12 Roberts*

Don't Miss the Last Session

The last six-week Sacred Vocation training session is **April 3 - May 8.** Patient care techs and assistants can self enroll on the Baylor Learning Network (BLN) and receive paid time to attend. The class is 1.5 hours each week for five weeks. A short graduation ceremony occurs the sixth week.

On June 2, all Sacred Vocation graduates and their families are invited to attend a special celebration with great prizes! Stay tuned for details.

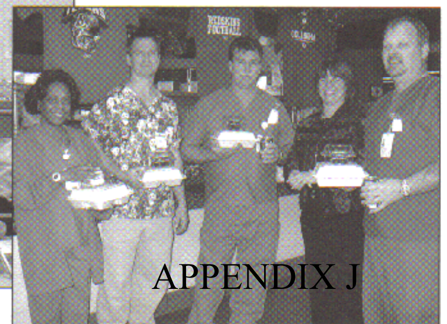
These patient care techs and assistants are graduates of Sacred Vocation training.

Phase 2 Training

Eight representative Sacred Vocation graduates who demonstrated commitment and enthusiasm for the training began a second, five-week phase on Jan. 18. "In this phase, the graduates are turning from personal awareness of their job as a sacred vocation to looking at enablers and barriers in their work environment," says Chick Deegan, facilitator for Sacred Vocation's Phase Two and associate director, UTA School of Nursing, Center for Leadership in Nursing and Health Care. The graduates will develop an action plan involving communication, teamwork, workload management, equipment and other issues identified as supporting techs and assistants in performing their jobs as sacred vocations. At the end of Phase Two, the graduates will present their action plan to BUMC's senior management team and spiritual companionship team. For questions about Sacred Vocation training, contact Chaplain **Jennifer Rowley** at 2-4835 or SoE Director **Teresa Schardt** at 2-1670.

Service to Stars Thanks Weekend Night Employees

Baylor leaders brought "Service to the Stars" to weekend night employees Sunday, Jan. 8. The event was a "thank you" for their service excellence. BUMC President **John McWhorter**, Chief Nursing Officer **Remy Tolentino**, Vice President **Mike Donnell**, Vice President **Marty Fordham**, Administrative Supervisor **Karen Pinkston** and ARAMARK Nutrition Services Director **Shannon Heard** donned professional serving attire to dish up a free meal to more than 460 weekend night employees. Next quarter, "Service to the Stars" will honor weeknight employees.



APPENDIX J

Spirit of Excellence
BAYLOR UNIVERSITY MEDICAL CENTER

Excellence in Action

FEBRUARY 2006

The Spirit of Excellence (SoE) newsletter serves to spotlight employees, teams and initiatives helping make Baylor University Medical Center (BUMC) world famous for its customer service.

Goal: 90% or Higher

When patients feel they experience excellence at BUMC they are more willing to recommend us to their family and friends when health care services are needed. People trust a loved one's personal experience. The trust described in Baylor's vision – "to be trusted as the best place to give and receive safe, quality, compassionate health care" – doesn't come easily. Trust is an emotion linked to what people consider safe and worthy of their confidence. To build patient trust and confidence in Baylor, we need to connect with our patients in meaningful ways.

Thirteen departments have achieved national rankings of 90% or better for patients' willingness to recommend BUMC (source: National Research Corporation (NRC)/ Picker Group patient satisfaction survey for July to Sept. 2005). These 13 departments focus every day on being trusted as the best place to receive care: **Outpatient Surgery Pediatrics; 2W Truett; 4 Jonsson; 12 Roberts; 16 Roberts; 7 Roberts; 6 Roberts; NICU; 8 Roberts; 3 Hoblitzelle; 7 Truett; 3 Jonsson; and Outpatient Rehabilitation.**

Our goal is for every department to reach 90% or higher for this key patient loyalty indicator. Exceeding our patients' expectations takes commitment from every employee, physician and volunteer. Congratulations to the 13 recognized departments! We hope the list grows in the coming months.
***Teresa Schardt**, SoE director*

Town Halls Address Quality and Patient Perception

BUMC President **John McWhorter** focused his January town hall message on the hospital's quality of care scores and the importance of providing a positive, memorable experience for every patient and family. The more than 1,860 attendees learned that although BUMC ranks in the top 1% nationally in quality measures, patients' perception of the hospital reflects how they were treated during their stay. Mr. McWhorter said patients expect to receive quality care from caregivers who are concerned about their fears, who inspire trust and confidence, and who provide them the information and education they need to handle their health issue. Providing patients emotional support and information involves every employee, he said. Casual contacts in the hall, cafeteria, parking lot or elevator influence patient satisfaction.

Staff members stop for refreshments before attending a town hall meeting in January.

Mr. McWhorter also talked about a new national survey that will publicize participating hospitals' patient satisfaction results beginning in 2007. The survey, called the Hospital – Consumer Assessment of Health Plans Survey (HCAHPS), will enable people to compare patient responses to 27 questions related to a hospital's patient care and service. The Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) developed the survey. Mr. McWhorter shared that Baylor wants the publicized results to reflect our vision statement: "To be trusted as the best place to give and receive safe, quality, compassionate health care."

High/Middle/Low Performer Conversations

Most employees want to work for a leader in the health care industry who focuses on doing the right thing for patients and employees, says **Teresa Schardt**, Spirit of Excellence director. When initiatives for improvement occur, these employees raise their performance to meet the new expectations and are proud to participate. However, there are other employees who have no intention of doing this and cause their coworkers to work harder to maintain good achievements, Teresa explains. Eventually, that gets old and employees leave or lower their performance. "We're back to business as usual, which leaves high and middle performers disappointed and less engaged," she says.

To avoid this cycle and to continue improving patient and employee satisfaction at BUMC through the Spirit of Excellence culture, the hospital recently completed high/middle/low performer conversations at every level of the organization. Teresa explains that only when low performers rise to expectations of middle performers will BUMC reap the benefits of an entire workforce committed to the people we serve: patients, coworkers and physicians. She adds that no organization can carry low performers and succeed in a culture change.

"Our good, solid employees and high performers deserve an organization that applauds their dedication and holds everyone equally accountable," says Teresa. "Thank you for your determination to make Baylor a better place for us to work and to give excellent patient care. Our patients deserve people who perform with purpose, do worthwhile work, and make a difference!"

APPENDIX J

Recognizing Excellence at BUMC

SoE's Reward and Recognition Team honors departments and individuals who demonstrate service excellence at BUMC. Congratulations to the latest winners!

Spirit Stick Winners

Martha Foster Lung Care employees show off their Spirit Stick Award received in Nov. 2005.

These departments earned the quarterly Spirit Stick Award for showing visible enthusiasm for service excellence through service-minded conversations and actions. Thanks for modeling service excellence!

Fall 2005

Inpatient: 12 Roberts

Outpatient: Martha Foster Lung Care Center

Ancillary: Emergency Department Lab

Support: Guest Relations

Satisfaction Trophies Awarded

Monthly trophies go to departments achieving the highest patient satisfaction scores and to those with the most improved scores (greater than one percent). The kite board on the first floor of Truett Hospital reflects all participating departments' patient satisfaction scores. Scores indicate 12-week "excellent" averages from surveys conducted before patient discharge. Thanks for showing BUMC is the best place to receive care!

Best Satisfaction Trophy (*highest scores*):

Inpatient: *October* – 2 South ICU; *November* – 4 West Roberts; *December* – 3 Hoblitzelle; *January* – New Family Center/L&D

Outpatient: *October* – Diabetes; *November through January* – Gastrointestinal Lab

Ancillary: *October through January* – Physical Medicine & Rehabilitation (PM&R)

Support: *October through January* – Pastoral Care

Best Satisfaction Overall Winners (*Dec. 2004 – Nov. 2005*): These four departments received the monthly Best Satisfaction Trophy most frequently during 2005.

Inpatient: 4 West Roberts

Outpatient: GI Lab

Ancillary: Lab

Support: Access Services

Wow! Pastoral Care (top) and PM&R employees won Best Satisfaction trophies four consecutive months, Oct. 2005 - Jan. 2005.

