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ABSTRACT

WHOLE-PERSON CARE MINISTRY: A STUDY OF DISCORDANT ATTITUDES
AT LOMA LINDA UNIVERSITY MEDICAL CENTER

by

Kenneth Lance Tyler

Adviser: Kendrick Curtis

ABSTRACT OF GRADUATE STUDENT RESEARCH

Project Document

Andrews University

Seventh-day Adventist Theological Seminary

Title: WHOLE-PERSON CARE MINISTRY: A STUDY OF DISCORDANT
ATTITUDES AT LOMA LINDA UNIVERSITY MEDICAL CENTER

Name of Researcher: Kenneth L. Tyler

Name and degree of faculty adviser: Kendrick Curtis, DMin

Date Completed: June 2013

Problem

The defining emphasis of Loma Linda University Medical Center is to “Continue the teaching and healing ministry of Jesus” and “Make man whole” through a whole-person care approach. This study aims to determine why a significant number of patients fail to establish rapport with their care providers resulting in less than desirable healing outcomes and longer hospital stays.

Method

A Qualitative Research study was conducted with 12 interviewees to ascertain their insight of what comprised an excellent care partnership with their medical providers and, conversely, what constituted unacceptable care in their view. A representative

balance of diversities in ethnicity, culture, age, gender, medical diagnosis and religion among the patient participants was achieved by selecting the first 12 former patients who agreed to contribute to the study.

Results

Study participants confirmed that effective communication is the basis for the establishment of trust in the provider/patient relationship. They are more apt to comply with recommendations for treatment, experience greater satisfaction with their care and are less inclined to seek legal redress in the event that treatment is unsuccessful if a trusting and responsive relationship with their provider is achieved. Partnership rather than paternalism is their preferred model for the ideal doctor or care provider relationship.

Conclusions

Care providers best connect with patients by engaging intentionally with them regarding their medical, emotional, social and spiritual needs. The additional time and effort invested in good communication pays dividends in securing patients' cooperation and investment in their care. Patients do not appreciate condescension, apparent disinterest in them as persons or being treated just as a case or as a disease to be beaten. A physician or care provider that manifests approachability, listens well, follows up with what is learned and goes above and beyond the call of duty is seen as a valuable asset by the patient and the institution.

Andrews University
Seventh-day Adventist Theological Seminary

WHOLE-PERSON CARE MINISTRY: A STUDY OF DISCORDANT ATTITUDES
AT LOMA LINDA UNIVERSITY MEDICAL CENTER

A Project Document
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Ministry

by
Kenneth Lance Tyler

June 2013

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LIST OF ABBREVIATIONS

BLK	Black
CAU	Caucasian
DIV	Divorced
ER	Emergency Room
HIS	Hispanic
MAR	Married
NASB	New American Standard Bible
SGL	Single (Unmarried)
WID	Widowed

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CHAPTER 1

INTRODUCTION

Description of the Ministry Context

Loma Linda University Medical Center is a high intensity Level 1 trauma center with a volume turnover of over 481,754 outpatients and 30,720 admissions per year as of the August 2012 American Hospital Association's Report (See APPENDIX A). With these numbers and the high levels of acuity of care very high efficiencies must be maintained to serve patient needs. Occupational stress can peak at unpredictable times, even in the most capable healthcare provider. Medical care is provided in a real-world context which incorporates the professional life as well as the personal strengths and weaknesses of those providing the care. Despite the best of institutional goals, overtaxed personnel and highly distressed patients functioning far below their optimal capacity due to their medical condition, fail to realize satisfaction with the medical care and customer service they were expecting. This project seeks to illustrate the role of chaplains as catalysts in this volatile context who role model the attitude of Jesus, who demonstrated approaches to varieties of people and situations in the gospel of Mark.

Further, the literature since at least the early 1970's has been increasingly insistent that the human interface between patient and the healthcare provider is indispensable if whole-person care is to be meaningfully provided. With new directives arriving as a result of President Obama's Affordable Care Act (ACA) aimed at combating

increasing costs and shrinking budgets, more effective approaches than simply treating symptoms must be adopted. Modeling effective whole-person care is one such answer.

Statement of the Problem

Loma Linda University Medical Center is a 750 bed Level I trauma hospital for one-quarter the state of California. The defining emphasis of the hospital is the whole-person care program which integrates the spiritual along with the medical and psychosocial elements. In the majority of cases this integrated care is successfully provided. However a significant number of patients and/or families fail to establish rapport with their care providers resulting in less than desirable healing outcomes. Prejudicial patient, family or personnel attitudes jeopardize the potential for successful outcomes and prolong patient length of stay. When these scenarios arise, and other interventions are exhausted, the medical team often opts to try a spiritual approach by calling for chaplain involvement to encourage greater compliance, and shorten patient stay.

Statement of the Task

The task of this project was to interview selected patients or former patients at Loma Linda University Medical Center with a view towards assessing attitudinal factors that interrupt the practice and reception of whole-person (medical, psychosocial and spiritual) care while they are or were in the hospital. The project formulated recommendations designed to mitigate these non-beneficial attitudes, and report them initially to unit managers for incorporation into staff development training at the monthly charge nurse in-service. Secondly, insights gained informed ongoing modeling with medical students preparing to graduate and begin their own practice.

Delimitations

The data for the study was gathered from qualitative interviews by the Student Investigator from patients (and in some cases spouses) who had been hospitalized at Loma Linda University Medical Center, California in recent times. The study is based upon interviews of recollections by individuals, for whom some time has elapsed since the hospital stay, thus introducing an element of subjectivity which must be carefully evaluated by the researcher (Krefting, 1991, p. 220). No sources of funding for the study were utilized outside of that provided by the Student Investigator.

Description of the Project Process

1. Theological reflection centered on interactions Jesus had with individuals, families, His disciples, and religious and community leaders in the gospel of Mark. He modulated his attitude to most effectively connect with those whom He desired to heal.

2. A review of current theological, psycho-social, and healthcare literature including books, articles and electronic sources was conducted to build understanding of the interpersonal aspects of attitudinal development and change.

3. Qualitative data from interviews was collected and evaluated to assess recurring factors that contribute to detrimental attitude formation. Utilization of open-ended question interviews will form the basis for collecting patient understandings hindering effective care in the hospital setting.

4. Recommendations arising from the data review was formulated for appraisal by the unit managers in the current setting. Promising strategies may be piloted with both graduating physicians and nursing staff.

5. Evaluation following the pilot implementation assessed the relative strengths and weaknesses of the adopted protocols.

Definition of Terms

4100, 9100 etc.

These numbers are floor and unit designations for patient care areas at Loma Linda University Medical Center.

Affordable Care Act (ACA)

For too long, too many hardworking Americans paid the price for policies that handed free rein to insurance companies and put barriers between patients and their doctors. The Affordable Care Act gives hardworking families in California the security they deserve. The new health care law forces insurance companies to play by the rules, prohibiting them from dropping your coverage if you get sick, billing you into bankruptcy because of an annual or lifetime limit, or, soon, discriminating against anyone with a pre-existing condition.

All Americans will have the security of knowing that they don't have to worry about losing coverage if they're laid off or change jobs. And insurance companies now have to cover your preventive care like mammograms and other cancer screenings. *The new law also makes a significant investment in State and community-based efforts that promote public health, prevent disease and protect against public health emergencies.* [Emphasis mine] (HealthCare.gov, 2012)

Cardiac Catheterization

Cardiac catheterization (kath-uh-tur-ih-ZAY-shun) is a procedure used to diagnose and treat cardiovascular conditions. During cardiac catheterization, a long thin tube called a catheter is inserted in an artery or vein in your groin, neck or arm and threaded through your blood vessels to your heart. Using this catheter, doctors can then do diagnostic tests as part of a cardiac catheterization. Some heart disease treatments, such as coronary angioplasty, also are done using cardiac catheterization. (Mayo Clinic, 2012)

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) is an agency within the US Department of Health & Human Services responsible for administration of several key federal health care programs. In addition to Medicare (the federal health insurance program for seniors) and Medicaid (the federal needs-based program), CMS oversees the Children's Health Insurance Program (CHIP), the Health Insurance Portability and Accountability Act (HIPAA) and the Clinical Laboratory Improvement Amendments (CLIA), among other services. (SearchHealthIT, 2012)

Differential Diagnosis

“The determination of which of two or more diseases with similar symptoms is the one from which the patient is suffering, by a systematic comparison and contrasting of the clinical findings” (WebMD, 2012).

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. (U.S. Department of Health & Human Services, 2012)

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. While many hospitals have collected information on patient satisfaction, prior to HCAHPS there was no national standard for collecting or publicly reporting patients' perspectives of care information that would enable valid comparisons to be made across all hospitals. (HCAHPS, 2012)

Intensive Care Unit (ICU)

Intensive care units cater to the needs of the most critically ill or injured patients and have specialized doctors, nurses and support staff as well as constant monitoring to maintain life.

Institutional Review Board (IRB)

The Institutional Review Board (IRB) is a local administrative body established to protect the rights and welfare of human research subjects with which the University is affiliated. The IRB has the authority to approve, require modifications in, or disapprove all research activities conducted by faculty, staff, or students on its premises or under its sponsorship. (Loma Linda University, (2012a)

Intravenous (IV)

Intravenous means "within a vein." It usually refers to giving medications or fluids through a needle or tube inserted into a vein. This allows immediate access to the blood supply. For example, your doctor may prescribe medications to be given through a vein, or an intravenous (IV) line. (MedlinePlus, 2012)

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 19,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. (Joint Commission, 2012)

Licensed Vocation Nurse (LVN)

“An entry-level health care provider who is responsible for rendering basic nursing care” (Department Of Consumer Affairs, 2012).

Medical Futility

Physicians may employ the concept of medical futility to justify a decision not to pursue certain treatments that may be requested or demanded by patients or surrogates. Medical futility means that the proposed therapy should not be performed because available data show that it will not improve the patient's medical condition. (Bernat, 2005)

Medical Service Lines

Healthcare providers, being service businesses, have service lines as well. Different types of providers have different types of service lines. For instance, hospitals tend to have surgical lines of business such as cardiac surgery, orthopedic surgery, colon and rectal surgery. (BeyeNetwork, 2012)

Named Hospital

The hospital was named by the patient but in order to prevent an unwarranted negative public portrayal of the facility a pseudonym “Named Hospital” was substituted.

OxyContin

OxyContin (oxycodone) is a[n] opioid pain reliever similar to morphine. An opioid is sometimes called a narcotic. OxyContin is used to treat moderate to severe pain that is expected to last for an extended period of time. OxyContin is used for around-the-clock treatment of pain. (Drugs.com, 2012)

Patient Care Associate (PCA)

PCA’s assist with basic patient care such as bathing, grooming, transfers, positioning and assistance with nutrition under the direction of a registered nurse.

Peripherally Inserted Central Catheter (PICC)

A PICC line is, by definition and per its acronym, a peripherally inserted central catheter. It is long, slender, small, flexible tube that is inserted into a peripheral vein, typically in the upper arm, and advanced until the catheter tip terminates in a large vein in the chest near the heart to obtain intravenous access. (PICC Line Nursing, 2012)

Qualitative Research

Qualitative research is by definition exploratory, and it is used when we don’t know what to expect, to define the problem or develop an approach to the problem. It’s also used to go deeper into issues of interest and explore nuances related to the problem at

hand. Common data collection methods used in qualitative research are focus groups, triads, dyads, in-depth interviews, uninterrupted observation, bulletin boards, and ethnographic participation/observation. (Mora, 2012)

Whole-Person Care (WPC).

Whole person care is the differentiator in healthcare ministry. It focuses beyond a patient's presenting illness. It blends together care of the physical, intellectual, emotional, social and spiritual components of personhood—the “innerweaving” of these components produces whole person care. (Alexander, 2008, p. ix)

CHAPTER 2

THEOLOGICAL FOUNDATION FOR WHOLE-PERSON CARE AT LOMA LINDA UNIVERSITY MEDICAL CENTER

Introduction

For many, one of the most distressing existential experiences is to be faced with a life-threatening health crisis. It hardly seems to matter whether it arises suddenly or gradually manifests to a degree that it can no longer be ignored. The sense that something is seriously wrong with the medium of our existence and that there is the possibility that whatever future we have will be radically different is something that can overwhelm even the most competent of individuals. Every day in the hospital, chaplains encounter people struggling with the recognition that for them and/or their families life as they have been used to it, will never be the same again.

Reactions vary tremendously. Cultural conditioning, education, socio-economic status, personality and more; all modulate a person's response to facing formerly unimaginable life changes. From passivity that borders on resignation to violent remonstrations which frightens bystanders; each patient endeavors to integrate an unwelcome diagnosis and prognosis. None of the patient's inner turmoil occurs in a vacuum, and family and medical personnel are often drawn into the resulting theater of corporeal and emotional reassessment. Commonly this process advances in waves, not without frequent reverses and roadblocks that test coping skills to the limit. It is at this

time that the chaplain and his or her spiritual ministry is often able to provide an anchor that allows an individual to begin to piece together enough insight and courage to make some needed decisions for the future.

Jesus' ministry in Mark's gospel is accentuated from the outset by interactions with sick and hurting people. While His mission far transcended merely responding to the plentiful medical and social needs, He is identified as One who is involved with people in their most vulnerable and painful experiences. At times He is recorded as initiating the encounter, and on other occasions, individuals who have heard of His abilities come seeking His help. There are instances where Jesus healed large numbers of people (Mark 1:32; 6:54)¹, in fact whole villages, but it seems that He derived special satisfaction from ministering one to one. A larger purpose at these times would have been mentoring His disciples who were tasked with continuing the ministry following His death, resurrection and ascension. The value of demonstrating His principles, attitude and methods in real-life situations cannot be overestimated. In the modern healthcare context chaplains are benefited by reflecting upon Jesus' responses to human need in the light of their own challenges in ministry. While the particular circumstances may differ, I will show in the following discussion, that the approach and attitudes Jesus manifested recall values and principles familiar to clinicians of most religious and spiritual backgrounds.

Impact of Illness in New Testament Times

The gospel narratives only briefly discuss the medical and technical aspects of diseases afflicting individuals whose stories appear in the accounts recorded by New Testament writers. This is in harmony with the writers' purpose of proclaiming Jesus as

¹ All references are from the New American Standard Bible (NASB).

the long-awaited Savior who not only restores lost physical health and ability, but reconciles humanity to God as it was in the beginning. This noble vision is the good news heralded to the shepherds as the gospel author Luke reports at the outset of his writing and provides the agenda for Jesus' mission. What description is included serves to contrast the enormity of the suffering with the power and authority of Jesus to overcome it. The scope of His power and authority is best demonstrated in seven miracles He performed in the gospel of John; comprising victory over disappointment (John 2:1-11), distance (4:46-53), time (5:1-9), hunger (6:4-13), nature (6:16-21), circumstances (9:1-12), and death (11:30-44). No wonder then that His presence and message awakened a keen sense of anticipation wherever He went.

But prior to His coming the plight of people unfortunate enough to be struck down with illness or injury was tenuous indeed. One Christian writer described the era as being "dark through misapprehension of God" (White, 1898, p. 22). It had been more than 400 years since the last prophet brought direct messages from Jehovah. The nation had drifted in this absence, forsaking adherence to vital health principles detailed in the Torah. Occupation by Roman garrisons only exacerbated some of these tendencies, further compounded by a wooden ascription to the ceremonial and legal traditions that so burdened the common people. Superstition (John 5:7), unsophisticated medical care (Mark 5:25, 26), and treatments that were limited to a kind of first-aid response (Luke 10:34) possibly due to cost, let many serious conditions continue unabated. In commenting on sickness and healing within Judaism Kittel and Bromiley (1995) remark:

In Israel some ailments, such as mental illness, leprosy, and mortal sickness, are associated with demons, but we also find the beginnings of hygiene, and the conviction develops that God sends or withholds sickness. Thus it may be a sign of divine wrath (Is. 38), but this raises problems for the righteous (e.g., Job) when

there is no obvious cause. When there is, repentance is a way to healing (2 Sam. 12:15ff.). Judaism tries to assign particular ailments to particular sins, but recognizes that sickness may also be a chastisement of love or a means of alleviating eternal pains. (p. 346)

This ambivalence may help in understanding the attitudes expressed in scenarios by John (John 5:7, 9:1) such as the man waiting at the pool and the man born blind. These disease states were of long duration (John 5:5, 9:1; Mark 5:3, etc.) and individuals eventually lost hope of any recovery, reducing them to a life of poverty alleviated only by begging (Mark 7:31-35, 10:46). Some diseases such as leprosy mandated a separation from others (Luke 17:11-13) with resulting social and emotional isolation. Cases of mental illness, epilepsy, and/or demon possession (Matt 17:14-16; Mark 5:1-5) featured in a number of the gospel anecdotes and these seemed to be largely untreatable (Matt 17:16) with human interventions available at the time. A woman who was unable to conceive bore the guilt of her inability regardless of the cause of her childlessness (Luke 1:6, 7, 24, 25). The power of social stigma associated with many of the health predicaments, bit hard the already deflated ego, layering existential and spiritual suffering upon the physical and financial burdens already imposed by the loss of health or ability. The time was ripe for a message of hope that brought healing to the whole person.

Principles and Values Jesus Modeled in Ministry with Individuals

Mark provides an insight into Jesus' attitude to individuals in trouble and I have selected 13 of the healing pericopes he includes in his gospel to illustrate aspects of the Savior's approach to caring. In harmony with the purpose of this study we will observe Jesus modeling approaches to patient visits in the way I propose that chaplains model caring and communication styles for healthcare personnel in the medical setting. Each

episode contributes one or more aspects of God's attitude towards the sick and unfortunate that will help in building a theology of partnership in healthcare. Further they illustrate principles which if adopted thoughtfully may strengthen both the ministry and the patient's quality of care. The chaplain by evaluating his or her ministry in light of what is demonstrated in these scenarios will become more comprehensibly prepared with the insights gained to serve in the current fast-paced healthcare environment.

Authority: Restoring a Man With an Unclean Spirit (Mark 1:21-28)

This is a very brief interaction with an "unclean spirit" which seems to be controlling the man even while he is in the synagogue. Besides the physical and emotional disability that curtailed normal work pursuits, the stigma of impurity has also been noted by commentators adding to the significance of this brief story: "The frequency with which this character of "impurity" is ascribed to evil spirits—some 20 times in the Gospels—is not to be overlooked" (Jamieson, Fausset, & Brown, 1997, para. Mark 1:23).

Jesus' arrival and remarks however, initiated a radical change to the order of events. Apparently, as Cole (1976) observes, the outburst was in response to Jesus' teaching that the demon recognized both His person and authority (p. 61). The issue regarding Jesus' right to heal arises numerous times in the gospels and his authority is cast in contrast to the scribes and Pharisees in attendance. One commentary notes that, "Mark has it "as having authority" (ὡς ἔχων ἐξουσίαν [*hōs echōn exousian*]). He struck a note not found by the rabbi" (Robertson, 1933, para. Mark 1:22). In this case Jesus entered into no dialog; in fact He forbade it, demanding simply that the demon submit to His lawful authority and trouble the man no longer. Jesus adeptly bridged the need to

advocate on behalf of the sick man while restraining the abuse of privilege that denies assistance to the needy. Respect for Him and His teaching grew significantly in the eyes of the open-minded as a result of this episode.

Intimacy: Curing Simon's Mother-in-law (Mark 1:29-33)

Immediately upon exiting the synagogue Jesus and a few of His closest followers entered the house of Simon and Andrew. It was not uncommon at this time for extended family to live in the same dwelling as the husband and wife. Here the disciples drew Jesus' attention to the sick woman which caused Him to go to her and clasp her hand. His touch dispelled the fever and she consequently resumed her activity to provide hospitality for her guests. In contrast with the previous episode this one took place within the privacy of a home setting indicating Jesus' willingness to minister in the shadow places away from the public view. More than that, as Barclay (2001) remarks: "Jesus completely disregarded all the paraphernalia of popular magic, and with a gesture and a word of unique authority and power, he healed the woman" (p. 42).

Mark records the incident as Jesus taking her by the hand and raising her up, modeling a close and personal intervention that typifies His ministry, unlike the standoff attitudes demonstrated by many of the religious authorities of His day.

Approachability: Healing a Man With Leprosy (Mark 1:40-45)

The desperation emanating from the man afflicted with leprosy is barely captured in the brief account of this healing. Condemned to live in isolation and to exist through begging for daily sustenance until death brings release is a fate that is difficult for the Western mind to fully comprehend. It was forbidden to attend religious services that

ordinarily would bring some succor for most situations, and to add insult to injury a leper was required to announce his or her presence with the words “unclean, unclean”.

The biblical word for leprosy is derived from a word that means “to strike down” which lends support to the commonly held view that the disease was a judgment of God (Nichol, 1978, p. 761). Biblical examples supporting this view are Miriam (Num 12:1-15), Gehazi (2 Kgs 5:27), and Uzziah (2 Chr 26:16-21). However, evidence is lacking to support the view that a specific sin was necessarily or always the cause of leprosy. In fact Jesus created further distance between these commonly held beliefs by stating that neither the blind man’s nor his parents’ sin caused him to be born blind (John 9:3). Old ideas persist however, having to be refuted time and again while the sick must bear the resulting stigma in addition to their illness.

In spite of the prohibitions and previous rebuffs from repeated calls for aid the man galvanizes sufficient courage and throws himself at Jesus’ feet imploring healing. It is possible he has heard of this Teacher/Healer so he seizes the opportunity to present his request. Instead of shrinking back as many have when approached by a leper, Jesus reaches out with compassion and touches him bestowing through word and deed the much needed cleansing. The use of the Greek καθαρισαι for cleansing is distinct from εθεραπευσεν for healing in this story and lends credence to the fact that Jesus is meeting the man where his understanding is. The instructions that follow reflect the fact that this meeting was not an intervention that Jesus planned and therefore to protect His mission from becoming publicized as primarily a healing campaign rather than a proclamation of the coming kingdom of God Jesus gives the man strict instructions for follow-up. Sadly

the man's enthusiasm overwhelms his better judgment and the resulting notoriety ends Jesus' opportunity to further His mission in that area as Wuest (1997) observes:

What Jesus feared seems to have happened. The man went about telling of his cure, and neglecting the means necessary to obtain social recognition as cured. This cure and the popularity it caused may have cooperated to bring Christ's synagogue ministry to an abrupt termination by stirring up envy. (para. Mark 1:45)

This man and others (Matt 12:16; Mark 5:43; 7:36) failed to account for attitudes and actions that can unfortunately contribute towards hindering access for themselves or the rest who desire the help they so much need. Adequate counsel must always be provided, but the implications may not be fully understood or consistently followed.

Advocacy: Healing a Paralytic (Mark 2:1-13)

Jesus returned to Capernaum several days later and revived His teaching ministry to the extent that the gathering place was completely filled with eager listeners. Four men carrying a paralyzed neighbor arrive and are unable to get him inside due to the crowding so they decide to remove a section of the roof and lower him in front of Jesus. He notes their faith and pronounces the sought after blessing, "Son, your sins are forgiven." In the excitement that follows, not everyone is pleased, and Jesus turns to confront the yet unannounced thoughts and feeling of the unbelieving scribes. He succinctly summarizes the conundrum that angers them. It is known that only God can forgive sin, and yet before their eyes they have witnessed Jesus not only provide healing for the man's paralysis but to confer forgiveness for his sins at the same time. The real miracle with this healing is nicely captured by Cole (1976):

It was, in point of fact, a much lighter thing to heal the body than to restore the soul, for a prophet might heal, but no mere prophet could ever forgive sins; but the scribes, with their incessant demands for signs, were unlikely to see this (see viii. 11). (p. 66)

This statement regarding the miracle highlights the intentionality of Jesus' mission and the desire not to see the plan to redeem humanity distracted by signs and wonders, as important as these are in authenticating His work. Specifically, in this case Jesus advocated for the sick man by saving His concluding words for the one who had been brought to Him on the pallet; "I say to you, get up, pick up your pallet and go home" (2:11). This is significant, as it was not uncommon for the authorities and others to harass those whom Jesus healed (Matt 26:6-13; John 9:13-34) so as to discredit them and Him. Of great importance however is to notice that Jesus read the scene with a view of caring for the sick and alienated that their interests be protected. Robertson (1933) comments on this passage in these words: "The Master at once recognizes the hostile atmosphere in the house. The debate (διαλογιζομενοι [*dialogizomenoi*]) in their hearts was written on their faces. No sound had come, but feeling did" (para. Mark 2:6). Jesus was never so preoccupied that important needs of His creatures were overlooked as He attended to the demands of His ministry, and He never allowed an opportunity to direct adversaries towards a better life path to pass without recommendation.

