Practicing Sacred Encounters: A Narrative Analysis of Relational, Spiritual, and Nursing Leadership

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PRACTICING SACRED ENCOUNTERS: A NARRATIVE ANALYSIS OF RELATIONAL, SPIRITUAL, AND NURSING LEADERSHIP

MARGARET WOODROW MARK

A DISSERTATION

Submitted to the Ph.D. in Leadership and Change Program of Antioch University in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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This is to certify that the Dissertation entitled:

PRACTICING SACRED ENCOUNTERS: A NARRATIVE ANALYSIS OF RELATIONAL, SPIRITUAL, AND NURSING LEADERSHIP

prepared by

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is approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Leadership and Change.

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Abstract

This research examined one large health system that has, through a stated mission outcome that every encounter is a sacred encounter, sought to enhance relationships occurring within the health care environment. Seeking to understand the lived experience of sacred encounters through the lens of nurse leaders in one acute care hospital settings this study examined how nurse leaders experienced their leadership role in realizing sacred encounters. Participants were defined as nurse leaders from one hospital setting and included nurse managers, directors and one vice president. A narrative thematic analysis framed by situational analysis was the method of inquiry. Data was gathered through an intensive interview process eliciting an in-depth exploration of the experience of the participants, along with their personal interpretation of that experience. Two questions were asked to each participant, the first to gain an understanding about their personal experience with sacred encounters and the second to allow the nurse leader to reflect on his or her personal leadership behavior as it related to the realization of sacred encounters within their primary area(s) of responsibility. A review of research of current literature focused on relational leadership, spiritual leadership and nursing leadership theory. The major finding was that organizational culture can be defined from the top of the organization and, through well-defined and purposeful leadership behaviors, be realized at the point of bedside care. This study was limited to a one-faith-based hospital. Future research should focus on broadening the scope of inquiry about organizational culture and how espoused culture can be translated into action through purposeful leadership behaviors. This dissertation is available in open access at AURA, https://aura.antioch.edu/ and OhioLINK ETD Center, https://etd.ohiolink.edu/etd
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Chapter I: Introduction

Healthcare organizations have a specialized and extraordinary purpose. They are places where profound human experiences happen every single day. Most health care professionals chose their line of work to provide human caring to people experiencing great vulnerability in the form of medical or surgical interventions, illness, or extreme personal change associated with the wonders of childbirth or the devastation, loss, and grief of death (Koloroutis, 2004). Changes taking place in today’s health care industry have broad-reaching effects on relationships with patients, workers, work groups, organizations, and leaders. Organizations that provide a place for care to take place must find ways to meet society’s pressures and demands while never losing focus on what matters most.

Healthcare is one of today’s most complex industries, having experienced more than three decades of increasingly rapid change. Economic, political, and market forces require progressively more time and energy, leaving some within healthcare to wonder how patient care remains a leadership priority. In addition, the industry is faced with an increasing dependency on new technology, failing physical plants, sicker patients, and an aging workforce. Although healthcare has historically experienced similar issues today’s speed and intensity of change is new. Cycles of change have become continuous and turbulent requiring everyone, regardless of organizational position, to function far outside of traditional comfort zones, or in “permanent whitewater” (Vaill, 1996, p. 1). The resulting chaos has created an industry fraught with tension and an increasing struggle between survival and the core reason for existence—the care and healing of human beings.

This research examined one large health system that has, through a stated mission outcome that every encounter is to be a sacred one (St.JosephHealth, n.d.-c) sought to enhance
relationships occurring within the health care environment (Thies, 2012). Seeking to understand the lived experience of sacred encounters through the lens of nurse leaders in one faith-based, acute care hospital settings, I will examine how nurse leaders experience their leadership role in realizing sacred encounters.

Historically health care has functioned as a system of numerous independent parts working together to provide care. Although patients have moved from one care environment to another as needs required the parts have functioned as independent entities working together. Typically, the acute or hospital has been the center of the patient care experience (Zuckerman, 2014).