Soaring to New Heights Trophy (*most improved scores*):

Inpatient: *October* – 12 Roberts (5-point increase); *November* – 4 Truett (12.5-point increase); *December* – 3 Hoblitzelle (24-point increase); *January* – Bone Marrow Transplant Unit (5-point increase)

Outpatient: *October* – Respiratory Care (3-point increase); *November* – Baylor Diagnostic Imaging Center (5-point increase); *December* – Lung Care Center (6-point increase); *January* – Lung Care Center (1.6-point increase)

Ancillary: *October* – Environmental Services (3-point increase); *November through January* – no winner

Support: *October* – Pastoral Care (2.5-point increase); *November* – Nutrition Service's Host/Hostess Program (1-point increase); *December* – Access Services (17-point increase); *January* – no winner

3 Hoblitzelle staff members earned December's Soaring to New Heights Trophy for a 24-point increase in patient satisfaction scores.

APPENDIX J

Rounding Works!

Clinical Manager **Donna Betts,** R.N., 6 Roberts, says, "I never knew rounding would open up so many different avenues for improving patient satisfaction." She reports:

- Patients know her by name and sight;
- Patients share with her more employee names to recognize;
- She knows her patients better, which helps with referrals; and
- She interacts more with nurses/techs to share patient feedback and requests.

Heroism in the ED!

On a Saturday morning in December, a true team effort of physicians, nurses, technicians and guest relations gave a four-month-old infant boy emergency care that "was nothing short of amazing" reports **Karen Pinkston,** R.N., administrative supervisor. A CT scan showed the baby had a subdural hemorrhage. Quickly deteriorating, the baby became unstable for safe transport to Children's Medical Center (CMC), which receives all Dallas pediatric trauma patients. Emergency Medical Physician **Luis Portera,** M.D., called Neurosurgeon **Sam Finn,** M.D., who immediately took the child to the operating room (OR) in attempt to save his life. Within minutes, Chief of Anesthesiology **Michael Ramsay,** M.D., arrived and Chief of Pediatrics **Craig Schoemaker,** M.D., offered to assist with transport. **Carina Cardenas,** R.N., ED, and **Thomas Capistrant**, Guest Relations, translated everything as it happened to keep the baby's Spanish-speaking mother informed. **Jessica Ives,** R.N., ED, was the infant's primary nurse. Following surgery, Dr. Finn and Dr. Ramsay stayed with the patient in the OR until he could be safely transported to CMC. Karen concludes, "I'm so proud to work in a place that puts the patient first."

On the Calendar

March
- Sacred Vocation classes for patient care techs/assistants
- Quarterly spirit sticks awarded

April
- Sacred Vocation classes for patient care techs/assistants
- Employee recognition receptions with President John McWhorter
- Leadership Development Institute (LDI)
- Department celebrations for top quarterly satisfaction scores

May
- "Service to the Stars" appreciation for weeknight employees
- Town Hall meetings

Please post this "Excellence in Action" newsletter for BUMC employees in your area

Direct questions about the Spirit of Excellence to Teresa Schardt at 2-1670

Team "Wins" Making a Difference

Employee teams continue to make a difference in patient and employee satisfaction at BUMC. This issue highlights recent team "wins" or successes. Ideas or suggestions?

Contact the leader for the appropriate team.

Emergency Department Team

WIN: Continued focus on improving the patient and family experience in the ED. The team implemented a new triage system, AIDET and discharge phone calls. The team also added concierge and coffee services as well as a new salt water aquarium in the ED reception area. The concierge answers questions about visitor passes, patient location and campus maps. The aquarium helps provide entertainment and reduce stress for visitors while they wait. **LEADER: Lisa Ball**, ED.

Inpatient Satisfaction Team

WIN: Began evaluating ways to improve patient and employee satisfaction in relationship to NRC/Picker Group survey results and Sacred Vocation training goals. The team is also developing an audit tool for managers to use when rounding to evaluate progress of and compliance with SoE initiatives. **LEADERS: Olha Prijic**, 7 Truett; **Gracie Stowe**, 12 Roberts.

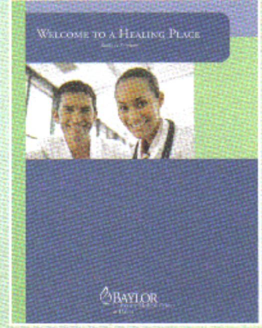
Outpatient Satisfaction Team

WIN: Gained new leadership to spearhead 2006 improvements using AIDET, service recovery and "work arounds." Team is recruiting new members. Outpatient services employees interested in joining should call Elaine Neufeld at 2-6695. **LEADERS: Elaine Neufeld**, Outpatient Clinic; **Matt Schweyer**, Center for Hyperbaric Medicine.

Service Education Team

WIN: Continued ongoing service excellence training for new public safety officers and new nursing staff. January training focused on rounding for 6 Roberts, diet clerk education for nutrition services, service excellence for bone marrow transplant unit (BMTU) staff and patient information/emotional support for town hall attendees. **LEADER: Teresa Schardt**, Spirit of Excellence.

New Patient Services Guide



A new patient services guide is coming to BUMC inpatient rooms in March. The SoE Communication Team spearheaded the development of the new guide to better answer patient and family questions about the many services BUMC provides.

This high-quality, padded vinyl guide is written in English and in Spanish. The guide's user-friendly tabbed pages cover subjects, including:

- Frequently Used Telephone Numbers
- Your Hospital Team
- Electronic Devices
- Pain Management
- Food and Nutrition
- Safety & Security
- Going Home
- Hospital Bills & Insurance
- Special Services and more

Along with the patient services guide, campus maps will be made available in patient rooms. Families can take a map to use while navigating the campus. Direct questions about the patient services guide to Communication Team leaders **Carolyn Adelman** at 2-2890 or **Jana Pope** at 2-2116.

Discharge Phone Calls Help Patients

BUMC administration is currently evaluating the best process for conducting inpatient discharge phone calls. In 2005, four pilot departments – 16 Roberts, 13 Roberts, 7 Roberts and NICU – and the emergency department had positive results from calling patients at home within 48 hours after discharge. The calls address patient questions about discharge instructions and, when needed, help staff appropriately refer patients for follow-up care.

These benefits rang true for a discharge phone call made by **Katheryn Gordon**, R.N., clinical manager of 7 Roberts. "One Friday," Katheryn recounts, "I called a patient who had previously told her care coordinator and social worker she had family and didn't need assistance at home. As I read my scripted questions, the patient began to say loudly, 'I need help.' I asked how she needed help and learned the patient was too weak to do everyday tasks. I immediately met with the patient's care coordinator and social worker who, in turn, called the physician for an order and called home health. I called the patient back and told her help was on the way. The discharge phone call really benefited the patient and made me feel worthwhile, too."

For questions about discharge phone calls or the pilot program, contact **Carol Clark,** R.N., clinical manager of 16 Roberts, at 2-3840.

APPENDIX J

Excellence In Action is a quarterly publication produced by the Spirit of Excellence office and BUMC marketing/public relations. Printed copies are delivered with the ***Baylor News – Dallas Campus*** by interoffice mail to Baylor supervisors and managers. An online version is posted on myBaylor.com. To submit news items for consideration, contact Teresa Schardt at 2-1670 or Carolyn Adelman at 2-2116.

√ 15R

APPENDIX K

Attentiveness by our patient care technicians (your techs) to your spiritual and emotional needs:

Excellent	Very Good	Good	Fair	Poor	Not Applicable
☐	☒	☐	☐	☐	☐

Please describe:

Had time to listen and talk with you about family and my heath problems

Thank you for your assistance in helping us to improve patient care.

APPENDIX L

SACRED VOCATION AT BAYLOR

Welcome to the Sacred Vocation Program© Survey

INSTRUCTIONS

- Please do not write your name on the survey. The Sacred Vocation Partnership© will report the results to you and Baylor.
- Your responses are confidential.
- Your answers to the questions below will be grouped with others to describe Baylor employees.
- This survey will take 20 minutes to complete.
- Mark an X in the box for your answer for each question.
- Please erase any changed answers.

Example:

	Strongly Disagree	Disagree	Some-what Disagree	Neither Agree nor Disagree	Some-what Agree	Agree	Strongly Agree
1. Today is sunny.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☒ 6	☐ 7

There are no right or wrong answers.
Thank you.