Sovereignty: Restoring a Withered Hand (Mark 3:1-6)

This case concerns a man whom commentators have concluded probably contracted his disability after birth (Robertson 1933, para. Mark 3:1; Vincent, 1887, p. 174), hindering his opportunity to work or serve as a priest (Cole, 1989, p. 132; Henry, 1994, para. Mark 3:1-12). Faced with a choice between helping a genuine case of need and risking the ire of those who perpetuated an ostentatious veneer of righteousness, Jesus once again provided an opportunity for His detractors to ally themselves as benefactors in ministry with Him. Sadly they let the moment pass, internally hardening

their position in opposition and grieving the Savior. Henry (1994) observes: “It is a great grief to our Lord Jesus, to see sinners bent upon their own ruin, and obstinately set against the methods of their conviction and recovery, for he would not that any should perish” (para. Mark 3:1-12).

Henry again notes in contrast His attitude to the man:

Christ dealt very kindly with the patient; he bade him *stretch forth his hand*, and it was immediately *restored*. Now, (1.) Christ has hereby taught us to go on with resolution in the way of our duty, how violent soever the opposition is, that we meet with in it. We must deny ourselves sometimes in our ease, pleasure, and convenience, rather than give offence even to those who causelessly take it; but we must not deny ourselves the satisfaction of serving God, and doing good, though offence may unjustly be taken at it. [Emphasis original] (para. Mark 3:4)

Again in this brief pericope Jesus models a multifaceted concern for the needs and feelings of each person present. He does His best to foster the development of new and enlightened pathways by initiating participation in a more principled approach to the brokenness and misfortune that invades so many lives.

Positivity: Facing Down the Gerasene Demoniac (Mark 5:1-20)

Immediately following the dramatic calming of the storm on the sea, Mark presents this scene with a demon-possessed man bearing down on Jesus and the disciples. He was one whom had been banished to live away from society among the graves and desolation of that region. Akin to the lepers, those whom were demon-possessed, epileptic or mentally ill were often segregated for either health or social reasons because medical care was such that it was not able to safely accommodate them:

For this was a man long ‘under treatment’ (like the woman suffering from a hemorrhage, mentioned in verse 25. It was in the failure of all human methods that Jesus acted decisively. The medical treatment given to this man was that commonly still used in many parts of the world today: he was loaded with chains,

in a vain attempt to curb his inner turmoil by outward restraint. Not surprisingly, this proved quite futile. (Cole, 1989, para. Mark 5:1-20)

Jesus was not intimidated by the sight or the manner of the man and it appears from the text that He had initiated the conversation by addressing the demon which controlled him. Every aspect of this man and his situation is presented as unattractive to the point where most would avoid the area altogether to avoid personal risk or injury. It would seem that even those who would attempt to subdue him had ceased trying as evidenced by the fact that “no one was able to bind him anymore, even with a chain” The NASB² uses a block of eighty-five words to describe the wretched state of this man and his bleak outlook. Again however, Jesus uses this worst case scenario to reveal His compassion for a created son of Adam and to release this captive and set him free.

Following the dispatching of the demons into the pigs and the dispersion of the herders, the townspeople become fearful and request Jesus to depart from their area. He consents, but when the formerly demon-possessed man requests to go with Him, he refuses and commissions him to return to his own people as a witness to what had happened to him. Jesus is driven by His kingdom mission and continually thinks ahead to capitalize on the successes and mitigate the reverses as they occur. Jesus as God’s servant is shown once again intervening in the most frightful and stigmatized cases that are brought to His notice. No one and no situation is unimportant in the integrated schema of His life.

Receptibility: Hearing a Leader’s Plea (Mark 5:21-24, 35-43)

The healing of Jairus’ daughter sandwiches another miracle in the same vicinity; the restoration of a woman suffering from a hemorrhage for 12 years, and another of

² NASB New American Standard Bible

several healings that are ostensibly the result of someone's faith other than the one who is healed (Mark 2:1-13, 7:24-30; Luke 7:1-10; John 4:43-54). Again Jesus is seen as capable of accommodating rapidly changing circumstances even while on a critical assignment in response to the official's pleading. This time the focus of attention is a child whose importance he may have desired to elevate in a society where children's mortality rate was high or to show His even handedness in serving the needs of the rich and influential, as well as the poor and disenfranchised. On a later occasion the disciples were still wont to turn away children who appeared to be unnecessarily co-opting Jesus' attention (Mark 10:13-16). Without question it seems, Jesus proceeds to Jairus' house but because of delay He is met with some who inform Jairus that it is too late and his daughter is dead. Jesus however insists, amidst the mocking, that faith is required in order for the girl's parents to see their daughter alive again. At the complex border between life and death Jesus is mindful of the range of needs and feelings of each person present and gathers the immediate family with a few of His closest disciples for the child's resurrection. The words Mark uses heighten the emotional intensity of all involved during what may have seemed like an eternity as they file into the dead girl's bedroom. Wuest (1997) makes the following comment regarding the incident:

The verb is *eisporouomai* (εἰσπορευομαι). It is the word often used of a person going on a journey . . . The factors involved make it a long walk. Our Lord was leading the sorrowing parents into the death-chamber, and the disciples into a room fraught with great possibilities. It was a journey for these. (para. Mark 5:35-43)

Jesus precedes this moment by injecting hope into the dialogue with the words, "do not be afraid." Once again we note Jesus caring for personal details and needs and at the same time seeking to protect His mission from being characterized as a solely

wonderworking movement even in the midst of the life-changing phenomenon that has just occurred. The story closes with Jesus forbidding the astonished parents from reporting the event and the girl to be provided with food to eat.

Sensitivity: Helping a Desperate Woman (Mark 5:25-34)

That this unnamed woman's story and the young girl whom He will shortly resurrect should be knit together in this fashion by the gospel writer is remarkable. Both stories have a genesis approximately 12 years previously and each reaches a crescendo of desperation from the point of fact that all of the options have expired. The synagogue ruler makes a vain attempt to secure the help of Jesus to heal his daughter and the woman who has been at the mercy of many physicians with diminishing success places all of her hope for healing in just touching the Teacher's garment. In both cases if no help comes from this final endeavor then all is lost.

Mercifully her faith is rewarded and she experiences the healing she so urgently sought. The anonymity she so much desired to preserve by virtue of the thronging crowd around Jesus was uncovered as He sensed a non-casual contact that infused therapeutic energy into someone nearby. Despite the disciple's dismissal of Jesus' observation, He located the woman and receiving her confession, commended her act of faith. Her health was restored and she left with a benediction of peace.

Again, the supreme awareness of Jesus regarding needs both large and small is demonstrated even in circumstances that are continually and rapidly changing. No detail is so small that escapes His notice and no person too broken to be unworthy of His care and touch. His mission to convey a true picture of God who cares for sparrows, lilies and even this dejected and disadvantaged woman is constantly being brought to the forefront

of His ministry. For Jesus it was not enough that healing and signs be manifested; the glory of God must also shine forth (John 11:4, 40).

A factor made explicit in this story though implicit in other places is that Jesus' healings may not have come entirely without cost to Himself. Two commentators make reference to this possibility:

This is an interesting verse, in that it shows that Jesus was at least sometimes conscious of the flow of healing power from himself to the sick individual. It may have been that such healings cost him much spiritual energy, for we read of him escaping for times of recuperation and prayer (6:32 etc.). (Cole, 1989, para. Mark 5:25-34)

The disciples were surprised at the sensitiveness of Jesus to the touch of the crowds. They were unconscious of the tremendous drain on our Lord from all this healing that tugged away at the tender heart and exhausted the nervous energies of the Son of Man even though He was the Son of God. (Wuest, 1997, para. Mark 5:31)

It is clear that Jesus invested Himself in His ministry to the extent that He maintained an awareness of not only His surroundings, but also the dynamics of the interplay between individuals in His vicinity. As God's servant He was constantly seeking to minister redemptively to all parties involved and this likely depleted His reserves.

Adaptability: Accommodating an Alien Woman (Mark 7:24-30)

In the service of humanity the unanticipated is certain to intrude in ways that will call forth adaptations to the usual course of the task. This was certainly the case with the Syrophenian Woman and her sick daughter in this story. While Jesus was intending to maintain a low profile here, word had circulated about His presence and the woman came to prevail upon His help. She was clearly outside of the priority of His mission (Matt 10:5, 6, 15:24) at this time and she likely already understood that; though she was not to be easily turned aside. Her response to Jesus' challenge to her importunity was such that

Jesus freed the girl of the demon that was troubling the daughter. Henry (1994) puts a very human face to both the woman's predicament with her resourceful response and Jesus' missiological constraints in this way:

The turn she gave to this word of Christ, which made against her, and her improvement of it, to make for her, v. 28. She said, "*Yes, Lord, I own it is true that the children's bread ought not to be cast to the dogs; but they were never denied the crumbs of that bread, nay it belongs to them, and they are allowed a place under the table, that they may be ready to receive them. I ask not for a loaf, no, nor for a morsel, only for a crumb; do not refuse me that.*" This she speaks, not as undervaluing the mercy, or making light of it in itself, but magnifying the abundance or miraculous cures with which she heard the Jews were feasted . . . Gentiles do not come in crowds, as the Jews do; *I come alone*. Perhaps she had heard of Christ's feeding five thousand lately at once, after which, even when they had gathered up the fragments, there could not but be some crumbs left for the dogs. [Emphasis original] (para. Mark 7:24-30)

This anecdote highlights a fascinating characteristic of Jesus that is evident in God in numerous other places in the biblical record. The Jewish and Christian God unlike the heathen deities is responsive to the human plight in remarkable ways. Examples include Cain (Gen 4:13-15), Abraham (18:16-33), Moses (Exod 32:7-14), and the number of incidents in the gospels such as this one where Jesus paused or turned aside to alleviate suffering. The healing of the centurion's servant (Matt 8:5-13; Luke 7:1-10) is a comparable case of Jesus responding to a non-Israelite and John includes Jesus' promise "If you ask Me anything in My name, I will do it" (John 14:14). Jesus models through His life and ministry that God notices every person and every detail even in the most complex situations. By healing of her daughter, Jesus provided the greatest gift of all.

Sensibility: Guarding A Deaf Man's Privacy (Mark 7:31-37)

On entering the Decapolis area unnamed friends brought a deaf, partially mute individual into Jesus' presence begging His intervention. Cole (1976) intimates that the

area where this healing takes place may be proximal to that of the healed demoniac discussed earlier and this man could well have been a product of his witness (p. 124). Jesus considerately separates him from the crowd so that He can work with him to bring about the needed cure. His compassionate touch, calming and instructive words and acknowledgement of His Father as the source of all restoration are the hallmarks of Jesus' way of caring for the person as a whole human being. This story recalls the intimacy of the scene where God creates Adam by working the earth with His bare hands (Gen 2:7). Again Henry (1994) captures the poignancy of the moment in these words:

He *put his fingers into his ears*, as if he would *syringe* them, and fetch out that which stopped them up. (2.) He spit upon his own finger, and then *touched his tongue*, as if he would moisten his mouth, and so loosen that with which his tongue was tied; these were no causes that could in the least contribute to his cure, but only signs of the exerting of that power which Christ had in himself to cure him, for the encouraging of his faith, and theirs that brought him. The application was all from himself, it was his own *fingers* that he put into his ears, and his own *spittle* that he put upon his tongue; for he alone heals. [Emphasis original] (para. Mark 7:31-37)

As has been noted before Jesus does not shrink from human contact that conveys in a very real sense the touch that those long alienated have because of their condition been starved from receiving. For some this would be the first touch in love they had ever experienced. The natural response is to share this newfound joy.

Familiar now though is the instruction to the healed man and his companions regarding keeping the matter quiet; but as before they found it difficult to hold their astonishment over how Jesus cured the man's deafness and caused him to fully regain his speech. Good news is hard to contain and no constraint is sufficient to hold back the tide of good will generated by this act of kindness. A man is made whole, the friends are empowered and God is acknowledged and glorified as Jesus responds to this non-life-threatening restoration of abilities.

Teachability: Instructing Through a Case Study (Mark 9:14-29)

While Peter, James and John were with Jesus on the Mount of Transfiguration, the remaining disciples were attempting to heal a very difficult case of a boy victimized from childhood by a demon. Much to their chagrin they were not able to cure the boy which resulted in an angry discussion with some scribes. After an interaction with the boy's father Jesus is able to mobilize his faith resulting in the demon's exorcism and the boy's healing. The puzzled and embarrassed disciples enquire of Jesus why they failed.

This story functions as a warning against presumption, that no matter how adept the practitioner may be, the spiritual forces for good or evil will suffer no cavalier attitudes on the part of God's servants. Jesus explains that the requisite preparation and deference to the work is vital and the failure to be fully equipped will be exposed in difficult situations as this episode reveals. Wuest (1997) offers the following:

Swete says: . . . The Lord seizes upon the essential weakness of their case. They had trusted to the quasi-magical power with which they thought themselves invested; there had been no preparation of heart and spirit. Spirits of such malignity were quick to discern the lack of moral power and would yield to no other. [Emphasis Original]

Robertson says that the words 'and of fasting' do not appear in the two best manuscripts (Aleph and B), also that it is clearly a late addition to help explain the failure of the disciples. Their failure was due to their prayerlessness. They lacked power because of that. (para. Mark 9:28)

The chastisement Jesus meted out to the disciples provided an invaluable lesson that if heeded would equip them in the future confrontations with the forces of darkness that would surely come in His absence (Acts 19:13-16, Eph 6:10-18).

Spirituality: Imparting Higher Values (Mark 10:17-31)

The incident featuring the “rich young ruler” is noteworthy for the observation that the space Mark devotes to Jesus’ discussion with the disciples which followed is greater than the event itself. The question asked and the answer given should shake every would-be aspirant to the kingdom to the very core. No physical inability or life-threatening illness is the subject of the discussion, yet it is probably only a matter of time before that too would be a relevant component to consider. This conversation shows that it is never too early to address the core issues of life and we are indebted to this young man for illustrating that truth.

At some level he recognizes that energy must be devoted to preparing for the day when life will not be as it is now. Perhaps he has heard Jesus teach before and decides to seize the moment to resolve an inner ambiguity. The answer however, seems more than he bargained for and reluctantly he passes on the opportunity to satisfy his eternal need as the cost is much more than he is willing to pay. But, as Jesus goes on to explain (10: 29), it is not only the rich who stumble on this quest. The “poor widow [who] came and put in two small copper coins” (Mark 12:42) is one such example of value judgments of this magnitude which figure in every person’s life at some time. These passages assure the seeker that God empathetically attends these deliberations because of His great love for each individual. Perhaps the most well-know of David’s Psalms in the Old Testament (Psalm 23) appropriately confirms the companionship and support of God in the valleys of life. There is any amount of reinforcement for the central idea of God ensuring that we do not need to tread the path of life alone.

When a person faces incapacity or serious illness thoughts of life presently and life in the future focus the conversations in a unique way. Some are prone to make rash promises in an effort to bargain for a return to former times. Perhaps hints of this component in the dialogue between the young man and Jesus did not escape the Teacher's awareness. In commenting on verse 18 Wuest (1997) observes:

The Lord begins by compelling the enquirer to consider his own words. He had used the word 'good' lightly, in a manner which revealed the poverty of his moral conception . . . Expositors says of the question, "Why callest thou Me good?"; "which means not, "the epithet is not applicable to Me, but to God only," but, "do not make ascriptions of goodness a matter of mere courtesy or politeness." The case is parallel to the unwillingness of Jesus to be called Christ indiscriminately. He wished no man to give Him any title of honor till he knew what he was doing. He wished this man in particular to think carefully on what is good, and who, all the more that there were competing types of goodness to choose from, that of the Pharisees, and that exhibited in His own teaching." [Emphasis Original] (para. Mark 10:18)

The nature of the kingdom that Jesus came to announce is one based on a relinquishment of selfishness and the kind of covetousness that leads to a dependence on manipulation of individuals or systems to gain advantage. Regretfully, persons facing difficult times in the hospital can sometimes veer into a bargaining mentality which can delay or even prevent the real healing they so much seek.

Agreeability: Allocating Time for the Needy (Mark 10:46-52)

Bartimaeus was occupied at the side of the road begging for sustenance when Jesus happened by. Unlike the lepers who were obliged to hold people back, he insistently called out to Jesus asking for mercy. Despite all attempts to silence him, his cries attracted Jesus' attention who requested he be brought into His presence. Those near Bartimaeus then encouraged him and he quickly responded. When given opportunity he clearly stated his case and received his sight. Again Jesus connects his faith to the

resulting cure, confirming the link, if it is to be rewarded, between mankind's desire and God's response.

This healing constitutes a last diversion as Jesus makes His way to Jerusalem for the final time. He has a lot on His mind and the growing recognition of the cost of redeeming humanity is pressing on Him from all sides. But no matter His preoccupation, there is time for one more desperate call for His help. Lane (1974) comments on the rapidly unfolding scene and the result with these words:

Those in the crowd who rebuked the beggar undoubtedly regarded his shouting as a nuisance and resented the thought of any possible delay. They had probably become quite hardened to seeing beggars along the roadside, and especially at the city gates, crying for alms. Undeterred, the man resolutely continued his chant until he succeeded in drawing Jesus' attention to himself.

Jesus took the initiative in directing that the blind man should be called. The rebuke of those who attempted to silence the beggar was not allowed to stand (cf. Ch. 10:13f.), for even on the way to Jerusalem Jesus had time for a man who appealed for His help in faith. The encouragement offered to Bartimaeus assured him that Jesus was concerned with his plight and relieved the anxiety and distress expressed in his cry. His response was dramatic and decisive. (p. 388)

Despite the rapidly diminishing vestiges of time before Jesus would enter Jerusalem for the last time, He recognized the pitiful plight of a blind beggar unlikely to be helped unless He personally attended to Him. Rebuffed by passersby for years and unable to earn a conventional living, he was in the right place to hear the crowd proclaiming Jesus' name and he took advantage to secure His healing touch. His importunity and faith was rewarded ultimately because of Jesus' sensitivity to his situation.

Reflections on Jesus' Ministry to the Sick and Discouraged

The vignettes chosen from the gospel of Mark provide snapshots or windows into the ministry of Jesus bearing on the work of the chaplain as He interacted with a number

of individuals and groups over the three years or so He was active in His mission. In this project I have endeavored to search for illustrations of how Jesus adapted His response and even His initiatives to meet the attitudes manifested by individuals and groups in His vicinity. The gospel accounts are a rich source for a variety of approaches that meet needs, concerns, questions and even criticisms that are extant in the anecdotes selected for this study.

As a Seventh-day Adventist I am privileged to have been exposed to an expansive interpretation of Jesus' ministry through the writings of Ellen White (1905) and though I have chosen rather to select the majority of the commentary from works other than hers, one quotation in particular from the *Ministry of Healing* does sets the right tone for the conclusion of this chapter on the theological foundation for partnership between provider and recipient in healthcare.

Christ's method alone will give true success in reaching the people. The Saviour mingled with men as one who desired their good. He showed His sympathy for them, ministered to their needs, and won their confidence. Then He bade them, "Follow Me."

There is need of coming close to the people by personal effort. If less time were given to sermonizing, and more time were spent in personal ministry, greater results would be seen. The poor are to be relieved, the sick cared for, the sorrowing and the bereaved comforted, the ignorant instructed, the inexperienced counseled. We are to weep with those that weep, and rejoice with those that rejoice. Accompanied by the power of persuasion, the power of prayer, the power of the love of God, this work will not, cannot, be without fruit. (pp. 143, 144)

Chaplaincy is a divine calling to minister amidst a complex diversity of persons in an intricate and often fast-changing environment of care. This vocation necessitates the ability to minister effectively and cooperatively with a large number of medical disciplines in a setting composed of a diversity of religious, cultural, socio-economic, educational, gender, racial and lifestyle orientations. As Jesus' ministry demonstrated it

will not be unexpected for the chaplain to have to earn the respect of his or her colleagues at times. A balanced and well thought through understanding of pastoral identity is invaluable when authority to act as an advocate for a patient and or family is required. Not uncommonly though, there is a need to speak on behalf of the institution so the chaplain will need to be adept at discerning the multiple and evolving needs as they play out. Jesus masterfully modeled an intentional ministry that always kept in view His primary goals even as He cared for emerging and changing needs.

Advocacy for patients in particular can entail confronting the stigma and isolation surrounding their circumstance. Despite ample education and sensitivity training not every person assimilates enlightened attitudes. Layers of social and emotional isolation are added to the debilitating condition inviting a sense of worthlessness. By moving close, touching and praying with the patient the chaplain models the attitude that God too considers their worth, bringing a feeling of consolation and peace. The desperation of the moment can be eased even in the worst cases, by moving close, spending time and repeating the comforting words of Jesus as if He were present on that occasion.

The real power of Jesus' mission was not in His ability to heal and restore, as wonderful as that was for those who benefited from His touch. Jesus came to restore the effaced "picture of God" that had long been buried under layers of institutionalism and superstition. There was a deep longing for an authentic connection with the God of Abraham, Isaac and Jacob and His words and teaching enthralled those who were receptive to the vision he portrayed. People wanted a Deity who was cognizant of their plight and took notice of the successes and failures in their lives. They desired a God who provided hope when life situations became intolerable. Both pilgrims and strangers,

young and old, rich and poor; were all included in the purview of Jesus. Chaplains will minister most effectively when they serve intentionally as Jesus did, keeping in view their primary purpose of modeling a picture of God and His attitude of ministering proactively to each person's need. While it may be tempting to ignore or reject the recalcitrant, the ministry of Jesus demonstrates that He sought to reach even the most reprobate (Mark 14:18) while there was still a window of hope that a change in attitude may occur. Awareness and creativity in the dynamic of ministry along with sensitivity to the voice of the Spirit (Luke 12:12) will foster the best outcome in that context.

In both pastoral care and chaplaincy, the satisfaction of serving in partnership with God can be exhilarating. Beneficial outcomes to difficult situations and the joy of seeing individuals resurrect a long-buried relationship with God are highly valued by chaplains. But the cost of ministry may be substantial in terms of emotional and physical demands upon them. Jesus experienced weariness, disappointment, anger, pressure to conform and ridicule among other things as He sought to do His Father's will. He sought times for prayer and solitude to regenerate His reserves and chaplains must understand the need to care for their own spiritual, mental and emotional health. It was noted earlier that the disciples were defeated in a battle with a demon primarily because they had neglected prayer. Chaplaincy is a vocation that will call forth everything a person has at times and if sufficient preparation has not been done for the work, or a nonchalant attitude is adopted the quality of ministry will likely be affected. Great care must be exercised lest the sacred calling be put at risk for unanticipated indiscretions that would not have been likely if a healthier balance had been made. Finally, even Jesus invoked the accountability of a ministry team where He could both mentor and at times gain feedback

regarding the day's activities. The model of ministry Jesus lived out as outlined in Mark's gospel encapsulates a balanced approach to meeting people in crisis in either straightforward or complex situations. The attitudes Jesus manifested towards individuals are worthy of the deepest contemplation in the face of the multifaceted needs of sick and incapacitated people in the hospital environment today. As White (1905) in the book *Ministry of Healing* encourages, "Christ's method alone will give true success in reaching the people" (p. 143).