The Evolving Health Care Industry

When Congress revamped Medicare to save a financially distraught health care system it forever transformed the hospital as an organization (Geist & Hardesty, 1992). The origin of Diagnostic Related Groups (DRGs) in 1984 marked the beginning of a sharp shift from providing care to managing dollars. Prior to the implementation of DRGs, doctors and hospitals had compatible economic incentives (Relman, 1985). The more services they rendered, the higher the reimbursement each would receive. With the advent of DRGs, incentives changed resulting in doctors and hospitals being no longer economically aligned.

The introduction of the DRG marked a change from a retrospective to a prospective cost reimbursement system. Medicare, through the DRG, split all illnesses into diagnosis categories and estimated the cost per case within each group. Adjustments were made based on various factors such as local wages, teaching versus non-teaching hospitals, and percent of indigent patients. The government established what was considered a fair rate of reimbursement. This change in payment incentivized hospitals toward a shorter length of stay and changed the
national discourse around cost versus quality in health care. “Placing a patient in a diagnostic group . . . is the first step in diminishing the quality of that patient’s care” (Dolenc & Dougherty, 1985, p. 23). Competing incentives for physicians and other care providers with no incentive to shorten the length of a patient’s hospitalization created conflict with hospitals who were mandated to control expenditures per patient forcing administrators into tough allocation decisions unlike any in the past (Geist & Hardesty, 1992).

This decades-long constant pressure to reduce costs has resulted in highly stressed institutions with equally stressed relationships within them. Dolenc and Dougherty (1985) cited three variables associated with quality that they felt were negatively affected by DRGs: access to appropriate tests and treatment, availability of support mechanisms that enhance the psychological well being of patients, and the patients’ relationship with health-care providers and with the hospital. Those challenges continue today as hospitals and health system strive to reach a balance between cost and care.

The complexity of the United States health care industry continues to rise with federal reforms and the ongoing need to reduce the overall cost of health care. Leaders are increasingly challenged with managing the balance between cost and care while adapting to changes such as new consumer protections, an increased emphasis on wellness and preventive services, payment based on outcomes, increased access to services, and a movement toward improvement of overall population health management (Molinari, 2014). Outcomes of the patient experience such as patient satisfaction, quality measures and safety statistics are monitored and compared at the local, state, and national levels. Results are publically available and are rapidly becoming the basis for service reimbursement (RTI International & Telligen, 2012).
Health Care Leadership

Health systems are continually adapting to ongoing changes and increased complexity as they strive to meet the increasing demands of a multitude of stakeholders including patients, physicians, and employees. Today’s challenges cannot be solved by old patterns of leading. As healthcare changes so must leadership, continuing its evolution from authoritarian, through participative, and into a mindset of co-creation where all parties share in understanding and actualizing the industry’s emerging future (Scharmer, 2009; Scharmer & Kaeufer, 2010; Surie & Hazy, 2006).

Health systems must now function as complex arrangements of interdependent parts where the patient, care providers and administrators are full partners in care. Zuckermann (2014) has prescribed “systemness . . . the desired future state of complex healthcare delivery systems” (para. 1). He graphically presents the interconnections among service areas that, currently, are often not well integrated, but that need to be to make a better and evolving system of health care delivery. The key service areas that he diagrams are:

- community health,
- ambulatory care,
- acute care; and
- extended care.

Given this increasingly complex organization, leaders and leadership must intentionally evolve from dependence through independence to interdependence (McCauley et al., 2008). Understanding this interdependence is key to overall organizational performance (Brass, Galaskiewicz, Greve, & Tsai, 2004). New leadership behaviors must emerge as healthcare

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1 See Zuckerman’s (2014) Figure 2, titled, “Rethinking the Organization of Delivery of Care.”
leaders learn to adapt to the complexities of the current and future state of the environment. As we look beyond the patient-caregiver relationship to the various interdependencies that exist within today’s healthcare environment, formal leaders can no longer be expected to distribute all the answers from the top of the organization. They must work with complex networks of interconnected social relationships that provide both opportunities and constraints on the organization’s ability to provide quality patient care.