Please turn the page and begin

Baylor University Medical Center
Sacred Vocation Program

APPENDIX L

Spirituality and Meaning of Work at Baylor

Please tell us how much you agree or disagree with the following statements about your work at Baylor.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
46. I experience joy in my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
47. I believe others experience joy as a result of my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
48. My spirit is energized by my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
49. The work I do is connected to what I think is important in life.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
50. I look forward to coming to work most days.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
51. I see a connection between my work and the larger social good of my community.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
52. I understand what gives my work personal meaning.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
53. All in all, I am satisfied with my spiritual level of work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
54. I am satisfied with the amount of meaning I get from work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
55. I am satisfied with the efforts by my organization to improve the level of meaning and spirituality from work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
56. I can bring my spirituality into the workplace.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

For office use only:

4609

4971329173

Baylor University Medical Center
Sacred Vocation Program

APPENDIX L

Today's Date: ___/___/20___
Month Day Year

Your Work at Baylor University Medical Center (Baylor)

Please tell us how much you agree or disagree with the following statements about your work at Baylor.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
1. All in all, I am satisfied with my job.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
2. In general, I don't like my job.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
3. In general, I like working at Baylor.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
4. I feel hopeful about life.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
5. My work does not give meaning to my life.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
6. I consider myself a spiritual person.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
7. I consider myself a religious person.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
8. I am not able to use my gifts and talents at Baylor.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
9. There is no room for spirituality at Baylor.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
10. I am not aware of what is truly meaningful to me.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
11. My spiritual values influence the choices I make.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
12. Spiritual values are not considered important at Baylor.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
13. Who I am as a human being is not valued at Baylor.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
14. Prayer is an important part of my life.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
15. I care about the spiritual health of my co-workers.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

For office use only:

4609

7582212445

Baylor University Medical Center
Sacred Vocation Program

APPENDIX L

Your Job Tasks at Baylor

In the past TWO WEEKS, how much of the time did your work stop you from:

	Never	Hardly Ever	Only Now and Then	Some of the Time	Most of the Time
16. Sitting and talking to patients?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
17. Providing patients a comforting bath?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
18. Providing physical support to patients?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
19. Providing emotional support to patients?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
20. Providing spiritual support to patients?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
21. Supporting co-workers?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
22. Spending extra time with patients?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
23. Comforting patients?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
24. Comforting patients through appropriate "touch" or closeness?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
25. Praising a patient?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
26. Praising a co-worker?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
27. Thinking of work as "more than just a job"?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
28. Answering a patient's questions?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
29. Answering a family's questions?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
30. Comforting a family member?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Communication at Baylor

Please tell us how much you agree and disagree with the following statements about your work at Baylor.

	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree
31. I get information on the status of patients when I need it.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
32. When a patient's status changes, I get relevant information quickly.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
33. There are needless delays in relaying information regarding patient care.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

For office use only:

4609

Baylor University Medical Center
Sacred Vocation Program

APPENDIX L

Your Feelings about Baylor

Please tell us how much you agree or disagree with the following statements about your work at Baylor.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
34. I do not feel a strong sense of belonging to Baylor.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
35. I do not feel emotionally attached to Baylor.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
36. I would be very happy to spend the rest of my career at Baylor.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
37. I think I could become as attached to another organization as I could to Baylor.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
38. I enjoy discussing Baylor with people outside it.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
39. I frequently complain about Baylor with people outside it.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
40. I really feel as if Baylor's problems are my own.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
41. I do not feel like "part of the family" at Baylor.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
42. Baylor has a great deal of personal meaning for me.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

Your Feelings about Working at Baylor

How much of the time in the past TWO WEEKS did:

	Never	Hardly Ever	Only Now and Then	Some of the Time	Most of the Time
43. Your work contribute to the general meaning in your life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
44. You think about leaving your job at Baylor?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
45. You think about being absent or late for work?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

For office use only:

4609

2407455669

Baylor University Medical Center
Sacred Vocation Program

APPENDIX L

Your Feelings

How much of the time in the past TWO WEEKS:

	Never	Hardly ever	Only now and then	Some of the time	Most of the time
57. Have you been a nervous person?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
58. Have you felt so down in the dumps that nothing could cheer you up?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
59. Have you felt calm and peaceful?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
60. Have you felt downhearted and blue?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
61. Have you been a happy person?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Participant Information:

Your answers to the questions below will be grouped with others to describe Baylor employees.

62. When did you start at Baylor? ___ / ___ (Month / Year)

63. When did you start in your current job? ___ / ___ (Month / Year)

64. In what year were you born? 19 ___

65. What is your ethnicity (optional)
   - ☐ AFRICAN AMERICAN, not of Hispanic origin
   - ☐ NATIVE AMERICAN/ALASKAN NATIVE
   - ☐ CAUCASIAN, not of Hispanic origin
   - ☐ ASIAN or PACIFIC ISLANDER
   - ☐ HISPANIC
   - ☐ OTHER (SPECIFY)

66. What is your gender?
   - ☐ Male
   - ☐ Female

67. What is your assignment in this nursing unit? (Mark one only.)
   - ☐ Permanent (hospital employed)
   - ☐ Temporary (hospital employed)
   - ☐ Floating (hospital employed)
   - ☐ PRN (hospital employed)
   - ☐ Agency

68. What is your employment status in this nursing unit?
   - ☐ Full time
   - ☐ Part time

For office use only:

4609

69. What is the highest grade or year of school you have completed? (Mark one only.)
   - ☐ 6
   - ☐ 7
   - ☐ 8
   - ☐ 9
   - ☐ 10
   - ☐ 11
   - ☐ 12
   - ☐ 13
   - ☐ 14
   - ☐ 15
   - ☐ 16

   More than 16
   Write the number: ______

70. What shift do you usually work? (Mark one only.)
   - ☐ Days
   - ☐ Evenings
   - ☐ Nights
   - ☐ Weekend day
   - ☐ Weekend night
   - ☐ Rotating
   - ☐ Flex time

71. What is your job title?
   - ☐ Patient Care Assistant
   - ☐ Patient Care Technician
   - ☐ Other

   ____

72. Nursing unit? ______________________

73. How many hours per day is your normal shift?

   ______ hours

1999090591

APPENDIX M

December 22, 2005

Sacred Vocation Program© 2nd Session Implementation

November 2005 – December 2005

Phase I Evaluation

SACRED VOCATION PARTNERSHIP©

Mission Statement:

The Sacred Vocation Partnership© is a collaboration between St. Luke's Episcopal Health Charities and the University of Texas Health Science Center Houston. This collaboration seeks to create beneficial and enduring changes in health, human service and other not-for-profit organizations by helping individuals experience meaning in and through their work, thereby enhancing the quality of care and service.

APPENDIX M

EMPLOYEE WRITTEN COMMENTS :

Its a very good program and very interesting it makes one realize the importance of our work. After the program I realized that its not just a job but a calling

----

Sacred Vocation program should not only be taught to all techs but it should be expanded and everybody should learned this sacred vocation program. It give help to the recovery of patients and families confined here in Baylor. Thanks so much.

Sacred Vocation Program = We learned alot to deal our patient and will recommend to my co-workers.

I enjoyed the Sacred Vocation Program for A-Z. I would very much like to see all Baylor UT come when we do this again. Thank you so much having me here

----

The Sacred Vocation overall was wonderful and Very healing for me and my Co-Worker of Baylor University Medical Center. Thank you Very Much

----

I thought the program was very informative and pertinent to my position at Baylor. I think this will be very helpful in day to day activitie.

I really enjoyed the Sacred Vocation Program. It wasn't like I though it would be until I attended the 6 weeks class. It really gave me a greater outlook on what my purpose here at baylor was. My

attitude toward my job will be more positive. The instructor was very awesome. I really enjoyed he if I had to do it again. I will.

I recommend that every employee should attend this meeting. It would improve the floor a lot.

This section has really helped me with my daily activities in my job expecially dealing with difficult co-workers. Keep up the good work on ---- this program, many of us need this.

I really got something out of it. Just knowing I'm somebody too.

The Sacred Vocation Program Has Been a tool In Helping me to Bond with Patients --- a lot my co-workers. This Program and my facilitator Deserve the Spirit of excellence! Thank you!