The people's critique of Jesus' ministry was that He communicated exceptionally and they flocked to him (Mark 2:13; 4:1; 6:2, 10:1) unlike the teachers of the day whom often lacked authenticity (Mark 1:22, 27). Many benefited not only from His instruction but physical and spiritual healing accompanied the teaching (Mark 1:32-34; 2:1-12) illustrating His desire to heal the whole person. This emphasis comports significantly with Jesus' mission of "preaching the gospel of God" (Mark 1:14) "for that is what I came for" (Mark 1:38). Credibility is attained when actions, principles and values match what is taught and promised. Jesus is often ascribed as the Teacher, which complements His role as a mentor to His disciples as He advocates for those He encounters, many of whom feeling understood for the first time. Jesus is seen in the pericopes as enacting the values and spiritual principles of His message and the attitude of God is incarnated in the actions He performs. The patient interviews and the literature will illustrate that there can be no perception of distance between the attitudes and actions of healthcare personnel and the identified values and spiritual principles Jesus sought to communicate to His disciples, and healthcare personnel must recognize that inconsistency in practice communicates negatively in the minds of patients and their families.

CHAPTER 3

REVIEW OF LITERATURE ADDRESSING THE RELATIONSHIP BETWEEN HEALTHCARE PROVIDERS, PATIENTS AND THEIR FAMILIES

Introduction

After debriefing patients' status with a nurse I began my morning rounds on the unit as I customarily do each day. From a distance I heard signs of distress in one of the rooms near the nurse's station and turned to see the same nurse making his way quickly to a room I had intended to visit a little later. Shortly he emerged from the room and called to me that I might be needed. Pulling on a pair of gloves as I walked, I could hear the increasing urgency of the family member's cries emanating from the room. It was obvious even to a lay person as I arrived at the bedside that our patient was likely beyond the reach of any human help.

While the nurse paged the doctor, I offered support and consolation as the mother wept and embraced her son. While waiting for the doctor the nurse and I continued to minister to the patient and his mother, answering questions, and providing water and repositioning a chair for her. Appropriately, she responded to an invitation to pray with her after a little time had elapsed. Presently the intern entered the room, and after quickly scanning the monitor, moved to the opposite side of the bed from the mother. His unimpassioned manner was striking; limited solely to clinical comments and actions. Two to three minutes elapsed in which nothing except medical jargon was spoken. His

detachment was so noticeable that the words offered to the mother, “He’s dead, I’m sorry,” seemed to fall like lead on the floor. The clinical needs were met, but lacking was the human to human interaction in the face of one of life’s cruelest moments; the death of a child. This absence of responsive communication compromises the otherwise excellent medical care that is available by diminishing the relationship that makes it possible.

Issues of Communication and Congruency in the Relationship

The phrase, "what we've got here is failure to communicate," taken from the film *Cool Hand Luke* (Carroll, 1967) aptly describes why a significant number of patients and healthcare providers are frustrated with the hospital or clinic experience. A growing interest in all aspects of patient care other than primarily the physical injury or disease process has been building for decades now, though healthcare practice lacks consistency of implementation in the patient/provider interface. Davis, Foley, Crigger, and Brannigan (2008) capture some of the scope and the implications of what healthcare might look like if effective communication was normative.

The optimal relationship between healthcare provider and patient is one of trust. This therapeutic relationship is dependent on the ability of the healthcare provider to communicate effectively with the patient. Research indicates that when healthcare providers listen to patients, there is more compliance with medical regimens, patient satisfaction is increased, and physicians are less vulnerable to malpractice lawsuits. Within the last few decades, the relationship between physician and patient has been reconceptualized from a paternalistic relationship to a partnership between provider and patient. This change is demanding a shift in how healthcare providers communicate and, in particular, listen to patients. (p. 168)

The impact of life-changing illness or devastating injury on a given person is an existential reality that onlookers struggle to assess at a meaning level. Individual diversity of life experience, emotional and psychological wholeness and tolerance of uncertainty

and pain each contribute to the context in which caring for this man or woman's health will take place.

Trust

From the outset, issues of trust will arise that must be satisfied before confidence in the medical team is established and care initiated (Laino, 2009), even for a doctor who became a patient (Manheimer, 2011). The establishment of a working trust relationship between the healthcare team and the patient is an important first work otherwise the delivery of care may potentially be fraught with resistance. Morse (1991) comments on one of many aspects of the caring relationship between the patient and provider in the hospital:

Relinquishing oneself to the patient role requires more than blind faith in the nurse's technical competence; the patient trusts the educational, licensing, hiring and supervisory system to ensure that a nurse knows how to satisfactorily perform a task. (p. 460)

Morse (1991) states that it takes time to learn to "mutually respect, trust and care for each other" (p. 459). Triangulated relationships between the medical team or with family members where the patient senses information is being withheld from them will interfere with the "development of trust between the nurse and the patient" (p. 464). Even charting of confidential patient information necessary for effective team processes may "seriously undermine the patient's trust in the system" (p. 464). These dynamics can result in patients becoming "difficult," and manipulative, seeking to "change the nurse patient relationship by increasing the investment of the nurse in their care to promote the relationship" by giving gifts (p. 461). Conversely, according to Morse, trust building can build effective working relationships with medical staff. Substantial and earned trust is

the basis for effectively guiding the patient through accepting and managing the illness and consequent treatment regimen.

Building rapport between the healthcare provider and the patient is “critical to forming effective and trusting relationships with patients” according to Ferguson and Candib (2002) and it increases “patient satisfaction, trust, and compliance” (p. 359). Smith, Adam, Kirkpatrick, A. McRobie, and McRobie. (2011) emphasize that taking the steps to identify the patient’s concerns allows healthcare providers to provide personalized care which inspires “confidence and trust” (p. 43). While primarily directed toward nurses and nursing, these remarks are pertinent to physicians and other healthcare disciplines as well. Anyone who has been hospitalized with a serious illness will readily identify with the issues surrounding trust that those to whom they trust their lives and recovery are diligent in all aspects of their care. Patients who know the consequences worry when their care providers skip basic hand hygiene before handling items used in their treatment. The list of issues contributing to a patient’s trust in the system is extensive and trust builds or diminishes over time. Healthcare providers must intentionally have the patient’s best interest in mind at all times.

Fear

Closely allied to trust is fear. The uncertainty of outcomes and concerns over the process and duration of treatment raises anxiety for all parties involved. Many components contribute to the mindset of a patient that morphs from an expected nervousness about their condition to a deeper foreboding as time continues. Medical personnel should anticipate these feelings and proactively seek to allay the fears of patients by their words and demeanor in every reasonable way possible (Josephson,

2011). Puchalski, Dorff, and Hendi (2004) nicely focus the clinician's opportunity in the following statement:

One of the key components of this relationship is the ability of the clinician to be totally present to their patient (i.e., the practice of compassionate presence). This means that the clinician should bring his or her whole being to the encounter and should place his or her full attention on the patient and not allow distractions, such as time pressures, focus on the biomedical aspects of treatment, or other thoughts, interfere with that attention. Integral to this is the ability to listen to the patient's fears, hopes, and dreams and to be attentive to all dimensions of the lives of the patient and the family: the physical, emotional, social, and spiritual. Some clinicians suggest that current medical practices do not allow enough time for this. Being wholly present to the patient is not time dependent, however. It simply requires the intent on the part of the clinician to be fully present for the patient. (p. 711)

The interest in and ability to enter the patient's world should be endemic to good patient care. For patients to have someone to listen to their fears and share in their concerns in a collaborative manner is a significant step in the healing process as ongoing studies continue to support (Burgener, 1999). Authors Berger, Shuster, and Von Roenn, (2006) add that sharing of this kind allows for encompassing the spiritual dimension as well. Puchalski et al. (2004) in the article above describe the relationship between the patient and the clinician as a caring partnership (p. 689). Berger et al. (2006) and Richmond and Middleton (1992) each highlight that the possibility of dying crosses patient's minds and clinicians should have that awareness in view during their conversations with them. If the nurse is present when the doctor makes rounds he or she should return at a later time to clarify any issues with patients and relatives and to "allay fears and concerns (Desai, Caldwell, & Herring, 2011. p. 34). But fear is not limited to patient experiences.

Family members likewise have many of the same concerns as expressed by Paget and McCormack, (2006) where, "The ER doctor was ready to pronounce her dead, but

her adult children refused to have the ventilator disconnected for fear of ‘killing Mom’” (p. 54). It is not unrealistic to imagine, as numerous family members have, that in some way by giving assent to discontinue life support that they had in some way ended that person’s life. The skilled clinician at that time would not want to rush the decision without devoting an appropriate opportunity to listen and understand the emotional and spiritual reservations of the family. Khan (2008) and Landro (2011) address the fact that many doctors fear dealing with patient’s psycho-spiritual concerns lest they overstep boundaries, appear incompetent, risk giving offense, or it will take too much of their time. In summary, regardless of the concerns, chaplains and healthcare personnel should work as soon as possible to dispel unnecessary fears that may arise as patients and families engage the medical environment (Flannelly, Galek, Tannenbaum, & Handzo, 2007, p. 24). Implementing this strategy would qualify as a best practice initiative for whole person care.

Communication

The forgoing discussion introduces the necessity for healthcare personnel to carefully evaluate the effectiveness of their communication with patients and families. While some medical needs seem to indicate obvious treatment responses, skilled physicians are cautious about short-circuiting the work up without proper inquiry lest important information be overlooked. Time invested at the outset of the consultation may result in a much enhanced response to the patient’s presenting condition. More than that, gaining the patient’s confidence and cooperation is a valuable goal as Sapolsky (1965) indicates in this statement:

Implicit within the treatment setting was the expectation that the doctor would strive to understand the patient. If he were able to communicate in a manner which resulted in the patient feeling understood, that patient's response to his doctor would likely differ from that of the patient who did not have the subjective feeling of being understood. (p. 71)

Davis et al. (2008) state that the momentum for improving bi-directional communication between the clinician and the patient and family has been strengthening since at least the 1970's (p. 170). Puchalski and Romer (2000) observe that historically medical schools have majored on the technical aspects of care resulting in graduates ill equipped to facilitate conversations about "end-of-life decisions or nonphysical suffering" (p. 130). The situation has improved somewhat in more recent times according to Davis et al. (2008), and Desai et al. (2011) with improved training and competency requirements in communication skills. But deficits remain when it comes to communicating with other health professionals. Davis et al. (2008) also lament that research on communication for practitioners and theory development is lagging in the current professional literature. An earlier comment by Morse (1991) highlighted a need to upgrade the communication skills of nurses from the default stimulus-response model to a more relational approach (p. 455). Clearly, broadening the curriculum with both mandatory and elective modules in communication theory and simulation would better prepare healthcare personnel in this area. The question that remains is; what do patients want from their consultation with a physician or other healthcare worker?

Serling (1964) in the *Twilight Zone* episode *The Masks* features a series of interactions between a dying man and his doctor. Many post WWII generation Americans can recall, as I do, the image portrayed of the family doctor interacting with his patient. In this longstanding relationship the doctor has stature and he and the patient have

developed respect for each other so that at this crucial time the needs of the patient and the expertise of the doctor are mutually appreciated. How differently this image of the doctor who does house calls appears, to the way healthcare needs are often addressed today. The challenge that has arisen in the intervening decades is how to best service the huge numbers of people seeking health care, without sacrificing the personal touch that characterized earlier times.

A compelling number of authors cite communication as an essential element in healthcare practice. Most clinicians are proficient at providing information, but patients too want to express how the illness or injury is affecting them. This calls for the healthcare worker to pause and listen to the patient's assessment of their condition. These interchanges call for what Davis et al. (2008) and Berger et al. (2006) term as effective listening. But listening is much more than hearing as Jesus taught long ago; "HAVING EYES, DO YOU NOT SEE? AND HAVING EARS, DO YOU NOT HEAR [Emphasis Original]?" (Mark 8:18). Patients bring much more than a specific symptom or injury into the hospital when they seek help and healing. Depending on the nature of the complaint a considerable range of thoughts, emotions, and questions along with the physical manifestations will be vying for attention.

Communication and in particular listening to patients is important according to Davis et al. (2008). Furthermore, he emphasizes that this communication is a "two-way street where both parties have a stake in how well the other listens and attends to the sharing of information" (p. 172). It is a collaborative partnership with no preconceived agenda except a commitment to be fully present with the patient (Berger et al., 2006). Some may argue that the time constraints in the current medical practice and the numbers

of patients that must be seen allows little margin for extended patient visits (Snyder, 2008; Snyder, 2009). But listening is not entirely time-dependent, requiring only that in the available time the physician be fully present to the patient and family (Berger et al., 2006; Puchalski, Dorff, & Hendi, 2004). The literature describes this approach as active-listening where each party devotes themselves entirely to the conversation in order to reach a fuller understanding of the other's point of view (Kliwer, 2004). This is not to deny that on some occasions the situation may demand an extended visit in order to comprehend the complexities of a case (Miksaneck, 2008; Tetz & Bell, 2005).

Almost everything that pertains to the doctor-patient relationship applies to the doctor-family relationship as well and Davis et al. (2008) concur. Developing a rapport with family carries added significance if the patient is unable to communicate effectively due to the debilitating effects of the disease process, powerful medications, excessive tiredness, altered mental status, infections that affect cognitive functioning, and chemical imbalances in the body due to organ failure. Additionally some patients prefer to largely absent themselves from the decision-making process in accord with the way they have lived their lives to this point. While this is not an optimum circumstance, family or even designated friends find themselves elevated to default decision-makers carrying the burden of interacting with medical personnel on a regular basis. Hence the importance of developing working relationships with family is highlighted in these situations.

Effective communication in the medical setting involves much more than asking questions and receiving answers to those questions. A full chapter in their book *Spirituality, Health, and Wholeness* (Sorajjakool & Lamberton, 2004) is devoted to exploring the cultural implications related to healthcare. A search in the Library of

Congress catalog in March of 2012 yielded 78 entries with culture and healthcare in the titles. An age of increasing diversity in languages, religions, cultures and lifestyles introduces levels of variability into communication that impacts the assessment of patient needs and the delivery of healthcare (Kizilhan, 2011). Patients can experience significant levels of frustration when they feel that they are misunderstood or not even listened to. Let me elucidate by providing an example of my own at the simplest level to illustrate the complexity that all must cope with. I was present with an older patient when his physician entered the room seeking consent for a small procedure. Unfortunately the doctor's heavy Indian-English accent together with the patient's hearing deficit rendered the conversation for him unintelligible. I assisted by repeating the doctor's information and requests into a form that he could understand and the needs were met.

The goal of medicine is to examine the patient when they present with a medical complaint and come up with a differential diagnosis (Fuentes, 2011). A physician's training is to define a list of symptoms and come up with a working diagnosis; order labs, decide upon a diagnosis and define a treatment list. It's all very straight forward and methodical and deviating to deal with emotions doesn't work well. Physicians are very good at working with facts but often feel out of depth relating to the emotional and spiritual. Given the task-oriented approach to their work; see a problem and fix it, doctors sometimes struggle with situations they cannot resolve satisfactorily (Baker, 2000), confessing to feelings of failure (Chustecka, 2009). Secondly, regulations and insurance providers have guidelines for the management of care when further treatment is considered to be "futile" Hospice services may be advocated at this point if the patient qualifies. The point of severance in the physician-patient relationship can come as

abruptly as the statement “We have used all of the treatment options that we have; we cannot do any more for you” One author described this shelving of responsibility in these words:

It must be news plus plan of action. Some of the worst actions I have seen in medicine are by physicians who hit and run, "drop the bomb" of the news, walk out, and somehow expect others to pick up the pieces. It is bad practice. It does happen. (Gilbert, 2001, p. 9)

Berger et al. (2006) however, stress that patients who are dying, and their families, look to the physician who has been providing care hoping to find an empathetic ear to “their unresolved conflicts, their hopes and their despairs” (p. 634). Earlier articles had also highlighted this need (Wilsterman, 1998). In this light almost all of the disease and injury conditions carry a spiritual dimension whether recognized by the parties or not. Questions regarding the meaning of their lives now, and in the future, with the limitations or quality of life that remains crowd the mind at opportune moments. Often during the long hours of the night when the usual round of activity has subsided, and sleep is denied, existential concerns with no easy answers surface. It is here according to Berger et al. (2006) that the alert physician can listen with respect to the patient’s spiritual beliefs, concerns and their preferences at the end of life. Patients don’t expect doctors to be theologians, but they would appreciate the physician who has guided their care during this hospitalization to spend some quality time with them as they attempt to integrate their medical situation into the social, emotional and spiritual aspects of their being. Nurses often find themselves as de facto physicians attempting to carry this kind of a conversation and fill the absence of a doctor who is just not available or lacks the necessary communication skills.

Some nurses perceived that given a choice, patients would prefer it to be nurses who undertook certain technical activities. The implication was that patients find doctors difficult to communicate with because of their status: I think the patients are more at ease with us doing these things because they can relate to us more easily. (Jones, 2003, p. 129)

An interesting corollary to this discussion is the changing roles of nurses and doctors as the boundaries between medicine and nursing shift to accommodate other changes in healthcare to better manage financial allocations. Nurses are taking on more tasks formerly assigned to physicians and physicians are placing more emphasis on communication (Collins, 2005). It is likely that if doctors genuinely open themselves up towards communicating with patients then more patients will feel secure enough to share their deeper spiritual pain as well.

Compliance

For doctors seeking to maximize their efficiency effective communication with their patients holds additional benefits. The most intuitive diagnostics and the most comprehensive treatment plan will accomplish little if the patient won't follow the recommendations. The foregoing discussion has emphasized the value of gaining the patient's trust through good communication; it lays the groundwork for ongoing compliance in a partnership of care. Miksanek (2008) describes the rationale in this manner:

Extended visits would likely improve patient and physician satisfaction, improve compliance, and upgrade the quality of care. Providing people with more face-to-face time with their doctors does more than merely help communication. Longer visits might actually be more cost-effective than brief ones by reducing the need for frequent follow-up appointments, curtailing the number of consultations and second opinions, decreasing excessive testing, cutting down on the cost of transportation and gas consumption necessitated by repeated short visits with the doctor, and minimizing the amount of missed work for numerous appointments. (p. 1428)

Berger et al. (2006) and Davis et al. (2008) concur that compliance is potentially maximized if the relationship between the provider and the patient is well established.

Patients often resist the therapeutic intent of the clinicians because they simply have not understood or are afraid of the consequences of the procedure or medication. Sometimes they recall a former negative experience or they know of a relative or friend who experienced a bad outcome. If the doctor or healthcare worker takes the time to carefully listen to the concerns, noting the patient's feelings or suspicions and then provides a reasoned response with opportunity to receive additional feedback then the chances of cooperation is greatly enhanced (Stewart, McWhinney, & Buck, 1979). Ferguson and Candib (2002) term this process "rapport building" which can ultimately lead to greater compliance (p. 354). The reasons why patients and physicians fail to engage in a healthcare partnership are complex but one factor that is almost always overlooked is the patient's attachment style. Adshead (2010) mentions how this insecurity might play out in the hospital:

Studies of patients with medically unexplained symptoms and chronic psychosomatic disorders show an excess of insecure attachment, principally ambivalent attachment. Patients' attachment styles can affect their relationships with health care professionals adversely and can also affect treatment and medication compliance. (p. 127)

Again, statements like this should heighten the awareness of each health professional that any one of a range of factors may be at the root of noncompliance to the recommended therapeutic regimen rather than pure recalcitrance. Great value exists in availing as many of the continuing education opportunities as possible in order to be informed on identified issues, and strategies to manage them. Intentionality of practice rather than stimulus-response is the preferred model of healthcare delivery (Reese, 2011).

Patient Satisfaction

The medical literature contains a wealth of references to the relationship between good communication and in particular listening skills that contribute towards patient satisfaction. The issues are not only of local import, as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) compiles statistics that rank hospital performance according to this variable. It is evident that a successful surgery or a return to health after a debilitating disease is not rated as highly as the quality and extent of the communication experienced by the patient. Indeed the studies made at 2500 hospitals in the United States show that higher patient satisfaction with the care resulted in lower 30-day readmission rates in the clinical areas surveyed (Boulding, Glickman, Manary, Schulman, & Staelin, 2011). Acceptability for polling consumers regarding satisfaction or dissatisfaction with their medical care began to take root in the late 1960's and has become one criterion for measuring excellence (Hulka, Zyzanski, Cassel, & Thompson, 1970). But reservations remain if the emphasis is misplaced. For Leebov (2008) and Boulding et al. (2011) the focus should rather be on paying better attention to patients, reducing anxiety, being fully present in the time with the patient and being mindful about what you are doing. Unfortunately, according to Leebov, sometimes the approach is just to make the patient "happy" rather than the more comprehensive concept "satisfied."

Borrowing the customer service mindset from the entertainment and hospitality trades, many healthcare leaders stress the importance of making patients happy. The response of many nurses is something like: "This is health care, not Disney!" For many nurses the focus should be reducing patient anxiety, not making patients happy. (p. 23)

Leaders must also be consistent in their approach to patient satisfaction, according to Leebov (2008), lest their staff see the ambivalence and not take their part in this seriously either. Clucas et al. (2011) see increased patient satisfaction as associated with fewer readmissions and better health outcomes “and reductions in the number of medications prescribed and in medication-related problems” (p. 88). One additional correlation deserves mention and that is doctors and other healthcare workers who talked with their patients about their religious and spiritual concerns, even if they did not request the conversation, resulted in improved patient satisfaction (Williams, 2011). The reverse also carries some support; satisfied patients enhance nurses’ satisfaction with their jobs because one of their main roles is to help patients (Smith et al., 2011).

Legal and Ethical Risk

Another significant concern that is associated with providing healthcare aside from shrinking reimbursement margins is unease over possible malpractice lawsuits. Doctors fearing legal actions are more prone to practice defensive medicine, ordering additional tests which in their clinical judgment are probably unnecessary thereby risking upsetting patients and delaying their discharge (Hermer & Brody, 2010). The increased cost of defending against dissatisfied patients is not inconsequential.

A similar cost increase came as the result of rising insurance premiums during the seventies and into the eighties. Dissatisfied patients increasingly resorted to malpractice suits resulting in massive judgments. Premiums for insurance escalated with costs being passed on to consumers through rising room rates. Multiple increases of \$25 to \$40 in daily room rates were not untypical. Doctors, fearing malpractice suits, began practicing “defensive medicine.” (Richmond & Middleton, 1992, p. 33)

The literature supports proactive healthcare practices that emphasize developing a substantial trust relationship with both the patient and family through effective

communication. Davis et al. (2008) and others in the foregoing discussions clearly articulate the multiple benefits associated with intentional reciprocal dialog. Specifically, he states that, “researchers have investigated the impact of communication breakdowns on malpractice lawsuits and have found that medical practitioners with good communication and listening skills are less vulnerable to lawsuits” (p. 171). Clearly this fact should incentivize all healthcare providers, including chaplains, to carefully evaluate their communication style and seek training if problems continue to surface as finely tuned people skills are invaluable in every care context (Culbertson, 2000).