Leaders are now managing across wide spans of complex care environments from health and wellness, through inpatient and outpatient care, home care, and the end of life experience. They are learning how to work in partnership with physicians in ways never seen before.

Organizational complexity does not necessarily mean more complicated but can be thought of as a more sophisticated or integrated way of thinking, doing, and being. These forms of complexity are catalysts for creative and adaptive responses to challenging situations (Day & O’Connor, 2003). Historically, Western culture has drawn lines and boxes around interconnected phenomena, chunking into pieces, rather than recognizing the webbed nature of our world. As fear and insecurity rise, boundaries are drawn stronger as people seek to protect themselves behind these make-believe walls (Wheatley, 2005). Drath (2001) addresses this complexity through what he calls complex challenges, those that are unpredictable and often result in unintended consequences. Complex challenges require a whole system and all the people in it to change. Therefore, it is impossible for an individual leader to accomplish the work of leadership alone and an inclusive and collective approach to leadership is required (Drath, 2001, p. 5).

In The Fifth Discipline, Senge (1990) argued that within organizations, the whole can and must exceed the sum of its parts. What he called “systems thinking,” (p. 6) addresses the need for leaders to understand relationships and interconnections that are ingrained in organizational and
business interactions. Survival depends upon our becoming better systems thinkers and learning to clearly see the systems within which we are participating (Wheatley, 2005). The increasing complexity of those systems drives us toward a deeper understanding of the interconnectedness between our self and others, as well as between our organizations and our world. “By failing to realize that we’re all in this together, organizations breed new levels of incapacity” (Wheatley, 2005, p. 205).

Complexity science suggests a different paradigm for leadership—one that frames leadership as a complex interactive dynamic from which adaptive outcomes (e.g., learning, innovation and adaptability) emerge (Uhl-Bien, Marion, & McKelvey, 2008, p. 185). A report from Center for the Study of Healthcare Management (n.d.), *Applying Complexity Science to Health and Healthcare*, revealed that in the complex organization leadership becomes more relational and less hierarchical. Their findings were that traditional organizational systems are mechanistic with control and decision-making typically stemming from a hierarchical organizational structure. Within these systems position and structure are highly valued and decisions. Self-preservation is often the driving force and individuals and organizations demonstrate high levels of autonomy.

Emerging complex adaptive health care systems are more open and responsive. Collaboration and participation are evident in organizational practices and a high value is placed on people resulting in multiple points of connection among individuals, groups and organizations. This movement to relationship results from the notion of complexity science theory that tells us to pay attention to the interconnections among the agents rather than focus only on individual agents as we strive to meet the demands of the changing environment.
Complexity Science encourages healthcare leaders to work with, rather than against, overwhelming complexity by focusing on relationship building, organizational values and culture, and widespread participation, rather than right integration, formalization, and centralized decision-making. The leader serves the organization by making sense of a complex world, rather than providing neat answers that promise success.

The focus on relationship “moves beyond unidirectional or even reciprocal leader-follower relationships to one that recognizes leadership wherever it occurs, is not restricted to a single or even small set of formal or informal leaders, and in its strongest form, functions as a dynamic system” (Hunt & Dodge, 2001, p. 448). It is a view of leadership in terms of rich connections and interdependencies and views persons, leadership and other relational realities as made in processes rather than standpoint of individual agency (Bradbury & Lichtenstein, 2000; Hosking, Dachler, & Gergen, 1995).