I really enjoyed the class and I love Chick she was the greatest of all Thank you so very much, and if nothing change it was an honor you helping me it in the class.

I have learn a lot, from this class. And well apple it to my work. And my daily life skill. Thank you

----

I like the program its help to share with other people how we help our patient. Make Baylor a better hospital.

I these classes can be very helpful for the future classes to come. I really enjoyed our class. and I hope that there will be more classes ------- future.

I believe this program has given me a hole new aspertion on my job as a Tech here at Baylor. I has helped improvs my abilitie to perform my duties as well as work as a member on my team or floor

---

I feel the program should be a couple more weeks long. It has benefited me but I wish it was longer so we could work more together. Thank you so much for the great xperience. It has made me feel that my job is important and that people do need me.

I really enjoyed the program. I think we need more of them.

I found the Sacred Vocation Program very helpful. It reminded me of what I felt like when I first started working as a nurse Nurse tech and how fulfilling my work was to me. And now because of the program I can feel that way again. I have truly enjoyed the program our facilator was wonderful.

The sacred vocation help me alot I learen different. I enjoyed for for 6 week I hope every year like this program for everybody. Thanks for everything

---

It was a fun and rewarding class. it help me turn negitives into positives I'm much more focused

---

It is a blessing to know that there are someone who care enough to bring us together as one to share or feeling, our strenght and weekness, to just bring to mind and soul that up are call to a very very important place for God to used us all.

---

all nurses need to attent a sacred vocation class

It had been a good experience to me because even if I don't talks a lot, I learned about their experiences and I learned how to cope with other situations. Thank you for thisl.

This was a very nice program. Its good to know that you are indeed well appreciated at your job, when you sometimes at least don't feel like it.

I think that everyone should attend this program it was beautiful and special to me. Everyone enjoy the program keep up the good work and promise you everyone will come out on top!!

---

it was fun and we/I learn alot. please keep it up

This Vocation program was a very good idea and Very helpful and help you too keep focus on the reason you're here even at the most difficult times. So thanks again.

APPENDIX M

THe class was exciting and very fun. I learned how to look at things in a different prospected and deal with situation in a different manner. The class was a joy to have. The other classes will love the experience.

Sacred vocation program is an helpfull program. Help you to get out all your feelings without worring about who it will get to or if you will be in troublle for stating your feelings

----

Made me more patient ---- and soften my heart!

The was very interesting. I am happy that Baylor was interested in taking the time to show an interest in the PCT's.

I enjoyed the program very much and it was good to know that alot of other people share the same feelings I have and think this program was a good experience.

CERTIFICATE OF EXCELLENCE

THIS CERTIFICATE IS PRESENTED TO

VONDA RUNNELS

SACRED VOCATION GRADUATE

BAYLOR UNIVERSITY MEDICAL CENTER

Teresa L. Schardt — 4/1/06
Signature — Date

Jennifer Holder Rowley — 3/29/06
Signature — Date

IN APPRECIATION FOR HER
COMMITMENT TO BEING A HEALER IN
THE LIVES OF ALL SHE TOUCHES
MARCH 2006

APPENDIX N

APPENDIX O

APPENDIX O

APPENDIX P

Sacred Vocation©
Session Five Thursday Afternoon Coping Tips

HELPFUL HINTS FOR HEALING ACTS

Keep a positive and healing attitude

Collect your thoughts before speaking

Communicate with (Patients, Co-workers, and Supervisors) when things are not clear

Maintain a pleasant tone of voice

Ask for help from others (when demands seem overwhelming)

Smile and pray for inner strength

Take a Break (to avoid a harmful situation)

Sacred Vocation©

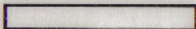
Session Five Thursday Afternoon Oath

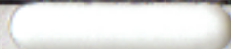
I will…..

Pray for others and myself before coming to work
Give nothing by quality care to patients
Show love and kindness to all patients
Openly listen and communicate with patients and co-workers
Take the negative and turn it into a positive experience
Show patience and maintain a pleasant tone of voice during a difficult situation

Nobody can take away my power to heal

APPENDIX Q





BUMC Scale

Comparison Summary

September, 2006

SACRED VOCATION PARTNERSHIP©

APPENDIX R

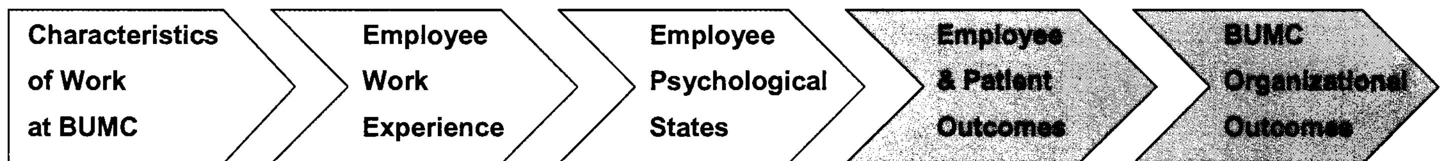
Authors: Ashweeta Patnaik, Jessica Tullar, MPH,

Christine Plourde, MA, Ololade Coker, Benjamin Amick, PhD

EXECUTIVE SUMMARY

Data collected from SVP© Baseline Surveys, during the fall of 2005 and the spring of 2006, benchmark current attitudes and beliefs of Baylor staff that the Sacred Vocation Program © is designed to improve. Data collected from SVP© Follow-up Surveys, administered during the summer of 2006, are designed to assess Sacred Vocation Program© effects on BUMC employees. Baseline surveys were obtained from 100% of participating employees, and follow-up surveys were obtained from 61% of participating employees. In this report we compare whether individual BUMC employees have changed as a result of SVP©.

The Sacred Vocation Program © is designed to change an employee's spiritual connection to BUMC, enhancing the Spirit of Excellence, and increasing the effectiveness of work at BUMC through the Sacred Vocation Action Plan. The Sacred Vocation Program© causal chain illustrates the cascading consequences of changing work and work experiences on employee and patient outcomes (i.e. turnover, absenteeism and health care utilization) and BUMC organizational outcomes (i.e. patient satisfaction, increased productive time, branding of BUMC with Spirit of Excellence and improved work culture).



The SVP© survey is designed to benchmark organizations and assess the impact of the Sacred Vocation Program© on key work characteristics:

- Blocks to Spirituality
- Sacred Vocation Acts
- Communication

These changes are expected to affect employee psychological states:

- Work Satisfaction
- Intent to Stay
- Affective Commitment
- Mental Health

BUMC has already shown that the SVP© has affected one key BUMC organizational outcome – patient satisfaction. We expect that if the changes in the causal chain can be demonstrated, then more employee, patient and organizational outcomes will change.

APPENDIX R

KEY FINDINGS

Due to the success of the Spirit of Excellence, BUMC already has high scores for many SVP© scales like work satisfaction (6.2), inner life (6.3) and meaning from work (6.2). But the follow-up survey results show further increases in the SVP© scales. Listed below are the specific percentage improvements for each SVP© scale.

- There is a 2% increase in the work satisfaction scale *
- There is a 2% increase in the inner life scale
- There is a 7% increase in the blocks to spirituality scale *
- There is a 7% increase in the affective commitment scale *
- There is a 1% increase in the meaning from work scale
- There is a 7% increase in the intent to stay scale *
- There is a 15% increase in the sacred vocation tasks scale *
- There is a 3% increase in the communication scale
- There is a 8% increase in the mental health scale *

* Statistically significant

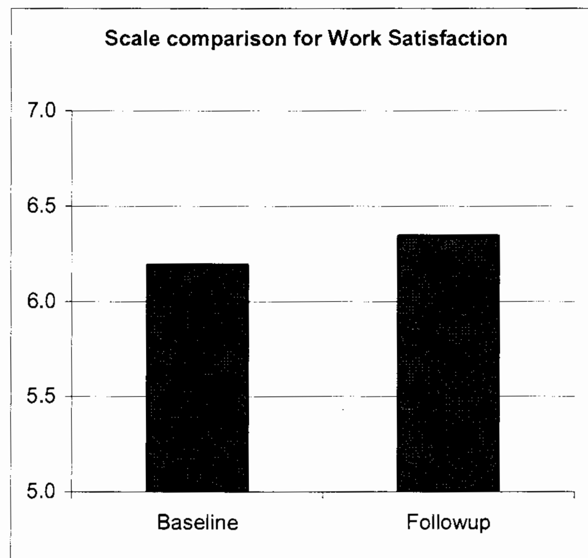
These results indicate that the SVP© causal chain appears to be working. Continued implementation of SVP© at BUMC (phases I, II and III) will be likely to produce synergistic effects as all patient technicians embrace the Spirit of Excellence through the Sacred Vocation Program ©.