Paternalism

Given the significance of the issues raised above it is worth considering the mindset that is brought to the bedside conversation. Paternalism, as it impacts patients and families in the healthcare setting, is the final component of attitude that will be addressed in this review. A general recognition prevails that the paternalistic approach to medicine is resented by patients and has diminishing support in the medical community itself (R. Calne, J. Calne, & Calne, 2009; Davis et al., 2008; Smith et al., 2011). In more recent times clinicians have settled on a preferred model of relating where the patient and the clinician partner in the former’s care (Gandey, 2006). Calne et al. (2009) describing the new relationship in this way:

Whereas medical paternalism had the doctor at the centre of the relationship giving the patient advice and treatment, supposedly without much input from the patient, by the late 1990s there was a gradual but substantial shift towards what is now referred to as ‘patient centredness.’ (p. 996)

Resistance to change in a decade’s old approach still continues, with some valid concerns remaining to be assuaged. Both Calne et al. (2009) and others agree that paternalism is

outmoded but that, “there is a danger that paternalism has been replaced with more autonomy than vulnerable, sick and fearful patients can manage” (p. 998). Author Gethmann-Siefert (2003) likewise presents a robust discussion highlighting concerns on this topic. Medical needs often contain complexities that substituting a new patient choice model without adequate forethought may carry unintended negative consequences. There can be no short-circuiting the discussion that comprehensively represents the options, benefits, risks and costs associated with medical interventions.

The secular and religious literature reviewed in this chapter allows for the integration of the 13 spiritual principles and values discussed in chapter two. Nothing learned to date is averse to the ideals illustrated by Jesus in His ministry for people in various situations of need. Different names and sometimes similitudes capture the essence of what genuine caring means to patients in the hospital. Chaplains in their role are sometimes the intermediary that demonstrates to the entire healthcare team how these principles and values are interpreted in the patients care.

To bookend the case example at the beginning of this review, we may ask the question about what a more optimal physician-patient interaction would look like if the relevant spiritual principles are incorporated. The following story captures many of the elements that illustrate a true partnership between the physician, patient and family that will endure the difficult moments when tough decisions must be made. Further it illustrates the commitment that each has put into the relationship in order to achieve the desired outcomes. Lastly the story evidences the satisfaction that each realizes from the journey to wellness that has been shared that is above monetary compensation.

While participating on rounds with the plastic surgery team I witnessed a patient being understood. The physician conducting the rounds was surrounded with

approximately six students and the chaplain. As we entered the room I noticed the patient had tubes in his mouth. Though fully alert he could not communicate verbally. The physician wanted the students to understand the history and concerns of the patient. Without notes or a chart the physician walked us through the man's family and medical history. He spoke of the patient's little son and daughter and how he longed to go home. He then reflected on the patient's spiritual resources with the Catholic Church and the good support he was receiving from his family. The doctor also expressed the patient's fears accurately. The patient's eyes were locked on the physician as he spoke. Unsolicited, he reached out and squeezed the doctor's hand. Later, the family said their loved one felt like we really understood his plight because of the way the physician summarized his situation for the students. (Sorajjakool & Lamberton, 2004, p. 106)

Chaplains as Modelers of Dialog in the Partnership

Workplace Stressors in the Context of Care

Tension exists within the healthcare setting at all levels from administrators through employees of every discipline and service. The perception of providers is that there exists too little time to implement all of the treatments and interventions that are needed for patients who along with their families, for whom time appears to drag on endlessly, wait for the relief from suffering they seek. Frustrations with patients continually seeking to access care from medical personnel are sometimes conveyed during the visit as indicated in the following statement.

Given the pressure to see as many patients as ethically possible during the day, it is unsurprising that physicians might sometimes project frustration with their inability to resolve the patients' illnesses onto the patients themselves. (Wagner, Warren, & Moseley, 2010, p. 302)

Economics can drive the way care is delivered and the doctor-patient relationship may suffer as a consequence. It is right here that alienation of the patient begins to build. Unfortunately negative attitudes come in many guises. In an article discussing people with disabilities, the authors found that negative attitudes can also impact the delivery of healthcare (Tracy & Iacono, 2008). Attitudes such as ageism can likewise subtly and

sometimes not so subtly affect the way care is delivered to hurting people. A study regarding changing nursing students' attitudes was done in 2008 to help improve recruitment of nurses (Ferrario, Freeman, Nellett, & Scheel, 2008).

Great diversity is represented in these individuals as well. Consider the variety of tensions that exist in the environment of care from all parties. Administration concerns itself with regulations from the various health and state authorities as well as the need to maintain financial solvency. Place large numbers of professionals in a highly regulated environment with tight scheduling and often taxing physical and mental challenges and significant stress is generated among all parties (Stokowski, 2011). Patients come seeking healing sometimes for basic needs or more commonly a major health crisis. The fact that misunderstandings occur and emotions run high on occasion can be understood when this scenario is explained. Into this volatile environment the chaplain often enters, or is called to resolve an incident with an angry patient. The words, "The patient may benefit from some spiritual help," is the introduction provided by the doctor or nurse.

Patients Distressed by Illness or Injury

The prospect of an extended stay in the hospital or a diagnosis of terminal illness may create an intense spiritual crisis. Patients do not check their spiritual worldview, spiritual needs, or spiritual concerns at the door when they become ill (VandeCreek, 2004). When an event or condition disturbs, distorts or destroys an individual's life journey or threatens their very existence as a person, they may experience intense spiritual pain (Puchalski et al., 2009). The chaplain, as an interdisciplinary team member, is trained to help facilitate the integration of this crisis into a life perspective that will foster hope allowing them to focus on getting well as much as is possible.

Catalytic Role of Chaplains in the Environment of Care

Chaplaincy is a particular ministry that differs in a number of ways from the parish or church setting. In the place of worship there is a consensus of belief, but on a given hospital unit many belief systems may be represented as well as variations in belief within the religion or denomination. A proportion of the patients and families entering the hospital may not have any religious affiliation or even any interest in religion at all. None of these contingencies would necessarily deny a person from availing themselves of the services of the hospital chaplain. While the chaplain may offer to reconnect people estranged from their church or religion if it is desired, this step is not mandated in order for a person to receive the spiritual help that they seek or need.

Chaplains are intimately involved in modeling communication skills as they minister to the most difficult and diverse situations facing patients. Chaplains are often heavily involved with the trauma units and Emergency Departments modeling death notifications and assisting physicians with speaking to families after the death of a loved one (Zanger, 2002). Recognition for the strength of this role has been slow to gain traction as shown by a survey taken among medical professionals where chaplains were seen as less important by physicians than other medical personnel (Flannelly, Galek, Bucchino, Handzo, & Tannenbaum, 2005). Another study lead again by Flannelly, Handzo, Weaver, and Smith (2005) emphasized that chaplains were better recognized by administrators for their work in supporting the spiritual needs of patients though providing emotional support for staff received a lower rating. In the environment of care, chaplains model spiritual care and support as the prerogative of every team member, not the responsibility solely of the chaplain (Craigie, 1998).

Economic uncertainty and reimbursement changes place strains on administration to more efficiently manage healthcare delivery; such constraints filtering down to clinicians in every discipline resulting in increased stress and burnout (West, Dyrbye, Sloan, & Shanafelt, 2009). Chaplains, while not immune from these concerns themselves minister among staff anxious about their futures. Further recognition of the tangible benefits of utilizing chaplains, is the diversity of roles and experience they can bring to the workplace when change is taking place. This has been realized in a Canadian study (Damore, O'Connor, & Hammons, 2004). There is a real value to be leveraged due to the chaplain's skills, respect for confidentiality, and experience with handling crises (Gibbons, Thomas, VandeCreek, & Jessen, 1991). Being already on site and providing 24-hour coverage lends utility to the role which often calls for extended face to face interaction.

When patients are sick or injured they desire and need medical care. In order to maximize the provision of that care, as the foregoing discussion has revealed, patients and families must be listened to, understood and have genuine opportunity to partner with their care providers in realizing the goal of the directed therapies. Cross-discipline interactions where the patient reaches out to the chaplain for medical advice or the physician for spiritual support are not uncommon (C. Corr, & Corr, 1983). It is to be hoped that when a spiritual need is identified, a response will be provided at the time, and/or a referral made to chaplain services. This has not always been effectively completed by non-chaplain staff (Koenig, Bearon, Hover, & Travis, 1991). One physician statement captures the need for awareness and balance in this way: "Your medical needs are important to us, but we're also concerned about your emotional and spiritual well-

being. Let's talk about that" (Gardener, 1985. p. 138). The chaplain seeks to weigh each of the areas of need in order to provide balanced care. Spiritual care may be desired by the patient and/or family and the needs of each may be quite different. Often the most effective support provided is to simply listen attentively to the patient and/or family member's story, particularly as it has developed in recent weeks or months. Chaplains understand that in verbalizing their story, a person stands to benefit by receiving constructive feedback.

A further recognition is that people who are very sick struggle to concentrate and tire easily. Visiting and processing difficult parts of life drain the available energy reserves. Healthcare personnel would do well to monitor the ability of a patient to focus on the conversation particularly when significant information is given or consents are requested. The chaplain observes the patient carefully and knows when it is time to pause the conversation and leave. There are a number of direct and indirect ways to accomplish this so that the patient will understand and look forward to the next visit. Often the time can be split between the patient and the family in order to transfer the direct attention from the patient, yet still accommodate both needs on the same visit. A summary of the chaplain's role and his/her relationship to the healthcare team is provided in the following statement:

While any and all members of the health care team can and should do so, often it is the Chaplain, and all he or she represents, who most helps humanize the situation. The Chaplain, by honoring the autonomy and integrity of the patient, being mindful of the patient's core concerns about being, belonging and doing/responding, connecting the patient to his or her own vitality, support and faith, offering conversational medicine and accompaniment on this stage of the journey, in these and other ways offers pastoral care through the ministry of visiting the sick or making calls in the hospital. (Ledbetter, 2001, p. 64)

By virtue of the chaplain's involvement on the care team ample opportunity exists to model attitudes towards patients and their families that integrate them as partners with the team in their own care. Chaplains model an unbiased approach to ministry with patients and families that is free of proselytizing as underscored by this Buddhist chaplain (Monnett, 2005), an Islamic physician (Khan, 2008) and Joint Commission which sees it as an ethical requirement (Hodge, 2003). As a primary "function of their pastoral call and responsibility, chaplains aim to offer a sense of God's attentiveness and compassion in the midst of suffering and struggle" (Piderman et al., 2008, p. 58). Working together with a holistic framework builds the integrity of the entire healthcare team as all are united with the patient and family in seeking a successful outcome for this admission. As the chaplain builds standing in the team opportunities to dialog with other disciplines and to demonstrate ways of relating in diverse situations these models can be observed by team members. But long-held practices and views naturally resist new approaches as Khan (2008) again observes:

The eclipse of spiritual and religious concerns in the practice of modern medicine has a root in the process of modern medical education. Adequately caring for a patient involves a mastery of multiple disciplines that, through thousands of human interactions, evolve into a unique and highly nuanced "skill set," the use of which, after rigorous primary training, is whittled into expertise that is specific for a particular specialty or subspecialty. (p. 79)

Established patterns of relating are not overcome or relearned overnight hence the need for chaplains to consistently model both verbal and non-verbal attitudes with patients, families and other team members especially when tensions are high. Fortunately, a partnership model is replacing paternalism in healthcare in recognition of the vital role of effective communication between medical workers, patients and their families (Davis et al., 2008). Recognition is also given to the fact that trust is lost when care providers

disregard the importance of developing a working relationship that endures even when bad news has to be conveyed. He notes that mistakes, lawsuits and bad patient relations stem from poor communication skills. The bidirectional model of communication now gaining ascendancy in healthcare training promises to reduce tensions and improve patient satisfaction with the stay.

Conclusion

Following the example of Jesus, chaplains seek to invoke healing of mind and spirit, as well as the body, while a patient is in the hospital. Jesus likewise modeled the preferred approach through His interactions with sick, alienated and discouraged individuals as He provided the healing they sought (Augustinsen, 2010). The journey to that destination may be fragile and circuitous at times as the interplay of emotions; fear and stress make its inroads. In this stress-laden context, the value of excellent communication skills by all participants, and a preparedness to cede the argument and listen carefully to others unless a moral, legal or ethical concern is at stake, may be the wisest course to pursue. The value of good, clear communication is thoroughly discussed by Graff and Birkenstein (2006), and while the book deals primarily with writing style, many of the concepts of listening and thoughtful responses carry over into oral expression. A retired physician summarizes the value of allowing the patient's need to emerge from their story in the following words:

Both patient and physician bring to the clinical setting an up-to-the-moment, personal story. Each story has an unspoken cumulative effect on how the patient and the physician understand and respond to each other—on how they communicate—and on their attitude. Where the attitude is one of trust, hope, courage and love, the mutual spiritual effect is dynamic and even beyond the highest expectations! (Alexander, 2008, p. 184)

Hospitals are places where it is crucial for communication to be carefully and respectfully expressed to the satisfaction of all parties. Thus I see as a central issue in this project concerning episodes of discord on the units, a failure in ensuring that effective and considerate dialogue has been delivered. It is only when each person lives up to their God-inspired mandate to treat every other person with the courtesy of full and undivided attention to their communication that the hope of a more harmonious working environment in the hospital will be achieved. The first step entails giving the time and intentionality to get the message right at the beginning.

CHAPTER 4

IMPLEMENTATION AND REFINEMENT OF A PROCESS TO MODEL THE PROVISION OF WHOLE-PERSON CARE BY HEALTHCARE PERSONNEL TO PATIENTS AND FAMILIES AT LOMA LINDA UNIVERSITY MEDICAL CENTER

Introduction

This chapter describes the methodology of the study. The research design and research questions are discussed along with a description of the population and data collection. The purpose of this study was to gather patients' assessment of their interactions with medical personnel while in the hospital regarding their level of satisfaction with the conveyance of information, responsiveness to needs, and respect for personhood; and to describe a model of care that promotes a genuine response to the concerns raised.

Development of the Intervention

The nature of the project task suggested an approach best illustrated by Jesus' interactions with individuals and groups during His ministry on Earth. He met with people experiencing varying levels of discord as they sought relief from their health, financial or social suffering. Some of the values that surfaced during the "visits" included facing social stigma, invoking and respecting appropriate authority, legitimizing physical, emotional and spiritual closeness, isolation, choice, forgiveness, alienation, and compassion; all of which relate to the whole-person care context in the hospital.

Individuals sought Jesus out because they were not receiving the help they desired, they had exhausted the resources available to them or they were alienated from the arena where help was normally provided. Not uncommonly individuals complained that the attitudes of those controlling access to help discouraged securing the help they needed. Patients experiencing medical isolation today face certain access and attitudinal constraints from caregivers that lepers and the insane experienced in Jesus' time. Fear of contamination in the first century is reminiscent of the early days of the AIDS epidemic where extraordinary means were used that shut people away from meaningful human contact. Jesus demonstrated repeatedly that every reasonable means should be exerted to ensure that whole-person acceptance within the physical, social, emotional and spiritual context was addressed.

The literature over the last four decades at least increasingly encourages developing a relationship of trust between the patient and the healthcare provider. In order for this to occur, meaningful two-way communication must be established and maintained throughout the hospital stay. Doctors, nurses, therapists etc. should ideally be proactively soliciting their patient's understandings and regularly informing them of progress and options for their ongoing care. Making this an intentional practice increases patient satisfaction and trust and buys credibility with the patient for when hard decisions must be made. Medical personnel should aspire to partnership with their patients rather than the paternalism of previous times. As the patient interviews repeatedly affirm, intentional listening to the patient is a practice that must be factored into the caregiving and this cannot be underestimated if whole-person care is the goal. Surgeon Levy describes the concept this way:

Whatever our profession or station in life, I believe that we all desire to make a difference in the world. In caring for the whole person in my surgical practice, I have encountered life-changing responses that go far beyond the procedures I perform. As with anything of value, though, there is a cost involved. For example, time is a limited resource; each of us is given the same daily amount. In my practice, my schedule needed to change to allow time for those in need. (Levy & Kilpatrick, 2010, p. 304)

Description of the Intervention

Design

Qualitative research was chosen to realize the goal of identifying and developing understandings of the meanings of the sentiments expressed by patients in the interviews that were conducted for this project. One author commenting on qualitative research offers, “Each story described, each experience recorded, reveals a different perspective on the particular reality that is being examined” (Swinton & Mowat, 2006, p. 36). The aim of the interviews was to record perspectives of patient encounters in the hospital as they experienced them so that an enhanced relational model of care may result.

Intervention Details

The intention with this project was to interview cardiac patients at Loma Linda University Medical Center while they were hospitalized and gain from them insights that spoke to the way whole-person care was implemented in their case. Two issues arose that necessitated some change in the implementation of the study. The first was that the Centers for Medicare and Medicaid Services (CMS) mandated a realignment of several hospital patient units at Loma Linda. Where previously cardiac patients had private rooms, the realignment allocated them to multi-bed rooms for the cardiac unit on a different floor, thus it was no longer possible to reasonably assure the patients their

privacy for the interview. In order to meet Institutional Review Board (IRB) protocols a different strategy had to be implemented.

The second issue that became apparent was that the pool of cardiac patient who were alert and oriented enough to participate in the interviews was too small. Thus it was deemed appropriate to open the pool to other services which in effect increased the diversity of the participant pool and added unique insights into patient care at the hospital. As a result three were interviewed in my private office, one in the patient's office and the balance in their own homes; thus patient privacy was assured.

The project goal was to personally interview sufficient patients until a saturation of unique themes describing patient satisfaction or dissatisfaction was reached. By interviews 11 and 12 little new data was accumulating though interviewees continued to confirm the dominant themes already revealed. Thirteen individuals were invited to participate and 12 accepted the opportunity to speak of their hospital experience. One person declined on the basis that her life situation demanded too much of her at this time for her to give the interview her best endeavor.

The Sample and Investigator's Relationship With Interviewees

Reasonable diversity was achieved in the pool by selecting individuals as they became available. If the patient seemed able to speak to both the good and the bad aspects of their care a brief explanation of the research project was given and an invitation to contribute their experiences and insights was made. The ability to be able to articulate their story in a cogent manner was also of high importance.

Prior to conducting the interviews I had visited interviewees numerous times in the clinical setting in my role as a chaplain and counselor. The level of trust already established allowed patients the freedom to broach sensitive information for the study.

Table 1 lists the interviewees' demographics and largely speaks for itself. Some observations though are in order. With the small sample size each person represents a little over 8% so changing the category of just one person results in a noteworthy change in the statistics for that category. Secondly, the Medical Service represents the current admission. Nearly one-half of the patients had at one time been admitted to the cardiac unit for heart-related issues. Most have received medical interventions for more than one body system over the years; several having life-long chronic conditions that require periodic hospitalization to stabilize the symptoms. Lastly, the average length of the interviews was a little over 26 minutes; confirming the significant interest the interviewees had in the subject of the study.

Table 1

Demographics of the Interviewee Pool

Code	Race	Gender	Age	Religion	Status*	Medical Service	Length**
Int01	CAU	M	61	NOD	MAR	Medicine	28.0
Int02	BLK	F	58	BAP	WID	Medicine	22.5
Int03	CAU	M	72	PRO	MAR	Transplant	45.4
Int04	CAU	F	28	NON	SGL	Medicine	25.4
Int05	CAU	M	56	SDA	MAR	Medicine	18.0
Int06	CAU	F	35	COC	SGL	Medicine	32.0
Int07	HIS	M	49	SDA	DIV	Transplant	14.5
Int08	HIS	F	31	NON	SGL	Medicine	29.4
Int09	HIS	M	38	CAT	MAR	Transplant	27.0
Int10	CAU	M	65	SDA	MAR	Oncology	23.4
Int11	CAU	F	46	CAT	MAR	Medicine	26.5
Int12	CAU	M	65	PRO	MAR	Transplant	27.0

Note. Int01 etc. = Interviewee. *Marital Status **Length of interviews in minutes

Data Collection Procedures

Patients who met the selection criteria for the study were approached with a brief explanation regarding the purpose of the study and, if agreeable, were invited to participate in an interview at a time and place convenient to them. On that occasion a detailed explanation of the informed consent was given along with an opportunity to ask further questions. The risks, rights and third party contact information were highlighted along with the confidentiality provisions to ensure the privacy of their contribution to the study. Permission to record the interview was explicitly gained before the consent was signed by the patient and the Student Investigator.

The interview proceeded with mainly open-ended questions except if some specific clarification was needed. Interviewees were given freedom to express their thoughts in the way most comfortable for them which in most cases resulted in stories of specific situations and incidents they experienced in the hospital. A closing opportunity for the patient to make a statement like the following proved popular; “If you were given an opportunity to give advice to a doctor, nurse or healthcare worker about how to treat a patient, what would you like to say to them?” Patients seemed energized by the fact they were being given a chance to process some of the difficult circumstances they had experienced, but also to render high praise to individuals whom they felt truly emulated the pinnacle of the whole-person care concept.

Duration of the Intervention

The specific implementation phase of the Intervention with Senior Medical Students was scheduled between August 22, 2012 and October 31, 2012. During this period I and a second chaplain assumed the responsibility of mentoring the students

during patient rounds and the following debriefing sessions. Neither I nor the second chaplain had met any of the medical students prior to our visits with them on the units. Students are randomly assigned to a chaplain by our office secretary. The tabulated results and student comments regarding their experience observing the chaplain are located in the appropriate section of Chapter 5.

Compensation of the Participants

No tangible compensation was offered or promised to participants in this study.

Instruments

A single instrument titled, *Senior Elective: Rounding Visits with Chaplain* was utilized to gather the medical student's assessment of the rounding visits on the units (Appendix B). The assessment was administered following the debriefing session while the students were alone in the debriefing room. When completed the assessments were placed in a folder by the students and turned in to the Chaplain's Office secretary.

Analysis of the Interviews

Following each patient interview the recording was transcribed using *Express Scribe* transcription software from NCH software. Upon completion of the transcriptions text analysis software titled *NVivo 10* from QSR International was used to code content and themes appearing in the interviews. Additional tools included in the program allowed recurring word and phrase searches and served to enhance the understanding of patient comments providing the basis for the appreciation of their experience with medical personnel while in the hospital.

Implementation Narrative

This project captures a specific segment of an implementation that was initiated and continues as a permanent program improvement. No assessment has heretofore been implemented or trialed to survey the strengths or weaknesses of the whole-person care elective for final-year medical students. Participants may elect for a two-week or a four-week rotation which includes instruction, patient visits with chaplain mentors, individual visits to interview patients regarding whole-person care issues, researching and writing an essay on a medical topic of interest with a view towards discerning and addressing the whole-person care issues surrounding that topic and a final session with the preceptor to summarize what was learned. During this session the research papers are presented and remaining questions answered. When I host this session I like to promote an exchange among the students around the idea of integrating learning from the rotation into the physician's practice.

Additional components included whenever possible is the review of selected portions of the film *Wit* (Bosanquet, 2001) to locate whole-person care issues that arise in the doctor- patient relationship portrayed in the movie and rounding visits with the author of *Innerweave* Dr. Wil Alexander (2008) who has invested more than 40 years fostering whole-person Care at Loma Linda University (p. xi).

Conclusion

From a practical perspective modeling whole-person care requires a modest investment of emotional energy, more so if a true understanding of the concept is not fully acquired. Developing a working relationship with a patient in crisis is no easy task and calls for a wider range of social and intellectual skills in order to meet the needs.

Further there must be a genuine concern for the patient's wellbeing. The aim of the rotation is to demonstrate that the principles of whole-person care which when properly integrated into medical practice will foster a healthier partnership between the doctor and patient which will subsequently improve efficiencies in the way care is provided. The elective exposes students to best practices for the most effective approach to patient care.

CHAPTER 5

PATIENTS' PERCEPTIONS OF WHOLE-PERSON CARE AT LOMA LINDA UNIVERSITY MEDICAL CENTER AND AN IMPLEMENTATION BY CHAPLAINS FOR HEALTHCARE PERSONNEL TO ADDRESS SHORTCOMINGS

Introduction

When given the opportunity to contribute to this project respondents openly shared insights about their experiences with hospital personnel while they were patients at the hospital. In this report I seek to present a picture, as seen through their eyes, of what it is like to be a patient at Loma Linda University Medical Center. One element that stands out is that perception, right or wrong, is the de facto reality that must be considered in any response to a patient's needs or concerns. Ignoring it can result in a much greater investment of time and energy than if the presenting issue was addressed purposefully at the outset. This issue will come to the forefront in numerous ways.