**Relational Leadership**

Relationships in leadership have been addressed in the literature for many years. We have heard the voices of Follett (1918/1998), Tannenbaum and Schmidt (1958/1973), Greenleaf (1977), Burns (1978), Vaill (1989, 1996), Rost (1991), H. E. Gardner (2000), Drath (2001), Bennis (2002), Heifetz (2002), Bolman and Deal (2003, 2011), and Palmer (2004), to name only a few who have emphasized the value of relationships in leadership. Conceptually, we find relational leadership in the literature related to emotional intelligence (Goleman, 1998), authenticity (Avolio & Gardner, 2005), learning organizations (Argyris, 1995; Argyris & Schon, 1996), change management (Argyris, 1993; Kotter, 1996; Weick & Quinn, 1999), and complexity (Plsek & Wilson, 2001; Uhl-Bien & Marion, 2009; Uhl-Bien, Marion, & McKelvey, 2007). The focus is typically on the quality of interactions between individuals, groups,
networks, organizations and/or communities. Although the leadership literature has addressed the concept of relationships for many years, relational leadership theory is a relatively recent addition to the leadership body of knowledge.

Relational leadership theory is rooted in psychology’s relational practice and in the social science’s social construction. Uhl-Bien (2006) described relational leadership “as a social influence process through which emergent coordination . . . and change . . . are constructed and produced” (p. 655). She identified two separate but complementary perspectives—entity and relational, addressing relationships as both an outcome of investigation and a context for action. The entity perspective focuses on identifying attributes of individuals as they engage in interpersonal relationships. The relational perspective of leadership is defined as “a process of social construction through which certain understandings of leadership come about and are given privileged ontology” (p. 655). She describes this perspective as “socially constructed and socially distributed, recognizing that organizational phenomena exist in interdependent relationships and inter-subjective meaning” (p. 655).

Utilizing a narrative inquiry with thematic analysis and framed through situational analysis, this study was designed to add to the relational leadership literature through exploring the lived experience of nurse leaders in a hospital environment where a mission outcome that every encounter is to be sacred, had been made explicit. Seeking to understand the lived experience of sacred encounters through the lens of nurse leaders in one faith-based, acute care hospital settings, I examined how nurse leaders experienced their leadership role in realizing sacred encounters.

**Positionality**

The issue of researcher membership in the group or area being studied is relevant to all approaches of qualitative methodology as the researcher plays such a direct and intimate
role in both data collection and analysis. Whether the researcher is an insider, sharing the characteristic, role or experience under study with the participants, or an outsider to the commonality shared by participants, the personhood of the researcher includes her or his membership status in relation to those participating in the research, is an essential and ever-present aspect of the investigation. (Dwyer & Buckle, 2009, para. 1)

I have worked as a Registered Nurse in the healthcare field for the many years. My experience has spanned long-term care, community health, Hospice, and acute inpatient care environments. Most of my career has been spent in administrative roles within the acute hospital setting. Over these decades, I have experienced the healthcare industry struggle to find a balance between patient care and the bottom line.

The introduction of Diagnostic Related Groups (DRGs) in the 1980s, marked the beginning of a sharp shift from providing care to managing dollars. With health care costs rising, Medicare changed the way it reimbursed hospitals for care by paying hospitals according to a patient’s diagnosis rather than by the amount of days a patient was in the hospital. The result was that hospitals became incentivized to shorten patients’ time in the hospital and reduce the number of procedures a patient received while hospitalized. Hospitals, care providers, and patients experienced a major shift in how hospital care was planned, perceived, and provided. Additionally, the industry was facing rising costs, changing technology, and increasing economic pressures. Three decades later, the health care industry today continues to face similar challenges in an intensely complex and rapidly changing environment where disparity continues to rise between the cost of providing care and payment for service.

The Affordable Care Act (Patient Protection and Affordable Care Act, 2010) created incentives for hospitals to manage care across the continuum of healthcare in close partnership with physicians and other care providers and focus on keeping patients healthy and out of the hospital rather than caring for them in the hospital. Payment would be based on the value of care provided as opposed to the volume of care provided. Through provisions in the Affordable Care
Act hospitals exist in a world where they would be rewarded for the quality of care provided rather than for the volume of patients they treat. As this transition progressed hospitals lived in two worlds—one where they continued earned money per procedure and another where payment was not based on volume of patients or procedures but on measures of a hospital’s performance. Patients would become partners with their caregivers across the entire continuum of care.