The following pages illustrate the changes in the SVP© scales. Specific items (questions asked in the survey) are also examined, and classified as:

- *statistically significant* (p-value<=0.05),
    - *Highly significant* (p-value <= 0.01)
    - *Significant* (0.01 < p-value < 0.05)
    - *Marginally not significant* (p-value=0.05)
- *important but not statistically significant* (0.06 <= p-value <= 0.08),
- *not statistically significant* (p-value>0.08), or
- *no change*.

APPENDIX R

WORK SATISFACTION



Survey	Obs	Mean	Std. Dev.	Min	Max
Baseline	106	6.2	0.78	3.00	7.00
Followup	109	6.3	0.72	4.33	7.00

The Wilcoxon signed-rank test gives a p-value of 0.0512

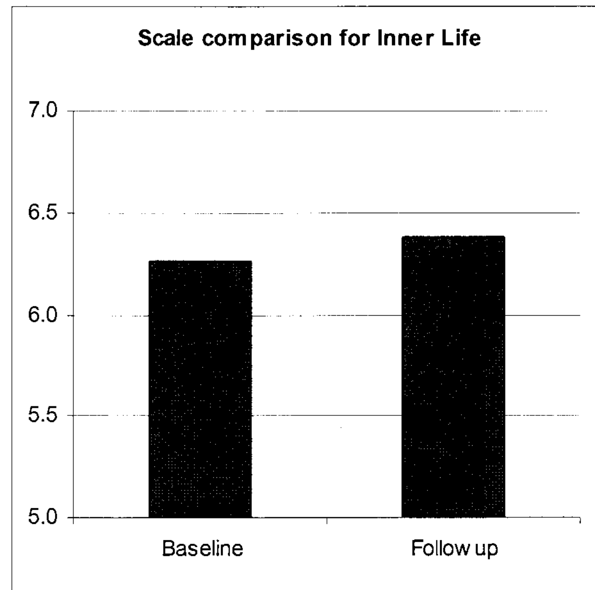
The difference between the baseline and follow-up scales for work satisfaction is <u>marginally not significant</u>.

SPECIFIC WORK SATISFACTION ITEMS

Question		increased from Baseline to Follow-up	Statistical Significance
1. All in all, I am satisfied with my job.		increased from 6.04 to 6.24	Significant
2. In general, I don't like my job.	reverse coded	increased from 6.05 to 6.19	Marginally not significant
3. In general, I like working at Baylor.		increased from 6.46 to 6.61	Highly significant

APPENDIX R

INNER LIFE



Survey	Obs	Mean	Std. Dev.	Min	Max
Baseline	104	6.3	0.69	3.00	7.00
Followup	109	6.4	0.60	4.00	7.00

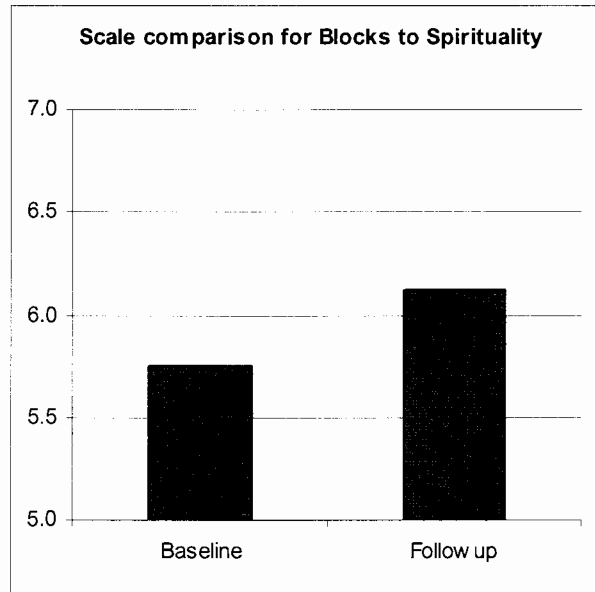
The Wilcoxon signed-rank test gives a p-value of 0.0581

The difference between the baseline and follow-up scales for inner life is marginally not significant.

SPECIFIC INNER LIFE ITEMS

Question	increased from Baseline to Follow-up	Statistical Significance
4. I feel hopeful about life.	increased from 6.13 to 6.38	Important, but not significant
6. I consider myself a spiritual person.	increased from 6.3 to 6.43	Marginally not significant
7. I consider myself a religious person.	increased from 6.11 to 6.27	Not significant
11. My spiritual values influence the choices I make.	increased from 6.13 to 6.15	Not significant
14. Prayer is an important part of my life.	increased from 6.51 to 6.62	Not significant
15. I care about the spiritual health of my coworkers.	increased from 6.37 to 6.4	Not significant

BLOCKS TO SPIRITUALITY



Survey	Obs	Mean	Std. Dev.	Min	Max
Baseline	105	5.7	1.04	2.17	7.00
Followup	109	6.1	0.75	3.20	7.00

The Wilcoxon signed-rank test gives a p-value of 0.0002

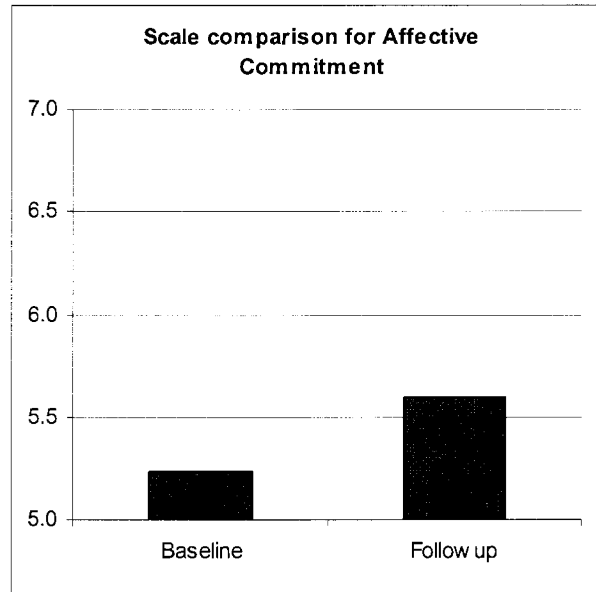
There is a highly significant difference between the baseline and follow-up scales for blocks to spirituality.

SPECIFIC BLOCKS TO SPIRITUALITY ITEMS

Question		increased from Baseline to Follow-up	Statistical Significance
5. My work does not give meaning to my life.	reverse coded	increased from 5.99 to 6.4	Highly significant
8. I am not able to use my gifts and talents at Baylor.	reverse coded	increased from 5.24 to 5.73	Highly significant
9. There is no room for spirituality at Baylor.	reverse coded	increased from 5.92 to 6.15	Important, but not significant
10. I am not aware of what is truly meaningful to me.	reverse coded	increased from 5.75 to 6.37	Highly significant
12. Spiritual values are not considered important at Baylor.	reverse coded	increased from 6.08 to 6.11	Not significant
13. Who I am as a human being is not valued at Baylor.	reverse coded	increased from 5.56 to 6.02	Highly significant

APPENDIX R

AFFECTIVE COMMITMENT



Survey	Obs	Mean	Std. Dev.	Min	Max
Baseline	5.2	0.96	2.00	6.89	105
Followup	5.6	0.77	3.44	7.00	107

The Wilcoxon signed-rank test gives a p-value of 0.0000

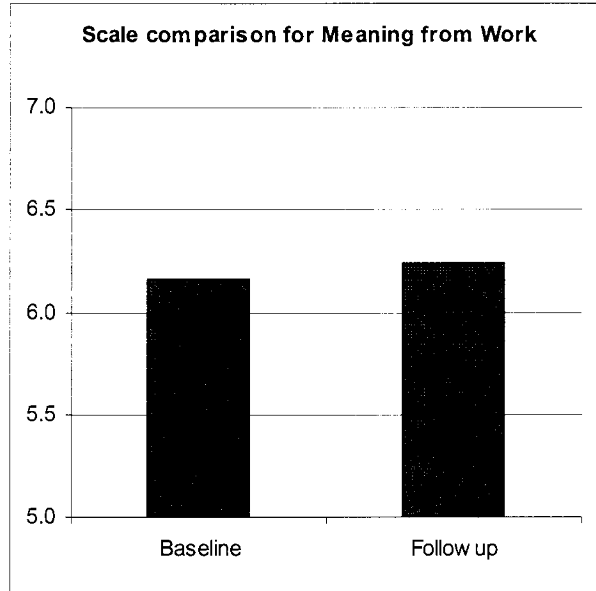
There is a highly significant difference between the baseline and follow-up scales for affective commitment.