As may be anticipated, there is a certain level of predictability that surfaces in the comments that will aid in setting goals for establishing best practices, but there are nuances that if listened to may cause a deeper reflection on the direction of healthcare for the future. Because of the sensitivity of the material personal names in these accounts are arbitrarily assigned pseudonyms of four letters so as to protect patient and family privacy and bear no relationship to anyone living or deceased.

Patient Perspectives

Patient Satisfaction

Anger

Anger did not feature significantly among the interviewees and in fact patients responded with remarkable constraint in the face of disagreeable situations. Adam stated that “Doctors don't like it when you disagree with them. You really have to deal with their ego, and I was aware of hers and she was aware of mine so I think that again we agreed to disagree without being angry.” Ivan’s wife spoke of her frustration with an Emergency Room nurse who seemed overly reluctant to dispense pain medication. But overall the attitude not to express anger seemed to prevail in the interviewee pool.

Attitude

Seven patients spoke to ways attitude influenced their hospital stay. For some it was the role of a positive frame of mind going into the experience that gave them a resilience to face their personal challenges and situations that arose with healthcare personnel. Adam, again, seems to capture this sentiment best by stating that “My attitude really kind of hinged a lot on the people who I came in contact with. They seemed to care and as a result I became comfortable.” Faye likewise attributed positive staff comments and attitude towards more adaptive coping during her admission.

Dana, in a confrontation with a nurse she believed was mistreating a roommate, felt it necessary to take an advocacy role for a patient who was not capable of standing up for herself. It appears that the issue stemmed from the nurse’s disagreement with the

roommate's lifestyle and concluded with Dana's statement, "And she [nurse] was very taken aback by it and she said under her breath as she walked away, 'anything else.' I [Dana] said, 'yeah, there is something else; you could stop having the attitude.'" While it may seem extreme, Kate delayed accessing the Emergency Room while she was having chest pain "for fear of that confrontation with the intake nurse or the doctors or nurses in the ER having sarcasm again and saying here she is again."

Kate goes on to modulate her comments by recognizing that "an aggressive attitude" may be necessary for certain patients who through willful neglect find themselves constantly accessing the Emergency Room. However, she believes doctors and healthcare personnel should learn to turn that attitude off for the many patients who consciously try to follow the doctor's orders. Erik suggests that patients be treated as "intelligent" partners in their healthcare.

While admitting that a "stern demeanor is not helpful" and that patients may be turned off by healthcare staff with a lack of personality Lary offers one of the most generous observations regarding the attitude he received from Loma Linda:

So, I think that that's always been a staple that I've cherished about Loma Linda. You know if you go to some public hospital that doesn't have that core belief; yes, they're there to help and treat and no way am I demeaning them, but it's just harder for them to generate the overall attitude of the community and the patients that these people have a focus to make man whole.

Caring

The largest grouping of responses by far arises from the belief by patients that they desire genuine respect and care while undergoing treatment for their health concerns. Many of the comments arose from interactions with doctors and nurses who truly manifested the kind of care that patients were seeking and expecting from their care

providers. In fact every interviewee commented multiple times regarding aspects of the care they received at Loma Linda. Comments like “She’s just a caring, wonderful person” by Adam; “The care was 100%, the nurses were 100%” by Barb; and “I can’t rave enough about the care I received on a personal basis. It was outstanding” by Carl, a heart transplant patient, were frequent. Carl and Erik among others also highlighted instances of how individuals and whole teams of personnel went out of their way to ensure adequate care for them. Perceptions are powerful and Lary captures the negative side of this where the patient is dealing with a difficult caregiver with, “But if you’re the doctor who never smiles and isn’t friendly . . . and isn’t warm, then you don’t feel like you can go to him and say this person’s not responding and taking care of me.”

A particularly distressing event related by Kate concerned an attending physician whom she said resisted her pleas to utilize pain blocking medication for a cauterizing procedure on the grounds that he did not have time to secure it. She says it was “an excruciating, very, very bad experience that I had to endure.” Several Residents stood around during this event accentuating her perception of the trauma. The one mitigating factor in this experience which redeemed her view of the medical team was that after the majority left one Resident remained to provide an apology. His statement in this context is profound:

He said, “I am so sorry Kate.” It makes me emotional just talking about it. But he said, “I want to apologize that the Attending doctor did that” and he said “I promise you,” he said “when I become a full-fledged doctor I will never, never do that to any of my patients.” And he said “we are supposed to be learning lessons from watching our Attending physician.” And he said; “I learned a big lesson from this.” And he said, “I would never put, I never will, I never would and never will put a patient through what that Attending doctor just put you through.” And through the rest of my hospital stay that Resident doctor came and visited me regularly, making sure I was OK and feeling OK. So in the end that made me feel really good. That was excellent

care, and that what was supposed to happen, Residents learning from the Attending. It happened, but the Resident got a very good lesson.

Unfortunately, not all incidents resolve in such a fortuitous way. Despite a generally very positive experience while in the hospital over her many admissions, Barb reports that one physician seemed particularly unresponsive to her case. She states that regardless of her feeling that she was far from well, “the doctor was very adamant about sending me home.” The intractable standoff resulted in a three-day stay with only one nursing visit a day to take vital signs and pain medication once every eight hours. Barb eventually left and was readmitted soon after to continue care under a different physician at her request. In spite of occurrences such as this patients are remarkably resilient and Barb affirms that “on the whole I’ve had good care. I’ve had very good care.” Carl’s wife recounts that, “He was so comfortable at Loma Linda, he was a little afraid to go home and have Mona take care of him.”

Patients are particularly struck when healthcare personnel go out of their way to meet their needs. Carl recalls that “what was very impressive to me at the time was the fact that the team was actually waiting for me when the ambulance arrived.” Lary likewise is still effusive with his praise that the head surgeon met him and his wife in the hospital lobby and prayed with them right then and there. What stands out are the many comments such as “I had been given such attentive care,” “everybody has been very efficient, very caring,” “they showed that they cared about me” etc. Erik mentions two events that stand out in his mind regarding the caring nature of his physicians; firstly “She came to the Emergency Room when I first went in and cared for me the first couple of days. I understand she was at my bedside as much as twenty hours in a twenty-four-

hour period” and second regarding his doctor who prayed for him, “He mentioned my wife by name and I was quite impressed that he remembered my wife by name . . . and I told him once, but he’d remembered. I thought that was pretty good.”

Gary too heaped high praise upon the healthcare staff while at the same time admitting that he likely pushed the limits with his aggressive behavior. A liver transplant patient with frequent bouts of encephalopathy which led to extended periods of moderate to severe confusion, he repeatedly underscored the excellent care he received in the hospital. He recalls one of these incidents in this way:

I can remember one time they had to, actually, had to help me back to the bed because I was really very aggressive and very violent and I think security, three or four security guards came and helped me to bed because I was acting up really, really, really wild.

He cites several examples of raiding the staff refrigerator late at night, verbally abusing the paramedics and the unit staff and yet, “I had excellent, excellent care, excellent care from everybody.” Gary understands that in spite of his behavior the unit staff were trained and able to integrate his aggressive behavior in such a way that they did not take it personally because they understood it was the disease that was causing the acting out. He summarizes the attitude of his caregivers after he apologized for his behavior with, “I said I’m sorry I was just not myself and they said, ‘Oh don’t worry about it, you know, we know you were sick, you know, we know you have been through a lot. So I remember that.’”

Patient Hope expresses a multi-dimensional picture of her care in her comments. Because of her long-time association with the hospital for her dialysis needs she has developed friendships with many of the caregivers. “They showed that they cared for me” and “At times I could tell they were tired but I still get great care from them regardless of

three-in-the-morning shift the day I have to be there.” However, because of what seems to be a false accusation by another patient she experienced some pushback from a few of the nurses. When asked about how she has been treated as a patient she volunteered, “Because I really care about these nurses and for them to treat me differently it really hurts; it really does hurt.” Ivan likewise mentions variation in the kind of care that he received while in the hospital. However, his portrayal points out that in his case it was more area-specific. The care on the Transplant Unit was exceptional while the admission process through the Emergency Room was slow and prone to unhelpful additional interventions. Ivan describes one such traumatic event this way:

There were a couple of times where we had to go to the Emergency Room where it seems like they weren't quite sure what they were doing. At the Emergency Room they would do stuff that normally most doctors wouldn't do, you know. One example was my potassium level was a little bit high so they put the IV in my hand and my hands are real thin so they went ahead and injected medicine through the IV into my hand. Well, it made my hand hurt so much that I was actually screaming and yelling and crying and I couldn't take the pain and they just kept doing it and said, “we just have to finish the injection of the medication and there was no way we could stop it.”

We knew already, since we had gone through this process many times that all they had to do was just give me a simple shot, and have me take another medication, instead of doing the shot that they were doing. We tried to explain this to them but they're like, “no, no; you are our patient and you don't know what you are talking about. We're professionals; we know what we are doing.”

The confounding aspects of situations like this may be partly due to the very nature of the Emergency Room itself. Patients come in needing immediate help from personnel who are expert in responding to emergent needs. But they may not be familiar with the patient's specific history at the hospital or their previous response to treatments in the past and exercise reservation with patients attempting to mandate how they should be treated.

Barb and other interviewees with a long history at the hospital spoke in a similar way regarding their experience at the Emergency Room and with care in general at times. The cause mostly commonly attributed to this is unfamiliarity with their particular case. If the caregiver has not consulted the patient's medical record sufficiently or with other services caring for the patient then a seeming incoordination of care can result. The foregoing premise seems to be confirmed by Ivan and other interviewees when recognized at the Emergency Room and the resulting admission process was facilitated more positively.

What rates highly among patients is the personal touch by caregivers. On the Transplant Unit Ivan related that they "made me feel they would treat us as family not as a number or just a patient" and "they treated you as a person." Some of the staff still phone for special occasions such as birthdays to check in to see how he is doing. For Kate something that evidences good care is:

When a doctor comes in and they're able to sit down. Actually most of the time they stay standing. To be able to sit down, take their time talking to you, you know, showing genuine concern for your condition and not acting like you're a number.

For Jeff excellent care consisted in the oncologist giving him his cell phone number and a pain specialist at the Cancer Center who "is so thorough, he makes you understand everything, I mean, my last appointment with him he spent an hour with me . . . I'm very impressed with him and what he does."

Any attempts to go out of the way to meet a need, personalize care, take additional time to answer questions or to carry a conversation in a personable manner without resorting to unintelligible medical jargon builds rapport with both the patients and their families and generally increases the esteem of medical personnel.

What proves unacceptable care is failure to respond to requests from patients who repeatedly press the nurse call button and are seemingly brushed off. Even by someone like Carl who gives an exceptionally positive grade for the care at the hospital, he felt neglected when his vomit was not cleaned up for more than ninety minutes despite repeated calls to the nursing station. He was informed that no housekeeper was available at the time. The Supervisor rebuked the attending nurse for not attending to it regardless of whose responsibility it was. Jeff also highlighted concerns regarding waiting for appointments with doctors following surgery. After checking in he was located in a consultation room where he waited for almost two hours without any update on why he was not being attended to. He recounts, “So finally at about three-forty I opened the door, looked around and said at the top of my voice, ‘I’m leaving if anybody cares.’” A Resident did come in for a quick exam but no reason was given for the delay in seeing him. Jeff’s conclusion:

And, like I said, when I waited that two hours for my post-surgery appointment; if he would have had an emergency, OK, but I still feel somebody every twenty to thirty minutes should have come in and said “the doctor is tied up.” It’s unacceptable.

Neglecting to keep patients informed regarding the status of their care constitutes in their mind a disregard for their comfort amidst the already debilitating circumstances they are enduring while awaiting treatment for their condition. Even if no update is available simply checking in with the patient regularly assures them they are not forgotten.

Erik surfaced the frustration of frequent bed and room location changes which resulted in his family and friends experiencing difficulty finding him and at the same time, him frequently needing to orient himself to different nurses and other caregivers. When a person is very sick this can be particularly unsettling because a new trust

relationship must be established each time before the patient can become comfortable.

While the reasons for the changes may be justifiable for epidemiological and level of care needs the patient's comfort is reduced.

Faye, who is a victim of sexual abuse, had to endure a particularly traumatic experience when her needs to have a female present during a procedure were not heeded and comes to a quite concerning conclusion about her care that day:

But they didn't give any credence, any thought to the fact that I was terrified; I was scrunched up on my bed like this and that maybe should have given a clue, "hey this is a special case, this is not just your normal run of the mill patient that we are going to put a tube in," you know. And I think that if they had even just asked me, you know, "hey are you scared," you know, or "is there something" or had a female nurse there I think that the whole situation would have been a lot less traumatic for me. But that's really the best I can give them because you can't, in my opinion, you can't separate the three. You know I think they all go hand in hand, the physical, goes along with the emotional, and the emotional goes along with the spiritual and if you try to separate the three and just address one aspect of the patient care, then *the patient may go away physically healed, but they might have some traumatic issues to deal with*, you know [Emphasis added].

If the team had really listened to the legitimate concerns of the patient the scenario that followed which culminated in Faye locking herself in the bathroom could have been avoided and a much different reflection on the care she received would have resulted.

In summary, providing care is the blanket that surrounds whatever treatment the patient undergoes while in the hospital. Serious illness or serious injury is extremely disconcerting and can cause patients significant decompensation in their functioning. In order to mitigate these factors thoughtful and intentional actions may make a meaningful increase in the patient's perception of the care they received at Loma Linda.

Comfort and Concern

The terms comfort and hospital may not be an association that might be expected but it did manifest a number of times during the interviews. Being away from familiar surroundings and uncertain of the future a person's thoughts naturally turn back to home. Adam stated that "they seemed to care and as a result I became comfortable." Even when there was disagreement with the focus of his care he felt composure, "but I had a lot of tension there and I was comfortable with telling her" because he and the doctor has established a good rapport. Barb suggested that "to make patients feel more comfortable, don't just come in, don't stand up over the bed and talk to them; there's a chair, sit down."

Carl "felt very comfortable and very confident that I was being given the best treatment and it was going to be successful." Dana felt very comforted when the chaplain visited and on longer stays the regular visits and familiar faces of other employees all contributed to her wellbeing. Notice how she expresses it in this statement:

As much as I hate going to the hospital, it's extremely hard to deal with all of the time, having a familiar face like you that's extremely caring. I know when I'm in the hospital you're going to come and pray for me at least once or twice and that's a huge comfort for me honestly. Also, there are too many of them and I can't even name names, but I've had everything from doctors to nurses to linen people, housekeepers, all of them are so equally important in their job at the hospital and every single one of those positions of jobs, and these people come visit me even if I'm not on their unit or they don't have me as their patient. And just come to say hi with their smiley face and that's been a huge relief for me.

Comfort was something Erik missed when he was moved from place to place in the hospital so often. Ivan's wife was discomforted when the nurse unnecessarily delayed starting an intravenous drip for her husband when he was so dehydrated. Kate on the

other hand was comforted by the untiring efforts of her nurse who persisted with paging the doctor until the right medication was prescribed:

She continually came in and let me know that even though I was having to wait a long time she was working on it and that was really comforting to know, that she was working on it and I wasn't just being left there and being forgotten. So, that was a really good experience.

Once again the responses reveal that even small efforts to engender comfort for a patient can provide a significant dividend when it comes to their perception of satisfaction regarding the care they receive in the hospital.

In this study concern seemed to be expressed both by patients and caregivers. Adam was concerned about a night nurse who was upsetting him with his lack of communication and also because this nurse was “condescending even to the Supervisor.” His concern was manifold but particularly regarding the medication the nurse was injecting without an explanation despite his repeated requests. Faye’s concern was centered on the fact that the doctors doing the procedure were more concerned about the physical at the expense of the emotional and psychological that was paramount in her mind. She states, “You know, there's the physical side of the patient, the physical needs, but there's emotional needs and there's spiritual needs too and you just can't be so focused on the physical.”

Jeff worried that, “he wanted to put me on Oxycontin and I had concerns about people getting hooked on that,” until his doctor carefully explained why this would be a better choice for him at this time. Barb’s doctors were concerned that her pain had become so severe so they consulted with her regarding a change in the medication. On another occasion she had expressed a concern about infections associated with a planned Peripherally Inserted Central Catheter (PICC) line that may cause blood clots. Kate was

appreciative that her doctors were concerned about her concerns and took the time to sit down and explain things to her to put her mind at ease. Lary was concerned about his wife after he was admitted to the hospital but was relieved when the head surgeon met them in the hospital lobby and prayed with both of them which left a lasting impression.

Well, as I said when we came here and he met us at the door and prayed with us it was immeasurable. It was huge. And I hadn't even thought about coming in the door and praying. I was, you know, concerned about my wife.

In the hospital environment concerns of both patients and caregivers can arise at any moment but medical personnel must be proactive in assuring patients they are aware and pursuing every avenue to promote their health and wellbeing. In this way many potential difficulties may be preempted and the patient may endure less unnecessary stress.

Timeliness

The experience of the passage of time for a patient in distress in the hospital can be quite different than for any of their caregivers. The overwhelming sensations associated with intractable pain or nausea for example feature an intensity from which there is no escape in ordinary ways. The usual avenues of distraction such as television or eating are unappealing resulting in long periods of unrelenting suffering. Minutes may seem like hours to someone in this position. So when caregivers are otherwise occupied they lack a real appreciation of what the patient is enduring.

Of the interviewees Kate seems to capture the impact of time most succinctly with these words:

Then I've had the other side too, where they seem to drag their feet, just seem unwilling when I've been in an extreme amount of pain and some have just dragged their feet and seemed tired and they don't want to deal with it and an hour or half-hour or an hour will go by and I'll have to call them back again and say "something's still

going on, could something be done?” It seems like the time just dragged by for ever and ever, where on the other hand others have really been good in acting quickly.

The feeling that time was passing in slow motion was expressed in a variety of ways. Carl described the time while he was in surgery by saying “my wife and family and friends went through a long, long night of praying and waiting to see what’s going to happen.” For Ivan with advanced liver disease being sick meant “sometimes you can’t even hold a piece of paper straight, you know, you can’t even read.” Larry described his lead-up to his liver surgery as an “unnerving time.” Faye was beginning to feel anxiety as time elapsed when:

They took me back to that unit and there was a point in time where they had forgotten to put me back on the oxygen and I don’t know if they were supposed to put me back on it or not but I felt that my chest was getting tight as I have asthma very bad.

It may seem like a misnomer but the most common designation of “slow,” was linked to the Emergency Room. Larry again described it as “slow,” and other patients told of spending from a few hours to more than 24 hours in the Emergency Room waiting for a transfer to a room in the hospital. Second to this are the sometimes lengthy wait times at clinics mentioned by several patients in the study and delayed responses when the nurse call button is pressed. Dana gives an historical perspective to the latter concern and an update with this report:

Like I said in the past you could push the button and sometimes they wouldn’t answer you or they’d ask “may I help you” and they’d hang up before you could even tell them, before even replying. What I notice a lot more now is if you push the button and like I was sharing earlier, you know, “nurse so and so is with [someone] or whatever and when they’re done they’re going to come in, but she knows.” That is a peace of mind. At least you get feedback saying, “hey we know you called, give us a couple of minutes and we’ll get there when we can.” So that makes like I said, a huge difference.

Updating the patient, keeping in regular contact with them is also expressed by Jeff and seems to be universally appreciated to dispel the sense of being forgotten. Carl, following heart transplant surgery confirms this observation:

Which just shows; I mean I had two nurses in the room at the time so there was a lot of care after the operation. I would be watched, there would be someone there all of the time to help me. So I had no fear there.

One final aspect of a patient's perception of time is the willingness of the caregiver to grant them reasonable access to discuss their case. Barb insists that in doing so doctors will "learn a lot more and the patient/doctor relationship would be better," and "I think it would have saved a whole lot of time." Jeff, who listed several negatives regarding his care, commended one doctor with, "The guy is so thorough, he makes you understand everything. I mean my last appointment with him he spent an hour with me." Kate values doctors who are, "able to sit down, take their time talking to you." Erik seemed almost astounded when he discovered that his doctor "was at my bedside for as much as 20 hours in a 24-hour period" while he was in the Emergency Room.

From all accounts patients seem to highly value caregivers' sensitivity to their perception of time, be it is mitigating distress or investing in the patient/caregiver partnership with their care. Thoughtful and intentional devotion to providing a space for the relational aspects of care seems to be highly coveted by patients.

Communication

Communication a Priority

The anecdotes affirm that good communication between the medical team and the patient likely portends a stronger sense of partnership and a greater degree of satisfaction

between all parties. If communication breaks down or dysfunction predominates additional time and energy is expended unnecessarily. For Barb it was not enough that the physician came and talked with her; she desired a more substantial indication that they had time to get a better understanding of the reason for her hospitalization. In her statement she succinctly expresses her need and why she believes this will advantage the doctor as well.

When they come in to see the patients, to make the patients feel more comfortable, don't come in, don't, don't stand up over the bed and talk to them. There's a chair. Sit down. I'm sure that they can take five or six minutes out and sit down and talk with the patient and, and answer the questions that they need, and not have the nurses get on the phone and say, "oh the patient wants you to come back up." If you cover that ground when you're supposed to be doing your rounds that wouldn't be necessary.

Other patients such as Adam voiced a similar desire for an unhurried opportunity to converse with their caregivers but found that "he didn't want to converse about that at all. He was not a good communicator." In spite of her hope stated above Barb lamented that "nobody told me anything" and "they didn't explain anything to me," "the communication was zero." At the outset of one procedure the anesthesiologist was shocked and stated, "They didn't explain this to you; they didn't explain what they were going to do to you?" In this case the issue was that the two teams of doctors handling her case were not communicating between themselves because, "if those doctors would relate to one another better when they come to see me they can know what's going on with me."

Jeff also struggled with issues regarding lapses in communication as this comment reveals, "So it just seemed that the left hand didn't know what the right hand was doing in a lot of instances." Kate described it as a "lack of communication" when the doctor performing her colonoscopy also did a biopsy but refused to tell her why that

second procedure was necessary. It seems that the doctor reluctantly told her that her colonoscopy was clear which raised the question in her mind regarding the need for a biopsy. Only later at an appointment with her primary physician did she learn that a polyp had been found, which proved to be benign. Lary did have one instance of the Transplant Coordinator failing to contact him but overall he recollected that “the physicians have always been very candid and very open and conveyed information, even to her [His wife] when I was in a coma.” Carl “knew at all times it seemed to me that I knew what was happening, what they were trying to accomplish.”

Ivan and his wife spoke of an exceptional communication experience with the Transplant team. They were provided detailed instructions of “Who to call. If it's after hours, call the hospital. How to get hold of whoever was on call. And, I mean, I had the unit's number saved on my phone and I memorized it.” He also stated:

You know it was very nice. I mean, all of our doctors gave my wife their email address and she would email them any time. “Oh there's this or there's that, what should we do?” Things like that were just unreal. I never, ever, heard of anything like that where you can email a doctor or text message a doctor directly to their cell phone and have them reply within minutes and saying “yeah, take him to the hospital and I'll see him there in forty-five minutes or an hour. I'll meet you at the Emergency Room.”

The way doctors and caregivers respond and communicate with their patients leaves an indelible impression in their minds, even years later. Good communication testifies to a genuine establishment of a partnership of care between the provider and the patient.

Providing Information

Good decisions are based on good information. Healthcare choices are often complex and result in far-reaching consequences. Patients, families and their care providers often have to balance the clinical issues along with insurance and financial

resources that are available. This task is best facilitated by up-to-date and relevant data which when paired with the clinician's experience can provide the most optimum result.