According to Mike Schatzlein, CEO of Saint Thomas Hospital, “all of a sudden, the country needs what faith-based Catholic health care was designed to provide, which is holistic reverent care across the spectrum of time and space” (as cited in Dubois et al., 2013, p. 110).

Much of my personal work experience has been in faith-based health care organizations. I do not bring personal religious beliefs or practices to my work but have a strong spiritual foundation that places high value on people and relationships. My experience working and leading in faith-based health care organizations has been that patient-caregiver relationships are highly valued and sometimes clearly defined through the religious foundation of the hospital. I have not encountered where leadership interactions were explicitly addressed in terms of religious or spiritual expectations and although employee engagement surveys pose questions about leadership behaviors, organizations have tended to be silent when it comes to defining behaviors in terms of religious philosophy.

I came to this study with a personal belief is that in leadership, relationships must be the primary focus. I have practiced my personal leadership in that way and been mentored by exceptional leaders with a similar philosophy. I have witnessed first hand the successes that come from the cascading effect of a positive work environment in which people feel respected, heard, and engaged.
Sacred Encounters

Within these tumultuous times, one large, faith-based health system in the western United States, St. Joseph Health (SJH), sponsored by the Sisters of St. Joseph of Orange, is taking definitive steps toward meeting this enormous challenge while remaining committed to its Catholic roots.

A *charism* is a particular grace given by the Holy Spirit to an individual or a group for the good of the whole church and is a call to share the mission of Christ (Geagley, 1987). Founded in the 17th century, the Sisters of St. Joseph of Orange have described their charism in the following way: “to assist and serve the dear neighbor and by dividing up the towns into various sectors, to find out what disorders exist in each sector so that they may remedy them through their own efforts” (Geagley, 1987, p. i). Weaved within modern day initiatives of physician-hospital partnerships, technology enhancement, performance improvement, and large-scale change, this 26,000-employee health system, grounded in the charism of the Sisters, has adopted a mission outcome of referred to as sacred encounters asserting that every encounter will be a sacred encounter.

The concept of sacred encounters was established by the leadership of the St. Joseph Health System as one of three strategic outcome goals that would support the mission, values, and vision of the health system. These three mission outcomes—sacred encounters, perfect care, and healthiest communities:

_Sacred Encounters:_ Every interaction with patients, providers and co-workers will be experienced as a sacred encounter.

_Perfect Care:_ We will strive to never fail to deliver care that is safe, timely, evidence-based, efficient, equitable, patient/family centered and spiritual.

_Healthiest Communities:_ The communities we serve will be among the healthiest in our nation. (St.JosephHealth, n.d.-b, para. 2–4)
These emerged through a process of discernment, cascading from the mission of the Sisters of St. Joseph congregation, through the Healthcare Ministry of the congregation, the Sponsorship of St. Joseph Health, and finally the mission, values, and vision of the St. Joseph Health system.

According to SJH leadership, “sacred encounters is not just good customer service; it is an expression of the system’s mission and values in its service to the whole person: body, mind, and spirit” (Catholic Health Association of the United States, 2011, para. 2). In setting the stage for making this concept a reality, the following inspirational statement was developed.

To be a community that serves, that speaks, that celebrates and prays in such a way that others—regardless of their religious belief—encountering this community experience a revelation of life’s deepest truths . . . about human dignity, community, success, power, growth, sacrifice, love, suffering, debility, and death. Experiencing a harmony between their heart’s deepest resonances and this community’s character, persons go from this encounter more healed, more whole, more able to live, to love, to hope, to die. (as cited in Thies, 2012, para. 4)

Although health system leadership acknowledged that a sacred encounter is an individual experience and eludes any attempt at creating a specific definition, a picture needed to be painted of how a sacred encounter might be expressed within the reality of work relationships. With this in mind, the health system engaged in a comprehensive process of asking employees, patients, and community members how they would describe a sacred encounter. Sixteen key concepts emerged from a text-mining analysis of the survey documents with four key attributes rising to the top—“dignity, connection, care and compassion” (Catholic Health Association of the United States, 2011, para. 4).