SPECIFIC AFFECTIVE COMMITMENT ITEMS

Question		increased from Baseline to Follow-up	Statistical Significance
34. I do not feel a strong sense of belonging to Baylor.	reverse coded	increased from 5.38 to 5.93	Highly significant
35. I do not feel "emotionally attached" to Baylor.	reverse coded	increased from 5.21 to 5.94	Highly significant
36. I would be very happy to spend the rest of my career at Baylor		increased from 5.87 to 5.97	Not significant
37. I think I could easily become as attached to another organization as I am to Baylor.	reverse coded	increased from 4.34 to 4.75	Highly significant
38. I enjoy discussing Baylor with people outside it.		increased from 4.94 to 4.96	Not significant
39. I frequently complain about Baylor with people outside it.	reverse coded	increased from 5.79 to 6.08	Highly significant
40. I really feel as if Baylor's problems are my own.		increased from 4.37 to 4.74	Highly significant
41. I do not feel like "part of the family" at Baylor.	reverse coded	increased from 5.45 to 6	Important, but not significant
42. Baylor has a great deal of personal meaning for me.		increased from 5.8 to 6	Marginally not significant

APPENDIX R

MEANING FROM WORK



Survey	Obs	Mean	Std. Dev.	Min	Max
Baseline	106	6.2	0.68	3.86	7.00
Followup	106	6.2	0.55	3.86	7.00

The Wilcoxon signed-rank test gives a p-value of 0.1535

There is an increase in the follow-up scale for meaning from work, but the difference between the baseline and follow-up scales for meaning from work is not significant.

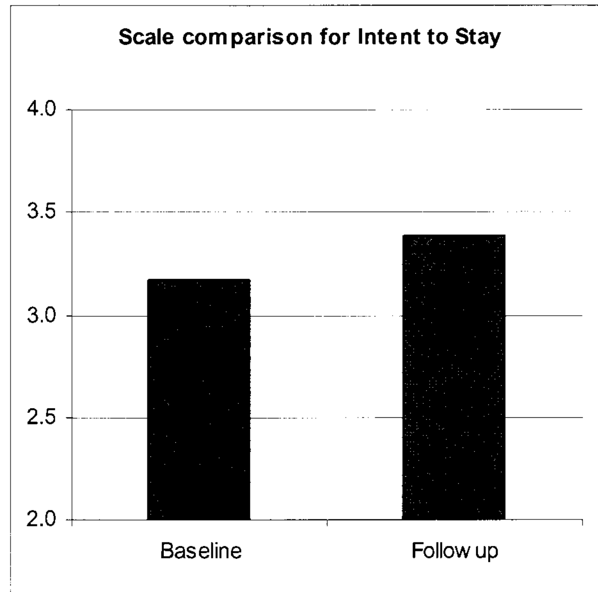
APPENDIX R

SPECIFIC MEANING FROM WORK ITMES

Question	increased from Baseline to Follow-up	Statistical Significance
46. I experience joy in my work.	increased from 6.18 to 6.23	Not significant
47. I believe others experience joy as a result of my work.	increased from 6.16 to 6.34	Significant
48. My spirit is energized by my work.	increased from 6.15 to 6.2	Not significant
49. The work I do is connected to what I think is important in life.	increased from 6.26 to 6.36	Not significant
50. I look forward to coming to work most days.	increased from 6.08 to 6.15	Not significant
51. I see a connection between my work and the larger social good of my community.	increased from 5.93 to 6.1	Marginally not significant
52. I understand what gives my work personal meaning.	increased from 6.31 to 6.31	Not significant

APPENDIX R

INTENT TO STAY



Survey	Obs	Mean	Std. Dev.	Min	Max
Baseline	106	3.2	0.78	1.00	4.00
Followup	107	3.4	0.61	1.33	4.00

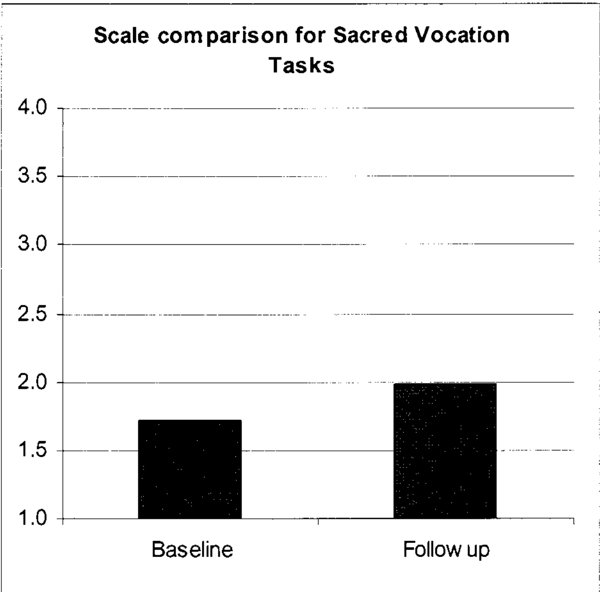
The Wilcoxon signed-rank test gives a p-value of 0.0013

There is a highly significant difference between the baseline and follow-up scales for intent to stay.

SPECIFIC INTENT TO STAY ITEMS

Question		increased from Baseline to Follow-up	Statistical Significance
43. Your work contribute to the general meaning in your life?		increased from 3.42 to 3.5	Not significant
44. You think about leaving your job at Baylor?	reverse coded	increased from 2.92 to 3.19	Highly significant
45. You think about being absent or late for work?	reverse coded	increased from 3.16 to 3.46	Highly significant

SACRED VOCATION TASKS



Survey	Obs	Mean	Std. Dev.	Min	Max
Baseline	100	1.7	1.33	0.00	4.00
Followup	106	2.0	1.41	0.00	4.00

The Wilcoxon signed-rank test gives a p-value of 0.0187

There is a significant difference between the baseline and follow-up scales for sacred vocation tasks.

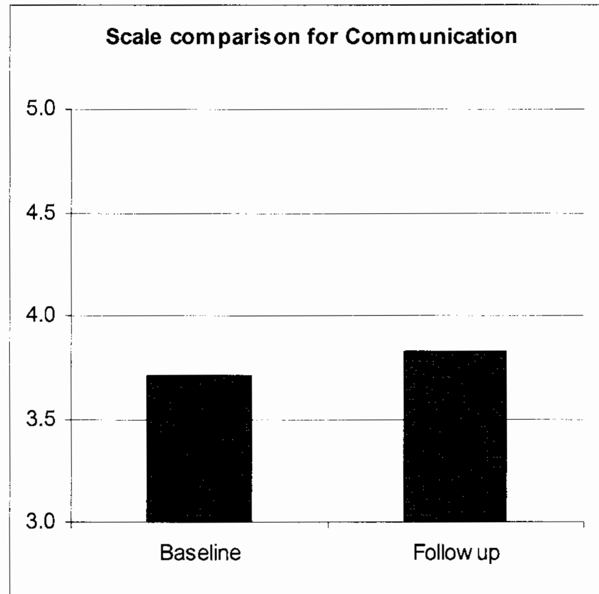
APPENDIX R

SPECIFIC SACRED VOCATION TASK ITEMS

Question	increased from Baseline to Follow-up	Statistical Significance
16. Sitting and talking to patients?	increased from 1.37 to 1.81	Highly significant
17. Providing patients a comforting bath?	increased from 1.7 to 2.18	Highly significant
18. Providing physical support to patients?	increased from 1.49 to 2.04	Highly significant
19. Providing emotional support to patients?	increased from 1.54 to 1.93	Highly significant
20. Providing spiritual support to patients?	increased from 1.57 to 1.99	Significant
21. Supporting Co-workers?	increased from 1.65 to 1.9	Significant
22. Spending extra time with patients?	increased from 1.44 to 1.78	Not significant
23. Comforting patients?	increased from 1.59 to 1.82	Marginally not significant
24. Comforting patients through appropriate "touch" or closeness?	increased from 1.65 to 1.93	Not significant
25. Praising a patient?	increased from 2.01 to 2.09	Not significant
26. Praising a co-worker?	increased from 1.99 to 2.26	Highly significant
27. Thinking of work as "more than just a job"?	increased from 1.54 to 2.05	Not significant
28. Answering a patient's questions?	increased from 1.86 to 2.03	Not significant
29. Answering a family's questions?	increased from 1.77 to 2.05	Not significant
30. Comforting a family member?	increased from 1.73 to 2.11	Highly significant