Among the study participants, in the majority of cases, they were pleased with this process. There were some notable exceptions however as Barb described, "no-one explained to me that PICC lines could cause blood clots," and "then after I contracted the blood clot then I was explained to that PICC lines cause blood clots . . . I wasn't angry, just disappointed that I wasn't informed before that." Erik felt that the use of medical jargon, or "medical-ese" as he put it was not helpful for him to fully understand his situation. Jeff highlighted a concern that causes considerable consternation among patients when it occurs; treating doctors not cognizant of the patient's status:

So, there was a couple of nurses on, I was only in five, four days, five days and they kind of booted me out because they were afraid I was going to get an infection. That morning, they came in about five-thirty in the morning and my one count was very low, so immediately moved me to a separate room by myself. The team came around to do rounds and then they stepped out and the next thing I know they're all gowned and gloved and masked [laughter] and then they said "we're sending you home." And then they realized that I was not on solid food yet, I was still on a liquid diet, so then they decided to keep me until I had lunch and so it just, don't they know where I'm at in my recovery?

Jeff noted other incidents where indecision on the part of his doctors perturbed his sense of calm and confidence about his care. He says, "I thought that was very strange that they wouldn't be on the same page on that procedure and how to handle it." On other occasions however his experience in this regard was exceptional. In this example he says, "Dr. Bairns . . . the guy is so thorough; he makes you to understand everything. I mean my last appointment with him, he spend an hour with me." Dana likewise who was unable to get the results of her biopsy from the treating doctor shared this positive mutual information sharing experience:

I had the situation where a doctor was able to sit down, see how my night went, how was my morning going. Were all my medications OK? Asking about them, what's working, what's isn't and taking note of that and just asking what my concerns were if I had any. That's one of the best experiences with a doctor in the hospital where they're really able to take the time and get some detailed info from you and showing genuine compassion and concern.

Ivan spoke well of his experience on the Transplant Unit saying, "It went really, really well because they not only hand write it but they make sure you understand when they are explaining it to you." Lary states that, "they were very candid and honest in explaining to me what was going on." Carl gained confidence in his medical team because, "I felt that I was receiving top notch information." Barb who described suffering a blood clot at the beginning of this section later reported, "They sat down, they would go into detail with me with what was going on, what to expect and what was going to happen as far as any procedure, anything."

Clearly patients prefer to be adequately informed so they can participate in their care in meaningful ways. Other comments indicated that the current attitude towards delays and cancellations must include regular updates so the patient knows when to expect appointments and procedures to occur. Patients resent personnel who treat their time with disdain and they feel entitled to the courtesy of regular updates in the care sequence.

Receiving Information: Listening

Medical personnel rely heavily upon what is termed the differential diagnosis to ascertain the likely cause for the patient's symptoms. This in many cases is an efficient way to arrive at the correct treatment protocol for the patient's condition thereby hastening their recovery and discharge from the hospital. Patients however can feel left

out and their insights are not taken into consideration. Adam for example had strong words for doctors who don't seem to listen:

Most patients know their bodies pretty good. Being in the hospital a number of times you know what's going on in your body and you can tell them real quick what to do. But if they're not listening it doesn't do any good. And I've had a number of doctors who don't listen. My technique for dealing with that was to tell them "you are not listening." I'm not afraid to tell a doctor that because it's just the truth. I said, "If you listen you will know what's going on with me." So that to me is a biggie. That is one of the biggest things a doctor or caregiver can do is listen to the patient.

Barb regrets that the doctor didn't listen which resulted in her readmission to the hospital shortly afterward. "I just feel like had she listened . . . I don't think I would have ended up back." When Faye locked herself in the bathroom following the traumatic event with the doctor mentioned in another section she reflected, "they weren't even listening to why I was in there" and "they wouldn't listen to me and they thought I was just being difficult." Jeff too expressed his disappointment with one doctor, "We just thought she was very cold and didn't have a listening ear, whatever, to what our needs were."

When given the opportunity to offer advice to the doctors Ivan offered:

Listening to your patients, you know, definitely listen to your patients because, I mean, we're our own doctors. We've been our own doctor for God knows how many years. We know what we feel, we know when we don't feel well, we know our own symptoms. Definitely listen to the patient. Listen to their family members.

Kate likewise emphasized that she appreciates nurses "where they really listened and they act on it right away" and "They really listened and they really act like they want to do something." Dana was impressed with her doctor who, "spoke to me as another person, with my family, listened to suggestions and truly did care." Her advice for doctors when speaking with patients is:

I would say, no matter what the case may originally appear to be, don't judge it by its cover. Really sit there and take time. Be slow, be patient and really try to listen to your patient and take time to really figure it out. Try not to rush into it. Try to listen to

your patient. I know you don't have a lot of extra time but if you sit back and really listen and feel out what's really going on I think it will be a lot easier for you to get to the bottom of whatever it is going on with that particular patient. And also a lot easier process because you are not rushing; you are actually listening to what the patient has feedback wise too. So I guess in other words when you go to meet, you could look at the chart but really listen when you ask these questions.

Dana, in common with other patients, recognizes that doctors are busy but that the time spent listening will be repaid in greater efficiency in gathering information that will better facilitate the diagnosis and the resulting treatment. Furthermore patients will likely feel more invested in their care when their insights are incorporated as a result of the doctor taking time to listen to them.

Trust: Fear and Surety

When health fails or we are seriously injured the sense of losing control can quickly escalate as apprehension grows. Patient volition is limited first by the illness and secondarily by life-sustaining tubes, wires and other devices. Hospital personnel can do much to alleviate patient fears by their caring attitudes. Nine of the 12 study respondents reported on how distress or absence of it affected their hospital stay.

It may be expected that the physical aspects of the disease process or dependence on equipment to maintain life support would be the primary cause of fear in the hospital. Faye experienced this “When I woke up I was on the ventilator I was really scared.” She had been intubated and as she was coming around she felt her chest tightening and her wheezing increasing due to her asthma, but the team was dismissing that stating it was the result of the anesthesia. In this case her primary fear was exacerbated by the team not recognizing what was causing her breathlessness.

The patient designated Hope expands this dimension of fear related to the way medical personnel relate to them. Her view is that inexperienced “LVN’s scare us because they walk in like they know us and know how our treatment should go when they’ve been on us for a few times.” Jeff also felt insecure when a different doctor almost every day visited him because “they didn’t seem to have a real good knowledge of what was going on with me and my case.” Dana felt scared for people in the hospital who don’t have anyone; “They can’t advocate for themselves and they have no one to advocate for them. That’s a scary place.” Barb discovered she had a staph infection and “was scared they were still going to take me to surgery anyway.” Carl on the other hand experienced no fear even though he had a heart transplant because his attending staff were unified to allay his fears. He says, “I had two nurses in the room . . . so I had no fear there.”

These comments indicate the significant impact that healthcare personnel can make for good or ill upon patients’ sense of peace while in the hospital. The physical toll of disease or injury is enough to deal with without the added burden of concern that those responsible for their care are negligent or unprepared for the responsibilities assigned to them. Doctors, nurses and other staff should work proactively to dispel any unnecessary cause for alarm on their part to ensure the patient’s peace of mind.

Among the many factors that relate to a person’s care in the hospital one that casts a long shadow is the patient’s confidence in the system. It is a somewhat intangible sense that in the end they will be okay; that trust placed in individuals who comprise the system will restore their health and function to an acceptable level.

Responding to whether he felt technical skill was sufficient Larry stated:

Yeah, you want somebody who really knows what they're doing, but if you don't believe in the person or you don't have a good relationship with them that affects your whole assessment of the situation and how well you're being taken care of.

Adam in his struggle with a male night duty nurse felt insecure enough to summon the Supervisor because, "if you look at the mission statement here in the hospital, he [the nurse] didn't believe any of it. He really didn't and that was the problem." Barb expressed her uncertainty with, "I wasn't sure at first what was going to happen to me as far as them going in and reconstructing my stomach." Ivan who gave high praise for most of his care felt reserved about some incidents in the Emergency Room "where it seems like they weren't quite sure what they were doing." Gary who acted out very aggressively at times due to his bouts of encephalopathy retained his confidence in the nurses who cared for him because a relationship had developed over time:

I'm sure I thought they were trying to kill me but, [laughter] you know, because they have to be aggressive. They have to be aggressive, they have to be aggressive. But nurses and the security guards held me down and gave me the nausea medications and everything. But I'm sure they did a good job, I'm sure they didn't hurt me or hit me. [Laughter] But I went through some of that when I was sick.

For Carl it was the daily Chaplain visits that gave him the confidence he needed. Dana believed in her doctor who was willing to advocate for her with the hospital to get the cutting edge treatments that defeated her staph infection. Simple things like a quick response when the nurse call button is pressed were remembered by patients. For Hope the quick response by the doctor to write a prescription for Vancomycin to clear up her infection gave her confidence in the system.

In all of these comments runs a common thread that pulls upon the need of patients embroiled in an existential state of uncertainty about their condition that they not be saddled with additional items to process. Feeling secure while they are undergoing

care is a gift that healthcare workers can contribute to for patients through attention to the details of their care and maintaining effective two-way communication.

Religious Values and Spirituality

Religious and spiritual values figured significantly among study respondents with high appreciation given when these principles were recognized and accommodated. With so much uncertainty in their minds about the outcome of their treatments, faith in God or a Higher Power can take on a new importance for them. The songs, prayers and messages customarily associated with the church become enervated with a new depth of meaning when in an unfamiliar environment.

Sometimes faith is rekindled as Adam illustrates with his comments:

I went through some pretty difficult times and some pretty difficult situations. But many people here helped get me through it. Again I can't speak highly enough of that. That was very important because there is a lot of times when you're sitting in here all by yourself in the middle of the night wondering what tomorrow is going to bring. And, my faith helped along the way as well. Had I not developed my faith more and more I think I would have had a very difficult time.

Yeah, when I first met you I can remember that I wasn't very spiritual and now as you know I am. So my evolution virtually took place in this hospital. Virtually, and I'm very grateful for that, very grateful.

Barb was drawn to Loma Linda because of the spiritual emphasis here. She says:

I've not gone to another hospital because Loma Linda, they do have good doctors, but it's not just about the care, it's about the spiritual part of it and it's whether its housekeeping, X-Ray, whatever, you don't have to ask for prayer. They are going to come up; "can I pray for you today?" And to have a doctor to come in and ask me that, that was not normal for me. I had never experienced that.

Because he knew how important this was to Carl his physician at [Named Hospital] readily endorsed his decision to receive his heart transplant at Loma Linda. The physician's words are significant in capturing the importance of spiritual values and

support for patients in their most challenging times, particularly when initiated by the caregiver.

But, when we related all of this to our physician who was at [Named Hospital] he said, “I must tell you that you have made the right decision.” He said, “you would have met the surgeon and other people but they would never come as a team. This is an interesting thing.” He said, “being a believer I would have prayed for you, but not over you” and probably well, anyway, he just said, he said “there would not be the people praying for you that there were at Loma Linda and you would not have had a team experience. You would have had very good physicians at [Named Hospital] but there would not be a team.”

None of the Interviewees in this section so far and the following three quotations has any affiliation with the Seventh-day Adventist church. Adam’s statement in another section and now Lary’s illustrate that the hospital’s mission and values are being assimilated to the extent that patients are able to articulate them without prompting:

Well, I think that the focus of Loma Linda on Jesus' mission to make man whole is huge. And I think that the chaplain's team coming in to rooms, not proselytizing, not forcing anything on anybody, but coming and asking if they'd like to pray, you know, is really helpful. And it gives the patient the option to say “yes,” as I did with Saul . . . Not putting anything on anybody but, you know, “if you'd like me to pray with you, I'll pray with you.” I think that's really significant and very, very helpful. And I think that it lends credence to the overall character of the university. And, the belief in everybody that's here and what they're doing.

So, I think that that's always been a staple that I've cherished about Loma Linda. You know if you go to some public hospital that doesn't have that core belief; yes, they're there to help and treat and no way am I demeaning them, but it's just harder for them to generate the overall attitude of the community and the patients that these people have a focus, to make man whole as a group, you know. Whereas in another public hospital, yes, varying degrees of desire to help, but when you realize that this is the whole emphasis of the church and this hospital, it's wonderful and you know.

Seven of the respondents mentioned the positive impact of chaplains visiting them during their hospital stay. Dana shares what it meant to her:

And also you, you guys as chaplains. You are all awesome. You know I know they always ask if you want someone to come for sure, “do you need your space,” but really when you are down and have those kinds of days to just have someone come in

pray for you or talk with you it makes a huge difference especially to see a familiar face. It's a lot more comfortable.

Because of the long-time chronic illnesses most of the interviewees suffer causing multiple admissions they remember and recognize the chaplain covering that Unit. Most ask the nurse to notify the chaplain so a visit can be made immediately. In two cases the on-call chaplain was paged late at night with different results:

And I was so scared and so frustrated, I was mad at God, I was mad and it was like three-in-the-morning and I called for a chaplain and they sent one down; they sent a lady. I can't remember her name but I was surprised as they said "Well you know they only come if it's an emergency." And I was like, well it's an emergency to me, you know. And so she came down and she really, really helped me.

Kate on the other hand when she requested a chaplain, was rebuffed:

I really need someone to talk to, you know, I'm feeling really bad. I'm feeling lonely and I just feel, having had this huge surgery I really need someone. And she said "no, Kate," she said, "first it's too late at night and the only time we contact chaplains or priests or anybody are for urgent matters only," she said. And that it was late at night we don't want to bother them, that's the word she used. She didn't want to bother them, only if it was an urgent matter, and this isn't an urgent matter. And so that's how it was left.

Unfortunately despite regular updates not every nurse is aware that chaplains are available by pager anytime day or night as the need arises. Sadly Kate's request could have been solaced by a visit and she needn't have had to bear it alone. Regardless, patients' know and appreciate the specific ministry chaplains provide.

Many patients and staff strongly believe in the value and power of prayer deeming it a significant factor in their return to wellness and health. Words and phrases such as "God," "miracle," "Master Physician," and "pray," or "prayer" are interspersed liberally throughout the patient interviews. Of particular note is the physician who prays with his or her patient and personalizes the prayer as Erik notes:

And I asked him, "I have a special request of you?" I said, "I always ask if we can have prayer before a surgery?" He said, "I'd be glad to." So he had his team that was setting up stop what they were doing and he said, "do you want me to pray or do you want to pray?" I said, "I would appreciate it if you would." He said I would be glad to and he prayed and he mentioned my wife by name and I was quite impressed that he remembered my wife by name. That was one little, you know, because he had only just talked to me a little while ago and he had asked and I told him once, but he'd remembered. I thought that was pretty good. He is now my cardiologist.

Faye's life and experience in the hospital revolves around her faith. She mentions her desire to "help that spiritual side of me" and that she was "able to utilize the prayer chapel" sometimes while in the hospital. When in the hospital her mind is reflecting on her absence from the church and its activities. Because of her love to interact with the patient she shares the room with she wondered why God would put her with someone who was dying and couldn't speak. In the quiet time of the night she went over to the bed and began talking to the woman and believes she made a difference for her before she died.

And so I had decided to go over there and see if I could talk to her, whatever, and you know they told me that she wasn't responding and that her moaning was just like the last parts of her body before she died or whatever. And so, you know, they don't hold a whole lot of weight for what I experienced but for me it was good because I felt like I was able to communicate with her by getting her to squeeze my hand. And, to the point where I was convinced that she wasn't just doing it out of the involuntary reflex. That she was really squeezing, you know, "yes" and "no" and stuff like that. And so I just started talking to her about God and stuff like that and I felt that I was able to get through enough that she became responsive to did she want to go to Heaven, did she know who God was?

Her eventual conclusion was that God had selected her to be there for the purpose of providing needed support for this woman while she died.

Patients interact with doctors and other staff as has been illustrated, but they also interact with each other. Spirituality and religion thoroughly permeate many of their lives and they do not check their faith at the door when entering the hospital. Chaplains assist

with triaging and modulating religious and spiritual needs for both patients and staff so that their issues may be heard and processed as is possible.

Paternalism

Authoritarianism

In many of the relationships we form in life there is a significant power differential that needs to be factored in when visiting persons in great physical, emotional and spiritual distress. Whether we admit it or not, doctors, nurses and other healthcare personnel are typically attributed with significant authority by patients and family members. In most cases patients and families will defer to doctors, though occasionally they will repudiate that authority either overtly or discretely. This power differential is often accentuated by an attitude that condones superiority as a mindset.

Adam's confrontation with his nurse illustrates this dynamic in play. He tolerated an imperious attitude for almost a week before confronting the issue seeking a resolution. While affirming that he had great doctors and nurses, "there just happened to be one who overstepped his bounds." In his recounting of the confrontation he had with this nurse Adam used a series of phrases such as, "his refusal to tell me, was the first red flag that ran up," "he decided that I did not know it all about my body and he knew better than me," "he didn't have the same point of view as the hospital's staff is supposed to have," "he really thought he was still in the military," "he was condescending even to the Supervisor," "he demonstrated all of those qualities that I was worried about" that describe why patients may be apprehensive in scenarios like this.

Barb experienced a very difficult time with one doctor who “was adamant about sending me home.” The doctor ordered that no treatment or medication be given except for pain so after enduring this rebuff for three days she left the hospital. Dana witnessed a nurse, who appeared upset by a patient’s moral choice, respond to the patient’s needs by “being very cruel, very crude, not even like acknowledging that she’s there and being real coarse with her.” Dana was upset by the paternalistic attitude venturing that “It wasn’t even so much her giving out raw emotion; she was neglectful to this patient.” Erik felt that the attitude of some doctors who “talked in medical-ese for lack of a better word” cut him out of the decision-making process. Here is how he frames it:

And I'm sitting there going, what next. What are they proposing to do? I mean, you know. Just “I'm the patient,” you know, you are going to be doing this to me. I would like to know what you're proposing to do.”

The surgeon who replaced Faye’s feeding tube was in such a hurry that he didn’t wait for the pain-numbing medication to take effect before beginning the procedure and he ignored her pleas to have a female nurse in attendance. She relates:

He just stuck it in there and within about ten minutes he was gone but that was the most terrifying ten minutes of my life because it was like, brought back memories of me being raped when I was eighteen.

Kate too experienced an attending physician who refused to use pain-numbing medication despite her request, stating that it wasn’t needed and he didn’t have it available at that time.

Hope encountered resistance to her requests to have her dialysis needles placed in a way that won’t jeopardize her vein access. But some nurses feel they know better:

LVN's tend they scare us because they walk in like they know us and know how our treatment should go when they've been on us for a few times. And it's hard because, well with me when I have a new nurse, I always tell that new nurse my needles go in this way and they tend to go in the opposite way and when they go in the opposite

way they hit a nerve and that's when it infiltrates your access and it hurts. And it makes me upset because I'm telling the nurse "don't go that way," you know, "you're hurting me." And they tend to go, "Oh you'll be fine, you'll be fine." And that makes me mad because it's like; you're not the one that's hurting, you know.

Ivan experienced a very similar situation when he was admitted to the Emergency Room:

One example was my potassium level was a little bit high so they put the IV in my hand and my hands are real thin so they went ahead and injected medicine through the IV into my hand. Well, it made my hand hurt so much that I was actually screaming and yelling and crying and I couldn't take the pain and they just kept doing it and said we just have to finish the injection of the medication and there was no way we could stop it. We knew already, since we had gone through this process many times that all they had to do was just give me a simple shot, and have me take another medication, instead of doing the shot that they were doing. We tried to explain this to them but they're like "no, no, you are our patient and you don't know what you are talking about. We're professionals; we know what we are doing."

Aside from this incident Ivan's wife was extremely frustrated with an intransigent nurse from an agency who delayed providing pain medication for Ivan as he didn't have time to locate an IV pole to hang the medicine.

Dismissive attitudes are viewed by patients as demeaning. Kate describes one such incident:

I had an incident with a doctor using sarcasm when the Attending doctor's standing by my bed with five or six Residents standing around and this doctor was asking me how my particular heart condition was diagnosed . . . I could not remember real quickly on how it was diagnosed. She was asking me, "was it done this way or that way" and I knew the diagnosis but I could not remember as quickly as she wanted me to remember how it was diagnosed. So, she was looking at the other Residents and rolling her eyes in her head and shaking her head like I didn't know what I was talking about. And then she finally, she threw her hands up in the air and she said "well, did that doctor just pull a number out of her head? Is that how she diagnosed it?" And it just, it took me back and I looked at the Resident's faces and they looked shocked too and it just, it took my breath away.

Abuse of the power differential in a medical setting is inappropriate. It decreases patient satisfaction and may increase risk for legal retaliation. Legitimate authority must be exercised with great respect for the relationship between the patient and the caregiver.

Jesus exercised considerable authority at times (Mark. 1:21, 22) and also confronted excessive authority in various forms during His earthly ministry. This is a desirable model for medical personnel to emulate in their professional relationships.

Partnership in Care

Patient care is greatly benefited when medical staff, patients and their families engage as partners in the healing process. Patients are becoming better educated not only as far as their medical condition is concerned but on what they should expect from their doctors as far as including them in the negotiation of their care. If they sense genuine interest in determining their insights patient satisfaction is greatly improved.

Among the interviewees Dana gives a notable summary of this concept with the following statement:

They involve me every single time in our main plan to get me home and that is a huge difference. I can't stress that enough. Like I said, I hate being there, but I have had a way easier time emotionally like in actually dealing with going in the last couple of years because I know that I have a team working with me. Not on me, but with me. That makes a huge difference. Because when the team walks out or the one doctor walks out and instead of me going, "oh my gosh why aren't they listening to my plight?" No it's not that. They walk out and thank you God that they know who I am and they know I'm doing the best I can and that they're working with me because it's hard on my body to control.

They know me well enough by now that my body's weird. I know my body's weird but let's work with trying. Because another thing too, I walk in and I go, "we know you are taking really good care of yourself and we've looked through your chart. We know you and if you weren't taking care of yourself you wouldn't even be here anymore," you know. That's again a huge, huge leap for me and makes it a lot easier and more tolerable.

Dana is speaking of a spirit of cooperation and understanding that characterizes the relationship which has built up over multiple admissions. But even Carl a first-time patient experienced what was for him an exceptional team experience. He uses phrases

such as, “the team was actually waiting for me when the ambulance arrived,” “the team came rushing into my room with big smiles on their faces,” “the team came almost every day, they came every day” to describe his sense of inclusion in the scope of his care. Further, at each significant stage in his care the surgeon and the team engaged with him in prayer providing an exceptional bond between them. His doctor at [Named Hospital] (Discussed in another section) compared the care between [Named Hospital] and Loma Linda affirming that “they would never come as a team,” “you would not have had a team experience,” and “You would have had good physicians at [Named Hospital] but there would not be a team.”

Faye who chronicled some difficult experiences with doctors provided this reflection to illustrate the ideal:

I tried to connect with at least one of the doctors that was on my staff, you know, on a personal level, not personal, personal, but just like telling them “hey my Mom's coming today or something like that,” you know, because I felt like then they were on my team, they're on my side, you know, and we were working towards a common goal and even though they were putting me through painful stuff they weren't the enemy, you know, they were trying to help me.

Erik, who had some difficulty with doctors using “medical-ese” advocates; “Just treat them as somebody that is intelligent enough that hey I'm a partner in this case. Treat me as such.” Lary also confirms the contribution of the team describing “the communication with the team was also excellent” and gave credit for “being here and having my life saved by this team.”

Not that there hasn't been difficult times between the patients and their care teams, but on balance there is a strong sense of satisfaction when patients feel they are together in partnership with their medical team. Effort invested in including patients and

families in an alliance that consolidates the insights and experience of each party seems to be the most desirable objective to aspire to.