A description of these four attributes as perceived by SJH leadership is important in understanding sacred encounters as a mission outcome. Each of the attributes has an in-depth description that places it within the Catholic tradition and the heritage of the Sisters of St. Joseph
of Orange. The following sections expand on each of the four attributes, dignity, care, connection, and compassion as documented by SJH leadership (Sacred encounter attribute, n.d.).

Dignity. Although the specific word, dignity, is not found in the Gospels, the notion of human worth is found throughout and speaks to the relationship between human beings, reflecting the concept of dignity. In Matthew 6:26 (New American Standard Version), the concept of human worth is expressed through the passage: “Look at the birds of the air, that they do not sow, nor reap nor gather into barns, and yet your heavenly Father feeds them. Are you not worth much more than they?” Also, in Genesis 1:26–28, the creation of the human person by God and in the image of God reflects “a character of intimacy that serves as the foundation for the dignity of human person.” The attribute of dignity, as it relates to sacred encounters, is summarized by SJH leadership in the following way:

If we close our eyes we could think of a face that might cause us to question whether all human persons deserve to be treated with dignity. They may have done something that would be considered inconceivable. Yet our tradition and our desire for Sacred Encounters tell us that our worth, our dignity, and that of others, is innate. As we attempt to make every encounter a sacred encounter, our tradition tells us that we must practice seeing the other as one who deserves to have their dignity honored, to even inquire about how that dignity is best honored from their perspective. (Sacred encounter attribute, n.d., p. 2)

Care. The attribute of care is foundational to the Catholic moral tradition and the heritage of the Sisters of St. Joseph of Orange. The SJH leadership note that there are many types of stories that demonstrate care, compassion, and restorative relationships reflecting how others cared for another. They cite stories from the Bible in the books of Luke and Matthew as well as stories within the history of the Sisters of St. Joseph or Orange. The attribute of care as it relates to sacred encounters, is summarized by SJH in the following way:

Providing care is often the human response to an experience with one who is suffering. Care requires companionship and compassion. Compassion calls us to “suffer with” those who are in need of our care. Providing care for patients is mandatory in our ministries, but the ways in which we provide care and envision ourselves as care
providers is an essential area of reflection. In the Christian tradition, providing care and offering healing is an opportunity to restore relationships among patients and families, patients and health care providers, and between patients and God. (Sacred encounter attribute, n.d., p. 5)

**Connection.** The attribute of connection is also demonstrated in the gospels and in the stories of the history of the Sisters of St. Joseph and in the Bible in the books of Mark, John, and Matthew. The story of Sister Henrietta, a Sister of St. Joseph of Orange tells of Sr. Henrietta, when discovering that the Protestants in her neighborhood were wary of Catholics, took it upon herself to establish good relationships between the Catholics and Protestants. The connections that she established led to sharing of schoolrooms, teachers, and social occasions. The attribute of Connections as it relates to sacred encounters is summarized by SJH in the following way:

Through the connecting act of healing and touch, profound and lasting relationships can flourish, as demonstrated by the restorative work of Sister Henrietta. Connection through providing care and healing “binds” us to one another, as Jesus bound himself to suffering individuals. Ultimately, this healing connection can be transformative for both patient and care provider. (Sacred encounter attribute, n.d., p. 7)

**Compassion.** Finally, the attribute of compassion is a virtue honored in all religious and spiritual traditions and demonstrated throughout the history of the Sisters of St. Joseph of Orange. Within the Christian scriptures, the story of the Good Samaritan is often pointed to as the Christian example of compassion. Compassion is defined as “both a discipline of presence and a receptivity, as well as a task not always in our control to master, a grace.” The attribute of Compassion as it relates to sacred encounters is summarized by SJH in the following way:

Compassion is a practice, a presence, a receptivity, an ability to enter into the chaos of another. It is directed to our neighbor, the “dear neighbor.” This practice is important to us because it is discovered at the birth of our SJH ministry. It is found in the example of a group of women dividing up the city and attending to the needs of the people. Whether the dear neighbor is our self, a colleague, or a patient, we are called to practice compassion in our journey to foster sacred encounters. (Sacred encounter attribute, n.d., p. 4)
Since the initial development of sacred encounters as a mission outcome, the St. Joseph Health System has committed a great amount of time and resources into taking this goal from a concept to a reality. Through ongoing discussion, education, pilot programs, and evaluation, they continue to seek ways in which sacred encounters can be realized throughout the health system.

In adopting sacred encounters as a mission outcome, St. Joseph Health, has embarked on a complex journey of transformational leadership where priority is placed clearly on not only the individuals but on the relationships that exist between and among them.

**Summary and Outline of Subsequent Chapters**

Health systems today function in a constant state of change with increasing pressures on controlling costs while striving to provide the highest quality of care. In the clinical care environment, human interactions are a core function to support health and healing. St. Joseph Health, a faith-based health system, has focused on these interactions by making explicit a mission outcome that every encounter is a sacred encounter.

Leadership literature is replete with theories addressing relationships between individuals and within groups. Researchers have explored these interactions since Follet’s (1918/1998) work in the early 20th century. What is not apparent in the leadership literature is an understanding of the lived experience of people working in a highly interactive environment where, organizationally, there are clearly identified expectations addressing how people are together, how, in accordance with St. Joseph’s mission to make every encounter is a sacred encounter.

Chapter II provides a review of the literature that to demonstrate the value of this research in relation to current and historic work and the gap that will be filled because of this study. Building on the early work of Follett (1918/1998), I explore the relational focus within
leadership theory, highlighting changes that have occurred over the decades since the early task
versus people studies of the 1950s. Although relational leadership concepts have not necessarily
evolved along a chronological timeline, there does exist a continuum of mutuality, or
relationship, based upon leadership theory spanning from the “path-goal theory” (House, 1971,
p. 321) that examines the motivational relationship between leader and subordinate, through the
realms of leadership with groups or teams, distributed or participatory leadership, emergent
leadership, and finally the leaderless organization. Foundational to this study the literature
review will also include reviews of complexity theory, social construction, and large-scale
change as the notion of sacred encounters is examined from the perspective of clinical leaders.
Given its basis in a faith-based health system, concepts related to spirituality and leadership will
also be touched upon.

Chapter III explains and supports the use of a combination of three qualitative
methodologies in this study: narrative inquiry (van Manen, 1990), situational analysis (Clarke,
2005, 2015), and thematic analysis (Boyzatis, 1998; Charmaz, 2006). In plain language, this
meant gathering the stories of nurse leaders; situating the research within the Mission Hospital
larger world or social arena (Clarke, 2005) in the, and drawing out the main and recurring
patterns that emerged from nurse leaders’ interviews.

Chapter IV reports the results of the interviews and the narrative, situational and thematic
analyses of these sessions.

In the final chapter, I describe the principal findings in regard to implementing the
mission of making every encounter sacred, outline the limitations of this study and point to
directions for future research, looking at how such a mission could be enacted in other settings in
healthcare and beyond.
Chapter II: Review of the Literature

This chapter is essential to understanding what my study flows from and into. All social and scientific research is part of larger ongoing narratives; mine is situated in such a dialogue relevant to several key streams of inquiry. The flow of the chapter is depicted in Figure 2.1.

Figure 2.1. Topics and flow of literature review.