APPENDIX R

COMMUNICATION



Survey	Obs	Mean	Std. Dev.	Min	Max
Baseline	105	3.7	0.86	1.00	5.00
Followup	108	3.8	0.87	1.33	5.00

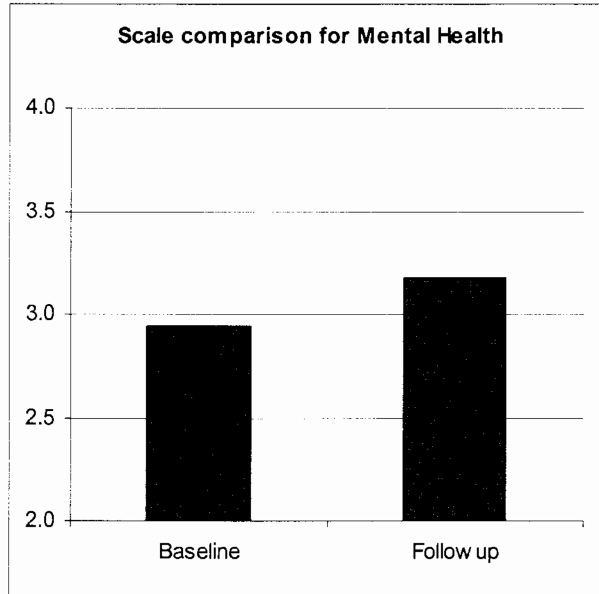
The Wilcoxon signed-rank test gives a p-value of 0.2204

There is an increase in the follow-up scale for communication, but the difference between the baseline and follow-up scales for communication is <u>not significant</u>.

SPECIFIC COMMUNICATION ITEMS

Question		increased from Baseline to Follow-up	Statistical Significance
31. I get information on the status of patients when I need it.		increased from 4.12 to 4.2	Not significant
32. When a patient's status changes, I get relevant information quickly.		increased from 4.06 to 4.06	No change
33. There are needless delays in relaying information regarding patient care.	reverse coded	increased from 2.91 to 3.19	Not significant

MENTAL HEALTH



Survey	Obs	Mean	Std. Dev.	Min	Max
Baseline	2.9	0.68	1.20	4.00	106
Followup	3.2	0.62	1.60	4.00	106

The t- test gives a p-value of 0.0001

There is a highly significant difference between the baseline and follow-up scales for mental health.

SPECIFIC MENTAL HEALTH ITEMS

Question		increased from Baseline to Follow-up	Statistical Significance
57. Have you been a nervous person?	reverse coded	increased from 2.38 to 2.78	Highly significant
58. Have you felt so down in the dumps that nothing could cheer you up?	reverse coded	increased from 2.68 to 2.88	Not significant
59. Have you felt calm and peaceful?		increased from 3.63 to 3.66	Not significant
60. Have you felt downhearted and blue?	reverse coded	increased from 2.2 to 2.69	Highly significant
61. Have you been a happy person?		increased from 3.84 to 3.87	Not significant

Baylor Health Care System
Department of Pastoral Care and Counseling
Interfaith Task Force

April 5, 2006 - World Health Day
Interfaith Service and Blessing of Hands

Program

Welcoming/Introduction — Ahmed Aquino, MDiv

Prayers for Our World

The Eternal reigns, clothed in majesty. — Ella McCarroll, MDiv
The Eternal is robed, yea, girded with strength.
God set the earth on a sure foundation.
God created a world that stands firm.
Your throne stands from the earliest time,
You are Eternal. The rivers may rise and rage,
The waters may pound and roar, the floods may spread and storm; above the crash of the sea and its breakers, awesome is the Eternal our God.
Your decrees never fail, Eternal One.
Holiness befits Your house, forevermore.

Praise God! May my soul praise God! — Lila Alexander, RN
I will praise You as long as I live, and sing for the whole of my life. Do not trust in princes, in mortals who offer no salvation, whose spirit leaves them and who return to the earth.
On that day their designs perish. Happy are those whose help is in God, whose hope rests on the Eternal their God, maker of heaven and earth, the sea, and all they contain, keeper of truth forever, granter of justice to the oppressed, Provider of bread to the hungry. The Eternal frees the captive. The Eternal opens the eyes of the blind. The Eternal raises up the bent over. The Eternal loves the righteous. The Eternal guards strangers, upholding the orphan and widow, but thwarting the way of the wicked. The Eternal will reign forever, your God, for all generations!

APPENDIX S

May we find peace with those we love Growing together over time. May we be at peace with ourselves, And with the labors that fill our days. May we render peace in our world, with wisdom and gentle patience. Blessed are You, Eternal One, Source of peace. Grant us peace, your most precious gift, O Eternal Source of peace. And give us the will to proclaim its message to all the peoples of the earth. May contentment reign in the entire world, health and happiness within our homes. Strengthen the bonds of friendship and fellowship among all the inhabitants of our world. Plant virtue in every soul, and may the love of Your Name hallow every person. Praised are You, Eternal One, Source of peace.

Barbara Gayton,
Sacred Vocation Graduate

Source of all being, we turn to You as did people in ancient days. They beheld you in the heavens, they felt You in their hearth, They sought You in their lives. Their quest is ours. Help us to see the wonder of being. Give us the courage to search for truth. Teach us the path to a better life. So shall we, by our lives and our labors, bring nearer the world we envision, one of justice, freedom and peace.

Ida Loum,
Sacred Vocation Graduate

In this moment of silent communion, a still, small voice beckons me: To pursue my life's work with full attention though no eye is upon me; to be gentle in the face of ingratitude, To meet the end of the day with the certainty That I've used my gifts well and with dignity. O let me become ever braver, facing life's trials with distinction. May I live on in deeds that bless others, and offer the heritage of a good name.

Andrea Jones,
Sacred Vocation Graduate

Song of Unity

Ahmed Aquino, MDiv

Behold how good and how pleasant it is for Brothers and sisters to dwell as one. Behold how good and how Pleasant it is to share the Creator's love.

APPENDIX S

Blessing of Hands

Jann Aldredge-Clanton, MDiv

Let us bless the Source of life, Hasmukh Vankawala, MD
Source of darkness and light,
Heart of harmony and chaos,
Creativity and creation.
Your unspoken name is Holy.
Your unnamed essence is Peace.
Your radiance is sun pouring down
over my head, coming up close
against me; moonlight widening my
eyes. It is ocean around us and vapor
rising; the journey of rock. It is light
in motion. Your unspoken name is
Holy. Your unnamed essence is Peace.

To be created in the image of God is Jennifer Rowley, MDiv
To come into this world with a spiritual
Center that is an avenue for Divine
wisdom. To find this center, listen to
the silence. Remember to imagine,
To dream, to envision, to create.
Recognize this internal beauty as the
holy within your being. Act as if you
are worthy of Divine command.
To be created in the image of God
Is to be granted a gift.

Loving life and its mysterious source Gabriel Ojih, ThB
With all our heart and all our spirit,
All our senses and strength,
We take upon ourselves and into ourselves
These promises: To care for the earth
And those who live upon it, to pursue
justice and peace, to love kindness and
compassion. We will teach this to our
children throughout the passage of the day
As we dwell in our homes and as we go on
our journeys, from the time we rise until we
fall asleep. And may our actions be faithful
to our words that our children's children
May live to know: Truth and kindness have
embraced, peace and justice have kissed
And are one.