Malpractice: Legal and Ethical Risk

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) brought many privacy issues to the forefront and caused numerous changes to how and where medical discussions take place. A high premium has been placed on confidentiality of patient information and their status while in the hospital. At the outset some very strict interpretations of the law restricted even beneficial arrangements aimed at enhancing patient care. Carl and his wife were active in visiting pending heart transplant patients following his successful surgery. Whereas previously they volunteered to visit people who were very sick and discouraged, they were no longer able to do so initially; “Another thing, the HIPPA law changed so many things. We were pre-HIPPA and when the HIPPA law came we were not called immediately.”

While the previous comment illustrated some initial limitations upon patient support Jeff describes a case where significant breaches of the patient’s privacy have resulted.

And then, when you came to visit me in 9200, I don't know if you know my roommate had been in there for thirty-two days. He was a Proton-beam mistake; they over-radiated him by fifty percent. A seventy-year-old guy. I learned all this listening to his conversations, doctors’ conversations, and his friends [etc.].

In multi-bed patient rooms it is almost impossible for medical staff to have private conversations with patients regarding their diagnosis, prognosis and care protocols. The difficulty increases in cases where the patient is hearing or cognitively impaired. Great

care must be exercised by all parties to minimize the dispersal of sensitive patient information.

Jeff introduced a second concern, which others had mentioned in passing that can be very unsettling for patients if they sense it. When trusting themselves to healthcare providers, patients desire the security of knowing that the doctors are competent and fully acquainted with their case. He notes his concerns in these statements:

A few things happened; the surgeon right after the surgery went on vacation so the Resident would come in every morning. She was the Senior Resident and I thought she was inappropriate because she would come in sweat clothes. I guess I was her first stop on her way to the Medical Center every morning. So she had a hoodie on and sweatpants and just didn't look professional.

The Attending physician, there was somebody different; there was almost somebody different every day because the surgeon was on vacation. So they didn't seem to have a real good knowledge of what was going on with me and my case and I think it was the Chief of the surgical, in fact he said to me, he says "I don't even know why I'm covering." I said, "Well Dr. Solomon is on vacation at a wedding back East." So I just thought here's the head of the department and he doesn't know why he's there.

The value of both looking professional and manifesting awareness of his condition are two important elements associated with quality care in this patient's eyes. Appearing overly casual especially when a relationship with the patient has not been established can be disconcerting when a patient is confronting a major medical crisis.

Adam's male nurse raised serious concerns for him and at the same time placed the hospital at risk through his behavior. Here is the situation:

Yeah because he was giving me injections and doing things without asking what it is he is giving me and refused to tell me, and that's a problem. That's a real problem as far as I was concerned because I always want to know what medications I am on.

The relationship between Adam and the nurse deteriorated over the week he was under his care until he arranged to have the Supervisor contacted and the nurse relieved of his care. Adam during the interview was incensed; "if you look at the mission statement here

in the hospital, he, he didn't believe any of it.” It was an untenable situation and the hospital did eventually terminate the nurse.

Despite an overwhelmingly positive rating of the hospital Barb did relate two incidents that suggest ethical and legal concerns that could have been avoided. The first concerned a doctor who “was very adamant about sending me home.” There occurred a verbal tug-of-war in which she challenged the discharge thereby resulting in her confinement to a room with only minimal care.

No-one was supposed to come in and do anything. She told me, “if I got sick again just go back through the ER.” And, I challenged the discharge. Three days later I decided OK, you know what, I've had enough of being treated like this. I'm going home. And sure enough, three days later I was back in the hospital and I ended up staying two more months.

Barb says she is not a litigious person so decided not to pursue the issue further. The second incident involved a failure to properly inform a patient of the risks associated with a procedure before they signed the consent.

But no-one explained to me that PICC lines could cause blood clots, so all that was new to me. So, that was a bad experience because I was told after the fact, not while they were, you know, while they were inserting the PICC lines or I was getting the PICC lines. They were just saying that because my veins were bad, I needed to have the PICC line and then after I contracted the blood clot then I was explained to that PICC lines cause blood clots. But I mean I wasn't angry, I wasn't angry, just disappointed that I wasn't informed before that.

Again Barb was generous enough in the light of her exceptional care otherwise to forego any legal action. To minimize risk to the institution it is important for all healthcare workers to gain informed consent before any procedure.

Faye's episode with the surgeon and male Residents left her feeling emotionally battered when it awakened memories of a prior sexual abuse where she was raped. She

had requested a female attendant be present during the procedure but this request was not honored.

But they didn't give any credence, any thought to the fact that I was terrified; I was scrunched up on my bed like this and that maybe that should have given a clue, "hey this is a special case, this is not just your normal run of the mill patient that we are going to put a tube in," you know. And I think that if they had even just asked me, you know, "hey are you scared," you know or is there something or had a female nurse there I think that the whole situation would have been a lot less traumatic for me.

Faye underscores the conflict of priorities that result in situations like this. The pressure to get the procedure completed led to a disregard of the patient's emotional state which could have been largely pacified by simply enlisting the help of a female nurse.

After a bad experience in the Emergency Room, Ivan's wife attempted to follow up with those charged with handling patient complaints.

I mean we called, I called the Patient Relations. Never got a call back. I called somebody else, I can't remember. The lady, there's a lady that's in charge of the Emergency Department, I can't remember her name, she's an older lady. They gave me her phone number and I called her too and until this day we haven't gotten any phone call. We do get those phone calls that do the reviews, but a phone call from Patient Relations, none.

At times the very mechanisms that are in place to provide patient support fail in their response to patient need. The anecdote above evidences a kind of selective hearing which treats the patient/caregiver relationship with disrespect. This is unbecoming behavior in an institution that cherishes the values of compassion, integrity, excellence, teamwork and wholeness.

Occasionally hospital caregivers encounter situations that are more complex than usual and desire some additional help with resolving the questions raised. Loma Linda is fortunate to have at the clinician's request the guidance of an Ethics Committee. Rather than settling for a quick solution, it may be the wise choice to request an ethics consult

from one of the resident ethicists. The guiding principles and scope of medical and clinical ethics are as follows:

Medical ethics involves the application of moral guidance to issues that arise in the practice of medicine. Medical ethicists address issues like abortion, euthanasia, research with human subjects, cloning, access to health care, allocation of resources, and many others. Clinical ethics, on the other hand, is the identification, analysis and resolution of ethical dilemmas that arise in the care of individual patients. It is case-based rather than issue-based. (Orr, 2009, p. 3)

When faced with uncertainty regarding an issue of patient care it is prudent to request the available help as well as the resources of a comprehensive ethics library so that the best course of action may ensue. Excellent patient care demands no less.

Comparison With Other Hospitals

In a few instances patients offered comparisons with other hospitals where they had received care. Each interviewee commented positively on the spiritual ambiance of the hospital which they had missed in other settings. Adam remarked, “Just because I've had 50 stays in Loma Linda doesn't mean that I'm not a hospital connoisseur. I've been in a lot of hospitals and this hospital is probably the most professional.” Carl who spent 60 days in another hospital and contracted Salmonella while there declared:

The kind of care that I received, I have nothing to compare it with other than [Named Hospital] which actually practically killed me. Salmonella from the food, the nursing staff very seldom came in unless you rang the bell a hundred times and you got very, very little care. Well that was just the opposite here. There was always someone who was present and available to you.

While nearly every patient had some unfortunate experience while at the hospital, they felt on balance that given a choice they would return to Loma Linda. There seemed to be a general recognition that individuals within a system can have a significant negative impact, but even this can be largely overcome by the combined weight of positive efforts

of a diversity of persons who live out their mission to “make man whole.” Erik recognizes that the capabilities of a large teaching hospital like Loma Linda probably saved his life and if he had been in a smaller hospital he might not be alive now. But, as Lary reported, a dysfunctional relationship with the Transplant Coordinator likely caused one patient he knew to go to another major hospital costing this institution hundreds of thousands of dollars in lost revenue. Relational factors are significant in the decisions people with options make when choosing medical care. This comment by Carl’s doctor at another facility sums up the sentiments expressed by others:

“This is an interesting thing.” He said, “being a believer I would have prayed for you, but not over you” and probably well, anyway, he just said, he said “there would not be the people praying for you that there were at Loma Linda and you would not have had a team experience. You would have had very good physicians at [Named Hospital] but there would not be a team.”

Summary of Patient Perceptions

Individuals make up departments and one person who underperforms can color the perception of a whole department. In every case interviewees were able to describe helpful and unhelpful events in any department area, highlighting the importance of every single care provider fulfilling their part of the mission to make man whole. What has been highlighted in these stories journaling their stays in the hospital is the encouraging accounts of caregivers excelling in the provision of whole-person care while providing the best clinical response to illness and injury. These same patients also provide snapshots of care that falls well below the ideal that the institution prides itself in delivering. In an age of constricting reimbursement and aggressive competition these accounts portray insights regarding the quality of care that patients look for and the neglect of human relationships that may cause patients to seek care elsewhere.

The Intervention Response

Modeling Whole-person Care With Student Physicians

The initial focus for this study was to model a whole-person approach to patient care primarily with doctors and nurses on the Cardiac ICU Unit 4700. As a result of several unavoidable logistical changes in the hospital the Intervention Response was redirected to focus on fourth-year medical students as they would be graduating the following year and beginning their residencies. I had the opportunity over several years, by participating in the whole-person care elective sponsored by the Faculty of Religion, Center for Spiritual Life and Wholeness, to take students with me on patient rounds so they could observe the approach chaplains use to minister to patient's spiritual needs. This elective is chosen by those medical students who desire to integrate spirituality into their medical practice in a wholesome manner.

For the purposes of this project my goal was to model whole-person care with patients in the rounds and to devise an instrument, *Senior Elective: Rounding Visits with Chaplain* (APPENDIX B), for the students to evaluate my execution of it as far as they could determine. Each one-hour session allows for one to six students to accompany me on the rounds. We start at the first room and visit each new patient in order as I would do if I was making my normal visits. Because I have not met these patients before we encounter patients who are asleep, experiencing significant confusion, or are unable to communicate due to their medical condition. Occasionally, because there is more than one patient in the room, we do visit with someone I have met before which provides a contrast for the students of having developed a relationship with the patient. During that period I hope to make three to five effective visits which will then allow 10 to 15 minutes

to debrief and respond to student questions and input. In the debriefing time after the discussion I pick one of the patient visits asking each student in turn, “If this visit had occurred with a patient you were visiting or a patient you were consulting with in your office, how might you have handled it?” I allow each student to make their comments before summarizing and offering any relevant additional insights that may be appropriate. The debriefing session can become very intense as students wrestle with questions they have never addressed before.

During, between and following the patient visits I teach about human interaction and skills of communication. If one person visits a patient a certain response will occur, but if six or seven enter the room then likely a somewhat different response will result. If the patient rambles in their discourse I note if the students allow their concentration to wander; a topic that will be addressed in the debriefing. When there are barriers to communication such as cognitive ability (due to the disease process, infections, medication), language or sleeplessness then alternative ways to communicate are explored. It is vital for the students to understand that it is not sufficient to simply give the information; the patient must be able to confirm that they comprehend.

For doctors in a busy medical practice time is of the essence. The students witness how to provide an effective visit even if the duration is short. In the patient rounds the students observe how to maximize the time to meet the needs. They watch how chaplains begin and end conversations so that the patient feels satisfied they have had sufficient time to state their concerns and gain a response. Physicians are sometimes reserved about introducing emotional and spiritual components into a conversation for fear of opening a discussion they cannot terminate. Chaplains in their role, model respect for all of the

diversities, even those who are disrespectful of others. Not uncommonly a patient visit uncovers a situation where the patient is in significant spiritual and emotional stress necessitating a more involved response. On occasion students have joined with the patient to offer an additional level of support they may not have anticipated in providing.

During the debriefing session the discussion calls upon the latest research and the issues doctors are debating as outlined in the Literature Review. I highlight journals that focus on the crucial importance of excellent communications skills that seek to inform patients not only of their diagnosis and prognosis but options regarding benefits and risks of medications or procedures. We weigh the need for patients to be able to trust their physicians and the fact that while the doctor is making an assessment of the patient, the patient is making an assessment of the doctor to ascertain whether this person will be a true ally in their battle with the disease or injury they are facing. I indicate that researchers such as Davis et al. (2008) link poor communication as one of the bases for poor patient satisfaction which if troubling enough may rise to the level of legal action. In the dialog I advocate a partnership model of care like authors Calne et al. (2009) rather than the paternalistic approach of prior times.

Our debriefing session is further informed by insights gathered from the patient interviews showing what patients are anticipating from the visit with their physician. As a chaplain on the units I witness many physician/patient/family interviews and consultations. I am present either coincidentally while visiting with the patient or at the patient's request to provide spiritual input as patients make decisions about their care. Thankfully, the vast majority of such interactions are well planned providing the patient with enough information to make an educated choice. The physician speaks articulately,

listens well, and gives consideration to the patient's cognitive abilities, moral and religious principles. Time is allowed for the patient and physician to connect, build or continue a working rapport. Questions are raised and discussed until there is sufficient understanding for the consent papers to be signed and the medical team ends the visit and leaves the room.

Typically, medical students will ask me to share examples of patient/physician interactions I have observed that portrayed attitudes to either avoid or emulate. I have used this preface and examples to illustrate. The doctor (and medical team on occasion) stands at a distance from the patient. A hurried delivery often with considerable medical jargon describes what is planned to address the patient's medical needs. A perfunctory "Any questions, no?" follows and the consent papers are passed for signature. There seems little genuine thought for the ability of the patient to adequately process the information and the implications in order for them to make the consent informed. I recall on one occasion a resident physician came in when I was present visiting the patient Barb and stood holding the curtain divider between the two patients. He hurriedly gave an update and that a certain procedure had been scheduled for late that afternoon. There would be no lunch and no food or fluid for the rest of the day. He quickly left without opportunity for response or questions. Barb seemed stunned to silence but eventually offered, "What was all that about?"

Kate, one of the interviewee's talks about the doctor coming in, sitting down on a chair beside the bed, and carefully explaining the plan of care to her; taking time to listen to her questions and responses. Typically physician visits fall along the continuum

between these two opposites. These cases can generate significant conversation among the students as they wrestle with time constraints and role definitions etc. on the unit.

Intentional care that respects the values of the whole person more efficiently carries forward the plan of care, potentially reducing the hospital length of stay. Ultimately, reduced stress on the part of physicians is a valuable byproduct of this approach to healthcare which is an important consideration in this era of face-paced, productivity oriented careers.

At times I'm also requested to introduce the students to the curriculum for the rotation by reviewing the learning objectives, course assignments, details of their research project, the chaplain preceptor rounds, patient interviews they will conduct on their own and report on, and a final debriefing with the main instructor. Students can opt for a two-week or four-week module for this elective.

Similarly I am often called upon to conduct the final debriefing with the students. During this time their research project is discussed. The project comprises a health or medical topic of interest to them that is addressed with whole-person care principles in mind. They must integrate a whole-person care perspective into the discussion and response they propose to the topic in order to successfully complete the course. After the sharing and discussion is complete I routinely propose a question like, "What have you learned from this rotation that will benefit you following your graduation and as you begin your practice?"

An additional component of the implementation was to orient and train another chaplain [Chaplain B] to utilize the instrument with students he took on unit rounds every other week. For comparison purposes the medical students also rated his performance and

modeling of whole-person care which is presented as a table (Table 2) and as a separate graph (Figure 1). By utilizing a second chaplain I am leveraging the effectiveness of the Project implementation and the Department Director plans to make the Instrument a permanent component of the whole-person care elective for senior medical students.

At the conclusion of the debriefing after visiting patients on the unit we give each student a copy of the *Senior Elective: Rounding Visits with Chaplain* and ask them to score it and hand back the folder with the responses to the Secretary on the way out of the Chaplain’s Office. The tabulated results and comments follow:

Table 2

Medical Student Evaluations of Chaplain Visits With Patients

Question	Chaplain A [Researcher]	Chaplain B	Composite
Q1	5.00	4.93	4.98
Q2	4.96	4.80	4.90
Q3	4.92	4.87	4.90
Q4	4.80	4.80	4.80
Q5	4.92	4.93	4.92
Q6	4.96	5.00	4.97
Q7	4.96	5.00	4.98
Q8	4.92	5.00	4.95
Q9	4.76	4.93	4.83
Q10	4.88	4.87	4.88
Totals:	<i>n</i> =25	<i>n</i> =15	<i>n</i> =40

Note. Scale used to calculate the *mean* above is *min* = 1, *max* = 5

Critique of Survey Results

As the numbers of the collected surveys from the medical students were not large, and the purpose of the survey was to gain an understanding of the student's views of the chaplains modeling approaches to whole-person care, no extensive statistical analysis was performed other than to calculate a *mean*. The responses from the medical students were not surprising, except for their assessment of the chaplain's visit under questions four and nine, "the chaplain conveyed that he/she had as much time as needed for the visit" and "the chaplain used an appropriate amount of time to explore the patient's concerns and requests." A third point of interest was evidenced in responses to question two, "the chaplain clearly explained the reason for the visit." The students identified that of all the values rated the chaplains did not seem to convey to the patient they had sufficient time to relate to the patient's needs and concerns. This was not true in every case, but often enough to be apparent when depicted graphically in the exaggerated scale at Figure 1 rating the responses.

Figure 1. Medical Student Evaluations of Chaplain Visits with Patients (N =40).



Note. Scale used to calculate the mean above is $min = 1, max = 5$ ($n = 40$)

From a modeling perspective, this is a valuable observation from the medical students as physicians are often criticized regarding the length of time allocated for a patient visit. In the debriefing following patient visits I routinely initiate a discussion on how a physician utilizes the available time during the visit for the most worth. There is a great need to creatively use the available time at work and after hours in order for the physician to retain balance from a whole-person perspective.

Student Physicians' Comments

Students were encouraged to make comments on the survey form, and I have included all that were offered below in date order. Some of the comments filled the designated space and spilled into the margin to complete the response.

[Chaplain A – 9/5/12] “I was impressed with his quiet and comforting style; I thought it was effective and I felt that I can incorporate some of it into my own practice.”

[Chaplain A – 9/5/12] “Was an excellent example of how WPC can be conducted in the hospital setting. He was warm, respectful, concise and consistent with his beliefs all the while putting the patient first. Thank you!”

[Chaplain B – 9/12/12] “Excellent discussion/debrief.”

[Chaplain B – 9/26/12] “The modeling that he used was very effective in reading the patient and incorporating wholeness. It was good to see his technique in entering into the patient’s life in a limited amount of time.”

[Chaplain A – 10/3/12] had a very approachable approach to the patient. Visits never felt rushed and he respected the patient and their beliefs, physical and emotional being. I learned to listen and to take to heart the message that the patient had with [Chaplain A].

[Chaplain A – 10/10/12] was able to approach patients very openly without any particular religious leaning so as to be sure patient was aware of chaplain’s office availability at [a] future time. He was very good at reading and responding to what patients’ wanted or did not want.

[Chaplain A – 10/10/12] was very effective in initiating conversations without forcing the patients. He has a way of putting everyone at ease. Patients are very receptive of him and he tends to make everyone smile. He is helpful in ways beyond spiritual guidance as well. He coordinates with care managers and social workers to ensure the patient’s needs are met. He also provides the patient with any information requested within his means.

[Chaplain B – 10/17/12] “Continue to do your work for God. Thank you for your help.”

[Chaplain B – 10/17/12] Connected very easily with the patients. He did not force any topic or conversation. It was easy to see that he was genuinely kind and caring. He has excellent intuition and sense of what patients are comfortable sharing.

[Chaplain B – 10/31/12] “Great job listening to patient.”

[Chaplain B – 10/31/12] “Appreciated his take on ministry to staff.”

[Chaplain B – 10/31/12] “Encouraging to know that our mission of whole person care is portrayed to patients.”

[Chaplain A – 11/7/12] “The visits were not as long and in depth as I was expecting. I was surprised that he didn’t do as much digging, but instead let the patient direct the conversation.”

[Chaplain A – 11/7/12] “Was a good example of compassionate understanding, discussion of patient’s concerns from patient’s perspective.”

[Chaplain A – 11/7/12] “I was impressed by his open-ended listening to his patients.”

On the whole the medical students appreciated the style and approach used with patient interactions. They commented on warmth and personality as key components in the visit which encourages the patient to feel comfortable bringing up issues of concern. Students learned that listening is the prelude to understanding the patient. Putting the patient first is an important observation that the medical students commented on. Students saw that when issues are identified, the chaplain involved other team members to bring additional resources to best help with the patient’s concerns. Incorporating wholeness and whole-person care was among the concepts noted in the comments. One student articulated that some of the concepts modeled could be incorporated into the medical practice.

Respect for the patient’s beliefs and time registered in the student’s minds which link in to comments indicating the importance of these factors made by interviewees in this study. The surveys in both grading and comments highlighted some differences in expectations between chaplains and physicians regarding the length of time spent with patients during the visits. Two questions in the survey, (Question 2, Question 9) relate to

time spent with the patient which the medical students considered insufficient as indicated in the grading recorded in *Figure 1*. Four students (10%) graded Question 2 and Six students (Nearly 17%) Question 9 negatively. The other anomaly was found with Question 2, where four students (10%) found that the chaplain didn't sufficiently explain the reason for the visit to the patients.

Modeling Whole-Person Care With Charge Nurses

In order to extend the influence of my modeling and teaching of whole-person care principles in my areas of ministry I arranged with the sixth-floor Nurse Manager to make presentations at the monthly Charge Nurse meetings. Two presentations followed; *Patience with Patients* and *Difficult Conversations*. The objective of the presentations and discussion that followed was to educate the charge nurses so that they in turn could guide the floor nurse through difficulties they encounter with their patients. With this approach whole-person principles would be more widely dispersed and the use of my time and resources maximized. More presentations were planned but the CMS visit to the hospital curtailed the teaching due to the pressure to relate to other regulatory and process requirements that needed to be implemented. The plan is to rejoin the conversation as soon as the CMS issues are fully resolved.

Modeling Whole-Person Care on the Unit

Every day I am approached by nurses, PCA's, or therapists on the units regarding patient care questions or concerns. Often the demands of a particularly challenging patient intersect with the accumulated stress of long days of caring resulting in frustration and depreciated morale for the healthcare worker. Not infrequently, conversations

surround strategies for meeting patient needs that seem to rise well above what is called for in managing their medical care. Nurses and doctors verbalize that they are seeing patients who are sicker and lack life skills sufficient to manage their health and keep them out of the hospital. After exhausting the available treatments the patients are discharged only to return in a few days for another extended stay. Some of these patients are very bitter about their lot in life and in their frustration can lash out at the medical staff as well as refuse to comply with the medical plan to manage their condition. A 12-hour shift under these conditions can seem interminably long.

The current reimbursement climate is a compounding issue in healthcare driving both providers and management's approach to outcomes. The ideal day focuses around consistent success in all of the activities that attend patient care so that patient turnover can be maximized. Delays cost, so, much depends on boosting productivity. Because it takes some time to accommodate patient surges staff are required to flex and accept more responsibility than they are comfortable with until additional help arrives. On a number of occasions I have offered to assist the nurse to transport a patient to the cardiac catheterization lab or held IV bags until a support is located. This serves to demonstrate that we work together in partnership for the good of both the patient and staff. No one is immune from extending himself or herself to better facilitate the needs of either patients or staff thereby reducing workplace anxiety for all in practical ways.

Teaching Whole-Person Care to Nurses

Four times a year I participate at the School of Nursing for a two-hour period in a dialog on the practical meaning of whole-person care with graduating nurses. Besides me, representatives from Social Work, Diet and Nutrition, Physical and Occupational

Therapy and Home Care nursing join in a small group discussion with six to eight students. Their assignment is to prepare whole-person care questions relevant to each discipline which they will invite us to respond to from our training and experience as we rotate between each of the groups. A genuinely robust discussion ensues in which I recount cases from my own ministry to illustrate my approach to the patient's questions or need. I sometimes provide a case example asking each in turn, "Suppose you are the chaplain for this person or this was a question your patient asked you as a nurse; how would you handle it? I allow the group to pool their best insights and I summarize with any additional content.

Conclusion

For the purpose of this project the major intervention is implemented with the student physicians but several concurrent additional implementations, as described above, maximize the modeling impact of whole-person care on the unit. I believe it is essential to layer the approach to underscore the imperative of all healthcare personnel seeking to build partnerships between themselves and their patients.

The profundity of human pain is such that even the Son of God weeps in its presence. This provides a perspective of understanding for relating to the illness-induced manifestations of brokenness that healthcare personnel confront on a daily basis. Patients Gary and Ivan perhaps capture the essence of this concept best with their descriptions of acting out in quite dramatic form which escalated to physical confrontations at times. They both recognized and described after recovering that it was illness and not character that drove the altered mindset and they were thankful for the nurses who understood what was happening and did not take it as a personal affront. How comforting for a patient

when they regain their equanimity to hear as Gary did, his nurse respond with, “Oh don’t worry about it, you know, we know you were sick, you know, we know you have been through a lot,” when they began to apologize.

This is the essence of whole-person care, when the context is far from ideal, and yet care providers move out of their comfort zone to accommodate the exceptional circumstances and make the patient as comfortable as possible in what is sometimes a frightening environment for them. Offering excellent care utilizing intentional and effective communication, providing evidence that informs decisions in an understandable way helps build a trust partnership that enhances patient satisfaction. This project is aimed at fostering changes in healthcare practice that will ultimately benefit patients, medical personnel and the institution where they are implemented.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

Summary

The onset of serious illness or major injury can introduce significant uncertainty at least, or an existential crisis if there appears no immediate resolution. It can be a frightening experience even for those familiar with the hospital environment and how it operates. Dependence upon intravenous lines and electrical monitoring further reinforces the loss of volition experienced by patients. My own experience in cardiac ICU some years ago recalls thoughts of potential catastrophic life change and disassociation from familiar home and work routines.

In addition to these environmental concerns come the interactions with medical personnel tasked with resolving a health crisis and ensuring a safe discharge from the hospital. Hopefully, the human touch will mollify some of the patient's immediate concerns with information delivered in a timely and caring manner. In practice, interventions must be implemented in far from ideal contexts straddling cultural, educational, philosophical, linguistic and religious divides in a race against time. Despite the challenges, in the majority of cases, patients leave the hospital satisfied.

In the instances where the outcome is less than satisfactory however, the fault in the majority of these can be attributed to a breakdown in communication. According to O'Daniel and Rosenstein "Communication failures are the leading root cause of sentinel

events reported to the Joint Commission from 1995 to 2004” (as cited in Hughes, 2008, p. 272) In my daily rounds at the hospital I am party to many conversations between medical professionals and their patients. My observation is that doctors, nurses and therapists jeopardize their communication with patients by speaking too quickly, with too much medical jargon, from too great a distance, and with too little opportunity for the patient to integrate the content and ask questions. These facts are born out unofficially at Loma Linda with almost 80 percent of complaints reaching the Patient Relations Department related to issues with a breakdown of communication.

The purpose of this study was to gather patients’ assessment of their interactions with medical personnel while in the hospital regarding their level of satisfaction with the conveyance of information, responsiveness to needs and respect for personhood; and to describe a model of care that promotes a genuine response to the concerns raised.

Justification for this project surrounds the fact that periodically, a patient or family member expresses significant frustration with the manner in which their care is being handled. Anecdotes often attribute the attitude of a staff member providing the care as causing them to lose confidence that they are receiving the unbiased, professional service they expected when coming to Loma Linda University Medical Center. Occasionally the complaint originates from caregivers that the patient and/or family are uncooperative to the extent that they are refusing the care to which they are entitled.

Patients and/or families enter the medical setting with expectations regarding their care, sometimes stemming from previous hospitalizations. Re-hospitalizations are common for those with chronic medical conditions, and a precipitating unhelpful event can set up a negative sense of anticipation which now confirms these reservations.

Staff members under stress may overreact, thereby setting up antipathy with the patient and/or family. Additionally, previous experience with this patient and/or family may precondition expectations, making it more difficult to rebuild fragile relationships.

My expectation for this project was to catalog self-destructive attitude dynamics with a goal of substituting interpersonal communication modes that promote healthier collaboration between patient, family, and hospital personnel. I wanted to develop awareness that attitude and communication impacts the implementation and follow through of the plan of care by suggesting proactive strategies to avert the formation of adversarial attitudes between patients, families, and unit personnel. The project was intended to assist healthcare personnel in taking initiative in creating an enduring working relationship with patients and families thereby demonstrating that effort invested in attitude management contributes to patients accessing the needed care earlier and returning to gainful employment or the home environment sooner.

The Doctor of Ministry Cohort in Chaplaincy has been instrumental in awakening a developed awareness of the value and power of ministry to hurting people wherever they may be seeking healing. My ministry context at this time is the hospital, but the principles studied and learned here can be applied under the direction of the Holy Spirit for the good of people in any setting. The program is rigorous enough to foster diligence in study with the right tools to acquire the insights available from many sources. Well-trained and godly professors encouraged the pursuit of the highest ideals in order to excel in the profession of ministry. Completion of this project demanded much in terms of research, application of strict discipline and fidelity regarding the patients' insights and understanding about their care and perseverance with the detail to reach a successful

conclusion. I wish to elaborate on four areas that significantly contributed to my learning and growth during this educational experience and deserve separate treatment.

Conclusions

The Theological Foundation

Revisiting Jesus' ministry with the sick and discouraged was especially enlightening and provided valuable insight that has been profitable for me in my daily rounds with patients on the units. The diversity of people he encountered along with the variety of circumstances that caused them suffering provided windows into the world of patients in the hospital right now. The physical suffering may be the presenting problem that causes them to enter the hospital, but sickness or injury intervenes in the ongoing affairs of living which are not left at the curb when a patient is admitted. Many hospital visits uncover short and long-term concerns that sometimes eclipse the immediate medical context and must be addressed. Looming vocational and financial concerns threaten the future for the patient and his or her family. Relational dysfunction can be exacerbated by a long-time hospital stay. A person's faith in God or an understanding of one's view of life can come up for serious review when health and volition are jeopardized.

All of these issues and more arise in various forms in the record of Jesus' life and ministry as He represented the attitude of God towards individuals and their daily concerns. I find myself continually referring back to the stories of Jesus and the people He meets for insights that might apply in a current situation. Thanks to the Doctor of Ministry course content in *Spiritual and Theological Foundations for Ministry* (Dybdahl, 2010) I have developed a fuller appreciation of how Jesus empowered His ministry,

effectively engaged individuals in their time of need and inspired hope when hope was all but lost. I learned additionally that Jesus' ministry was very intentional and focused on His mission for this world. This insight has helped with triaging and prioritizing the many claims upon my time and energies. Chaplains are not immune from overcommitting themselves to the many opportunities to minister and to involve themselves in numerous ancillary service activities. These understandings flow over to my work with the Medical Students as time constraints factor in to how they conduct their practice.

There was much about religious practice that Jesus criticized, but He did not decry the instituted religion per se. His concern for people guided His teaching and healing ministry, particularly those who were trapped by life circumstances beyond their control. His conciliatory attitude won Him respect among those with the greatest need. While having great authority He used it judiciously to promote His Father's kingdom and serve disenfranchised and hurting individuals. No hint of paternalism marred His concern for others in their time of necessity.

Besides utilizing appropriate authority Jesus' ministry confirmed additional spiritual principles that form the foundation for the chaplain's ministry in the hospital. When others kept their distance Jesus modeled genuine spiritual, emotional and physical intimacy. For the lepers and other outcasts His approachability was widely known (Mark 1:40, 41; Matt 9:10, 11) and welcomed by them much to the chagrin of the Pharisees. When others criticized, Jesus advocated on their behalf (Luke 7:39-50) even in the presence of rich and influential benefactors. The honest in heart were given no cause to believe that Jesus would forsake them or delegitimize their need.

The principle of autonomy or sovereignty is germane to the focus of Jesus' healings which opened the possibility for a person's return to a former productive life before the illness that struck them down. This is particularly apparent in the cases of demon possession or mental illness where Jesus' positivity in the face of others' pessimism opened the door to not only sanity but in some cases missionary work (Mark 5:18-20). The principle of Teachability in difficult cases such as this one is a two-way street for chaplains. Not only is there the likelihood of genuine help resulting but a real possibility of acquiring additional insights and skills to benefit other individuals. Nothing is ever wasted in the economy of God.

Jesus' receptibility and sensitivity are endemic to His ministry among the disenfranchised and alienated and are principles that are often called upon while chaplains are serving hospital patients and their families. A hospital admission can generate numerous personal indignities that must be negotiated respectfully by hospital personnel. Learning to relate professionally and yet authentically is an art acquired through many interactions as well as remaining teachable through our mistakes. Once trust has been established the chaplain's agreeability to remain in a tense and sometimes hostile environment is a skill well illustrated in the people to whom Jesus ministered.

Willingness to relinquish our comfort zone for the benefit of another is a principle Jesus demonstrated often. He, the Son of God, was the celebrated Teacher but He didn't hesitate to accommodate the real life needs of hurting people (Phil 2:5-8). This adaptability was manifested by His ministering to people who weren't Israelites such as Canaanite and Samaritan women, and the Centurion. Protecting the deaf man's privacy is another example of Jesus' sensibility (Mark 7:31-37), a principle that has growing

implications both ethically and legally in healthcare settings. The last, but certainly not the least of 13 spiritual principles identified in Mark's gospel is spirituality. A chaplain's ministry will flounder if it is not based on a living connection with Jesus (John 15:1-8). Jesus' familiarity with the scriptures and His regular and substantial engagement in prayer with His Father are practices that empowered everything He attempted.

These 13 identified principles are not exhaustive; the ones selected are most relevant to the focus of this project. They provide an overview, along with illustrations of Jesus interacting with individuals in ways illustrative of chaplain visits in the hospital. In the rounds with medical students I seek to portray the attitude Jesus may have manifested had He been the chaplain of the day. This has been a meaningful incarnation of Loma Linda's mission of seeking "to further the healing and teaching ministry of Jesus Christ to make man whole." in this context (Loma Linda University, (2012b). I have experienced a renewed vigor in my ministry as a result of my research for this project thereby benefitting not only patients, families, and hospital staff but myself as well.

Finally, I fully believe that I do not minister alone or I would not be able to function at the level I do. The chaplain is the human instrument under the mentorship of Jesus to carry out the purpose of God to the suffering. It is not that we always perfectly sense the leading of God in every situation, but there is a real difference in a ministry that commits the day first to prayerful reflection on the life of Jesus. As a direct result of my research and instruction from this program I have considerably reduced the vocational stress of patient care because I understand that not everything depends upon my efforts. This brings a freedom and joy to ministry that allows the chaplain to enter more fully into the moment with the patient in seeking the comfort and encouragement of God for them.

The Spirit is at work concurrently in the patient so that at the point of meeting both the chaplain and the patient experience growth and development in their understanding of God and His provision for their needs. On numerous occasions I have been blessed by having the patient offer to pray for me and my continuing visitation for the day. Jesus Himself experienced this kind of enervation when He met with the Samaritan woman at the well, much to the surprise of His disciples. (John 4:31-35)

The Literature Review

Since the early 1970's a growing interest has been emerging to cater more fully to more than just the physical needs of patients. The clinical outcomes are vital and every effort must be made to sustain progress towards more effective treatments and cures for the various medical conditions encountered. At the same time patients are becoming increasingly enlightened by news reports, disseminated information on the Internet and first-hand accounts to expect a fuller partnership with their treating medical personnel in the manner in which care is carried out. In an age of a growing awareness of personal autonomy patients and their families are expecting to be consulted and involved in the decision making process. Many patients including most of the interviewees for this study are well-informed on their medical challenges and do not take lightly doctors arbitrarily making decisions without their consent.

The literature I reviewed for this study is very aware of all of these concepts. Articles, books, webinars and online web resources are replete with copious documentary and multi-perspective analysis which if assimilated all medical personnel could readily benefit. But as I learned, long-established patterns of behavior don't surrender easily to new approaches. So while the doors of change are opening, not every physician, nurse or

therapist has yet walked through. It may take many more experiences such as the one interviewee Kate recounted where the young resident physician promised he would never put his patients through what Kate underwent at the hands of his attending physician. This illustrates that even the negatives can be instructive to those who desire to promote the highest level of care for their patients. To serve that need the literature offers substantial and comprehensive content including many peer reviewed studies.

The opportunity and privilege of browsing large numbers of medical journals gave me insight into the mind of the physician and a deeper appreciation of the struggle they face to balance the need and at times the demands of patients with the vast array of regulations, protocols, financial and insurance considerations that must be met. The proposed federal budget for the fiscal year 2013 amounts to US\$897 billion and represents a growth from 7% to 24% of the total federal budget over the last four decades (National Priorities Project, 2012). Increasing discussion in the literature outside of the scope of this project illustrates a great deal of concern regarding what the future shape of medicine will look like. Suffice to say that the many variables in play in uncertain economic times raise numerous career choice concerns for doctors and nurses that sometimes crowd out concentration on the patient and on his or her needs. In this light the support and modeling of chaplains is a welcome asset to the medical treatment team.

The Patient Interviews

I visit with patients and their families every day and have done so for more than twenty years. Their stories and illustrations of excellent care given and also where they felt the care missed the mark are very familiar to me. But I had not anticipated to be so profoundly touched by what unfolded in the interviews. I have witnessed many well

executed physician dialogs with patients and have been impressed with how professionally and yet so empathically the doctor was able to bridge each of the communication barriers to provide the necessary evidence for patients to make informed decisions about their care. Conversely though, some patient and doctor consultations lacked not only sufficient content for the patients to determine the right choice, but were devoid of any real connection with them as persons deserving to be acknowledged and respected.

Patients too were moved by their experience in the hospital. They came with expectations from what they had heard and no doubt testimonies from friends or relatives. In many cases these expectations were met and even exceeded. Each interviewee ably presented one or more stories that captured examples of medical staff going beyond what they had expected to meet their needs. For some this assumed the dominant pattern that characterized their care in the hospital. The transcribed interviews capture the words used by patients but are largely unable to convey the emotion behind the words. Laughter, tears and indignation at times filled spaces between words and sentences as stories were related. When the conversation turned to situations where the patients' fears were aroused, the sense of that in their expressions was palpable. Serious illness places all possibilities, even death, on the table and patients have to reckon with thoughts and feeling unlike anything they have faced before. In their minds the last thing they want to entertain is a conflict with the people who potentially hold their fate in their hands.

What medical personnel must appreciate is that in reality it doesn't take extraordinary steps to gain the patient's confidence. Conducting the interviews reawakened memories of my own medical journey at the hospital. While walking across

the car park one afternoon I was startled by a sudden onset of disconcerting cardiac symptoms, so intense were they, that I walked directly into the Emergency Room. After an initial triage I was placed on a gurney in a room and assigned a teenage volunteer to sit with me. She never left me for the next two hours until I was moved to the ICU but I still remember how comforting it was to have her there as I pondered what my future held. She had no medical skills and didn't offer much conversation but in my mind she was my lifeline if I needed urgent help. This was the most reassuring thing of all and likely quelled my potential psychic disequilibrium.

In my work as a chaplain I listen for emotion behind the words that are used as patients relate concerns that are bothering them. When I advocate with the doctor or the nurse I acknowledge their duress followed by a perspective on the patient's request that has not been fulfilled that includes some of what the patient is feeling or fearing. Because physicians are under heavy time constraints it is easier to justify disengaging a conversation with a patient in distress before assuring adequate follow-up because other patients are also waiting. Interviewees however sense a form of abandonment that can result in long hours of fretful restlessness. Far better in the interviewee's eyes, to invest the necessary time and effort to establish a solid plan of care from the outset that includes caring for the emotions and the spirit.

The Intervention Response

The decision to tailor the intervention employing graduating medical students proved a very viable option. Physicians and residents already on the units are ordinarily settled in their modes of operation and by and large have little time to devote to additional changes to routines. This is not true in every case as many profitable

conversations have transpired regarding patient care with doctors on the units. But the medical students are at a place where they are receptive to fine tuning their approach to care because the majority of their training is complete and this is the final assignment before graduation. Sixty-seven percent of physician graduates elect to take the whole-person care rotation with chaplains which evidences a very hopeful mindset for the future of medicine at Loma Linda and other places graduates may begin their practice (Hoffman, 2012). The basic elective is two-weeks but many choose the four-week option to gain as much from the experience as possible.

I have found the students eager to participate in the patient visits we make together if given the chance. In my introduction I introduce, besides myself, each of the medical students explaining that they have chosen this final elective for the purpose of better understanding patient needs before they go into fulltime practice. If I determine a patient may be willing to entertain their questions about care they have experienced I will first gain their permission and then open the visit to the students to dialog on aspects of care and gain the patient's feedback. I commonly offer the students an opening for a discussion with a question like, "[Patient Name] is in the hospital for treatment for [Condition]. Is there a whole-person care question you wish to enquire about while we are visiting today?" I may also, if the patient has sufficient energy, offer them the opportunity to tell the students how they desire their doctor to interact with them. On occasion a lively discussion ensues as student and patient compare insights which will engender further review in the debriefing session following patient visits. Patients are inclined to be very frank about their experience with the students possibly because there is little chance of any negative ramifications in this context. The students are impressed

to hear firsthand how patients view the human side of medicine, often with a level of sophistication that surprises them.

An animated discussion usually ensues at the debriefing session after the patient visits. I offer to respond to any of the student's observations, comments, concerns and criticisms about any aspect of the time spent on the unit that day. In the critique when a concern arises I provide an opportunity for each student to first address it from the perspective, "If this was a patient of yours and this situation came up, how might you have handled it," before giving my perspective? When all the issues raised are covered, I invite the students to complete the *Senior Elective: Rounding Visits with Chaplain* questionnaire and hand it in to the department secretary. To date 100% of students have complete the questionnaire.

The difference between the scores is small but sufficient to highlight both questions regarding the length of time spent with the patient. From my hospice chaplaincy experience I am very conscious that serious illness is debilitating and patients often lack discretionary energy even for conversation. I am more inclined to protect the patient from exhausting themselves unnecessarily. In most cases I will not wake a patient unless given specific direction to do so. Physicians and nurses on the other hand function from the perspective that care must be provided for at set times and durations. Physicians lament the paucity of time because they must service so many patients each day but recognize the value of additional time in a different context. That being acknowledged, it may be well to reexamine this aspect of chaplain visits in case a modification is in order.

I am both thankful and humbled to have had opportunity to participate in a project of this nature in which everyone involved benefits in real and tangible ways.

Recommendations for Further Research

Whole-person care continues to emerge as a comprehensively viable approach to the needs and concerns of patients and their families. Further, the benefits pour over to all medical personnel who adopt whole-person attitudes as efficiencies in time and resources will be realized in both the short and long term. The following recommendations for additional research may benefit ongoing implementation at Loma Linda and other facilities.

1. In light of the full implementation of Federal government's investment in the Affordable Care Act in coming years an analysis should be made of the cost versus benefit implications that whole-person care introduces in patient care. This is particularly relevant because new models of caring for large numbers of aging patients and diminishing resources are calling for a greater emphasis in community based primary care to promote wellness rather than simply treat with more expensive tertiary care.
2. Utilization of the *Senior Elective: Rounding Visits with Chaplain* tool with the full chaplain staff to further test the adequacy of the questions asked.
3. Research the literature and survey chaplains in other medical settings regarding time allotments for patient visits to better respond to the student physicians' observations.
4. Survey current physicians' model of care and create additional opportunities for them to gain exposure to the whole-person approach as recommended in the literature.

APPENDIX A

**LOMA LINDA UNIVERSITY MEDICAL CENTER
PATIENT CARE STATISTICAL PROFILE**



Quick Report
Free Hospital Look-up
Loma Linda University Medical Center

System Classification	Moderately Centralized Health System
System Affiliation	Loma Linda University Adventist Health Sciences Center
Total Expense	\$1,069,164,415
Personnel	6,900
Births	2,654
Outpatient Visits	481,754
Admissions	28,066
Total Beds	815
Urban / Rural	Urban
Teaching Affiliation	Major
Primary Service	General medical and surgical
Ownership Type	Nongovt. (not-for-profit) - Other
Phone	(909) 558-4000
Zip	92354-2870
State	California
City	Loma Linda
Address	11234 Anderson Street
Website	http://www.llumc.edu
AHA ID	6930053
Hospital Name	Loma Linda University Medical Center

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APPENDIX B

SENIOR ELECTIVE: ROUNDING VISITS WITH CHAPLAIN

Chaplain Preceptor: _____ **Date:** _____

Description: This rotation provides the medical student opportunity to spend time in both study and clinical involvement in discovering ways to integrate health care to include the physical, mental-emotional, social-relational, and moral-spiritual dimensions.

Please evaluate your patient visits with the chaplain using the survey below:

Introductions - The Chaplain:

- 1. Identified him/herself to the patient and/or family
Disagree 1 2 3 4 5 **Agree**
- 2. Clearly explained the reason for the visit
Disagree 1 2 3 4 5 **Agree**

Listening – The Chaplain:

- 3. Demonstrated attentive listening skills with the patient and/or family
Disagree 1 2 3 4 5 **Agree**
- 4. Conveyed that he/she had as much time as needed for the visit
Disagree 1 2 3 4 5 **Agree**

Communication – The Chaplain:

- 5. Communicated clearly and without rushing
Disagree 1 2 3 4 5 **Agree**
- 6. Modulated his/her voice as needed to communicate effectively
Disagree 1 2 3 4 5 **Agree**

Respect – The Chaplain:

- 7. Respected the diversity of the patient’s race, religion and gender etc.
Disagree 1 2 3 4 5 **Agree**
- 8. Treated the patient’s comments/questions with sincerity
Disagree 1 2 3 4 5 **Agree**

Response to needs – The Chaplain:

- 9. Used an appropriate amount of time to explore the patient’s concerns and requests
Disagree 1 2 3 4 5 **Agree**

Value for You – The Chaplain:

- 10. Modeled Whole-Person care principles you could incorporate into your medical practice
Disagree 1 2 3 4 5 **Agree**

Comments: _____

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Personal History

Born 02/07/1947 in Yarloop WA, Australia

Education

2009–2013 DMin (Chaplaincy), Andrews University, Berrien Springs, MI
1998–2001 MA (Clinical Ministry), Loma Linda University, Loma Linda, CA
1974–1980 BA (Theology), PUC (Avondale College Campus), NSW Australia
1960–1962 Harvey High School, WA Australia
1953–1959 Yarloop Elementary, WA Australia

Ordination

03/16/2002 Ordained to the SDA Gospel Ministry

Experience

2002–2012 Chaplain II at Loma Linda University Medical Center
2008-2009 Living kidney donor Advocate for LLUMC Transplant Institute
1990-2002 Chaplain, Bereavement Coordinator and Manager (2002) of Loma Linda University Medical Center Hospice
1990-2002 Pastored a total of 13 churches in Tasmania, South NSW and South Australia Conferences

Mission Service

1977-1978 Assistant Youth, health & Temperance Director, Samoa Mission

Awards and Certifications

2012 Board Certified by Association of Professional Chaplains (APC)
2008 Certified as a Pastoral Care Specialist American Association of Pastoral Counselors (AAPC)
2007 Completed seventh Unit of CPE (five basic & two advanced)
2007 Endorsed by Adventist Chaplaincy Ministries (ACM)
2001 Listed in Who's Who in American Colleges
1995 Employee of the Year, Loma Linda University Medical Center

Interests & Accomplishments

2005 Tandem Skydive from 13,000'
2005 Two weeks trekking in Argentinian Andes to 16,400'
2004 Climb Mount Kilimanjaro, Tanzania Africa
1992 Completed my first of 11 Los Angeles Marathons & four 50km ultra marathons