APPENDIX S

We praise the One, Source of Eternity Rashed Khaleque, RPH
For insight and wisdom.
We praise the One, Source of Eternity
For clothing and for shelter.
We praise the One, Source of Eternity
For the courage to reach ever higher.
We praise the One, Source of Eternity
For ordering the universe.
We praise the One, Source of Eternity
For an earth blessed with abundance.
We praise the One, Source of Eternity
For paths and callings.
We praise the One, Source of Eternity
For hope in the face of despair.
We praise the One, Source of Eternity
For the mystery of creation unfolding.

Rejoice in the everliving creation, Jessica Escala, RN
Give praise to the greatness of the world!
Divine glory is revealed in the heavens above,
And in the earth below. Yet creation is never
ended, and the universe never full.
Potential is unrealized, promises unfulfilled.
Our place is to affirm the present, even as
We commit to the future, through the ideals
of sacred living, as revealed in our sacred
Teaching.

Steady yourself. Living takes time. Laurie Delalio, Palliative Care Nurse
Each moment is a moment to be lived.
Each emotion is to be felt. We are here in
this world to learn and grow. Fear can teach.
Confusion instructs. Sadness informs.
Love elevates. Take the time to experience
each breath. Especially the ones that make
you want to run. Patience, steady,
rush and race banish joy and peace.
There is wonder to experience if you take
the time. Step softly and deliberately.
What lingers must be lived and once lived
completely passes in its own time. To force
the natural rhythms of life is to deny yourself.
The Divine wisdom in each experience.

APPENDIX S

May the work of your hand bring healing to all the people you touch. Bless these hands to be instruments of healing.

4-18-06

Carla

You have been a dear person to me in my time of need. I feel God placed me here with you. You have blessed my heart

Geneva Galloway
1258 CR. 4698
Boyd TX 76023

APPENDIX T

APPENDIX U

BIBLIOGRAPHY

Arai, Tosh and Wesley Ariarajah, eds. *Spirituality in Interfaith Dialogue.* Geneva, Switzerland: WCC Publications, 1989.

Ariarajah, S. Wesley. *Not Without My Neighbour: Issues in Interfaith Relations.* Geneva, Switzerland; WCC Publications, 1999.

Bartel, Mark, "What is Spiritual? What is Spiritual Suffering?" *The Journal of Pastoral Care and Counseling* 58, no. 3 (2004): 187-201.

Chapman, Erie. *Radical Loving Care: Building the Healing Hospital in America.* Nashville: Baptist Healing Hospital Trust, 2003.

Clark, P. A., Drain, M., & Malone, M.P., "Addressing patients' emotional and spiritual needs," *Joint Commission Journal on Quality and Safety* 29 (2003): 659-670.

Cousins, Ewert. "The Nature of Faith in Interreligious Dialogue." *Interfaith Spirituality,* Autumn 1993, 78: 32-41.

Cracknell, Kenneth. *In Good And Generous Faith: Christian Responses to Religious Pluralism.* Peterborough: Epworth, 2005.

Dossey, Larry, M.D. *Healing Words.* San Francisco: HarperSanFrancisco, 1993.

Forward, Martin. *Inter-religious Dialogue: A Short Introduction.* Oxford, England: Oneworld Publications, 2001.

Fox, Matthew. *One River, Many Wells.* New York: Jeremy P. Tarcher/Putnam, 2000.

Gladwell, Malcolm. *The Tipping Point: How little things can make a big difference.* New York: Little, Brown and Company, 2002.

Gojmerac-Leiner, Georgia, "Revisiting Viktor Frankl: His Contributions to the Contemporary Interest in Spirituality and Health Care," *The Journal of Pastoral Care and Counseling* 59, no. 4, 2005.

Holder, Jennifer Sutton and Jann Aldredge-Clanton. *Parting:A handbook for spiritual care near the end of life.* Chapel Hill: The University of North Carolina Press, 2004.

Koenig, Harold G., M.D. *Spirituality in Patient Care: Why, How, When and What.* Philadelphia: Templeton Foundation Press, 2002.

Krebs, Kathleen, “The Spiritual Aspect of Caring—An Integral Part of Health and Healing,” *Nursing Administration Quarterly* 25, no.3 (2001): 55-60.

Lang, Peter. *A Great Commission: Christian Hope and Religious Diversity.* Bern, Switzerland: Peter Lang, AG, 2000.

Mitchell, Donald. “A Revealing Dialogue.” *Interfaith Spirituality,* Autumn 1993, 78:42-53.

McClung, Emily, Daniel H. Grossoehme and Ann F. Jacobsen, “Collaborating with Chaplains to Meet Spiritual Needs,” *MedSurg Nursing* 15, no. 3 (2006): 147-156.

Mitroff, Ian I. and Elizabeth A. Denton. *A Spiritual Audit of Corporate America.* San Francisco: Jossey-Bass Publishers, 1999.

Pierce, Gregory F. A. *Spirituality@Work: 10 ways to balance your life on-the-job.* Chicago: Loyola Press, 2001.

Senge, Peter, C. Otto Scharmer, Joseph Jaworski and Betty Sue Flowers. *Presence: An Exploration of Profound Change in People, Organizations and Society.* New York: Doubleday, 2004.

Shea, John. *Spirituality & Healthcare.* Chicago: The Park Ridge Center, 2000.

Sulmasy, Daniel P., M.D. *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals.* New York: Paulist Press, 1997.

Wedemeyer, Richard A. and Ronald W. Jue, *The Inner Edge: Effective Spirituality in Your Life and Work.* Chicago: McGraw-Hill, 2002.

VITA

Jennifer Holder Rowley is a native of Greensboro, North Carolina. Born to Worth Elijah and Lillian Ramsey Holder, she grew up in a loving extended family with one older brother, Ramsey. At age six, she and her family moved to Auburn, Alabama where her younger brother, Rodney, was born. The family moved again in 1963 to Abilene, Texas, where she completed Cooper High School, ranking third in her class of 500 students.

Rowley continued her education at The University of Texas at Austin, receiving a Bachelor of Journalism degree Cum Laude in 1973. After working as an editor of *Texas Highways* magazine while putting her first husband through Law School, she began a 25-year career in health care communications at Baylor University Medical Center (BUMC) in Dallas and at Hendrick Medical Center in Abilene. During those years, she welcomed daughter Emily and sons Jonathan, now deceased, and Mark into her world.

Seeking to better understand health care, Rowley obtained a Master's in Public Health from University of North Carolina at Chapel Hill in 1991. In 1996, she felt a distinct calling to hospital chaplaincy, and began to educate herself toward that end at Brite Divinity School, where she received a Master's of Divinity in 1999 with a concentration in pastoral care and counseling. From 1999-2000 Rowley left Baylor hospital to complete a residency in Clinical Pastoral Education at Children's Medical Center of Dallas. Concurrently, she navigated the ordination process to become a Deacon in The Episcopal Diocese of Dallas, ordained on June 8, 2002.

She worked in Geriatrics Ministry at BUMC for five years, during which time she co-authored *Parting: A Handbook for Spiritual Companionship Near the End of Life,* with colleague Jann Aldredge-Clanton, assisted greatly by editors Karen and Howard Stone. The small guidebook is published in English and several other languages by The University of North Carolina Press at Chapel Hill.

Her most recent academic pursuit stemmed from an interest she developed in building a hospital culture where spiritual companionship was seen as the role of every employee, and valued equally with physical care in the healing process. Under the direction of Kenneth Cracknell, her interwoven interests earned Rowley a Doctor of Ministry degree from Brite Divinity School in December 2006.

Rowley currently serves as Palliative Care Chaplain for BUMC and coordinator of Sacred Vocation, a program teaching bedside caregivers to value themselves as healers and their work as a sacred calling. She is also Deacon on staff at St. Anne Episcopal Church in DeSoto, Texas and will soon re-enter discernment for priesthood. On November 1, 2004, she married Lyle Bishop Rowley, Dallas-based architect emeritus.

Permanent Address: 3123 Bryan Street
Dallas, Texas 75204

This professional paper was typed by the author.