I begin briefly with complexity leadership, the writings and ideas that address how overwhelmed the medical system and notably, nurse leaders, the medical system and other contemporary areas of public policy practice are: What rethinking in ideas about the nature of leadership are needed to deal with this? This is followed by a much longer discussion of relational leadership. I consider the roots of what was, at its inception, a sea change in conceptualizations of organization, whereby the human side gradually came to be seen as no less
important than the technical and financial nitty-gritty of workplaces. This reframing towards relational practice brings up central problems of relationships with others, with self and with the very nature of leadership. Following a review of literature relevant to these changes, I turn to the applied body of knowledge concerning nurses and leadership, looking especially at writings about the application of a relational focus to this most intimate of practitioner-client settings. Finally, we need to examine the rapidly expanding concepts and literature on spirituality and leadership. Even in unexpected settings, many leadership scholars and even some leaders of large private and public institutions have embraced and wrestled with the meaning and application of a spiritual approach. This dissertation is about an unusually conscious initiative to raise the spiritual within everyday work in a healthcare setting.

**Complexity Leadership**

This study of how nursing leaders in an acute care hospital setting experience what their mission defines as “sacred encounters” (St.JosephHealth, n.d.-c, para 1) was set in a single hospital setting that is part of a larger complex health system. Although this study focuses on the experiences of nursing leaders within only that one hospital it is important to understand that the mission—every encounter a sacred encounter—was not established at the hospital or local level but at the highest level of the health system. Once the goal was set, numerous stakeholders from various levels and functions across the health system were involved in the process of creating a common definition of sacred encounters and determining an approach for bringing the concept to life. Although researching and portraying complex interactions of organizational systems is beyond the scope of this study, I believe there is value in a briefly describing this context as a prelude to trying to understand the nurse leader experience within the context of a larger complex system. An understanding of complexity leadership will lay the groundwork for the
study and provide rationale for positioning this research within relational leadership theory. This chapter will also examine relevant literature related to spirituality, social construction and meaning making.

Complex adaptive systems, as defined by Uhl-Bien et al. (2008), are “open, evolutionary aggregates whose components [that are] . . . dynamically interrelated and who are cooperatively bonded by common purpose or outlook” (p. 193). Health systems today function as complex systems evidenced by common mission, vision and values and interdependence across the continuum of care. As the health care industry moves toward a focus on the health of communities and populations, an increase in complexity and interdependence will become increasingly evident. Leadership within this changing environment will also evolve as health systems adapt to the industry changes.

Complexity science suggests a paradigm for leadership framed as “a complex interactive dynamic from which adaptive outcomes . . . emerge” (Uhl-Bien et al., 2008, p. 185). Manson’s (1999) “aggregate complexity” (p. 405) describes complexity theory as being concerned with “how individual elements work in concert to create systems with complex behavior” (p. 405). He defines the heart of the complex system as the relationships between components rather than by its constituent parts. Uhl-Bien et al. (2008) describe complexity leadership in organizations as a socially constructed, emergent, and interactive dynamic that produces adaptive outcomes appropriate to the vision and mission of the organization.

Health care organizations are an ideal setting for the application of complexity science due to the diversity of organizational forms and interactions among organizations that are evolving. Too, complexity science can benefit from attention to the world’s most complex human organizations. Organizations within and across the health care sector are increasingly interdependent. Not only are new, highly powerful and diverse organizational forms being created, but also the restructuring has occurred within very short periods of time. (Begun, Zimmerman, & Dooley, 2003, p. 253)
Understanding the health care organization through the metaphor of a living system as conveyed by the science of complex adaptive systems rather than as a machine, the traditional description adopted by system theorists, can best facilitate the efforts toward improvement (R. A. Anderson & McDaniel, 2000; Begun et al., 2003; Plsek & Wilson, 2001; Weberg, 2012). Health care as a complex adaptive system cannot be understood by examining agents individually but by examining the network as a unified whole. It is a function of the quality of connections within the system rather than the quality of individual agents.

Having a complex and social nature, health care must adopt certain leadership behaviors including participation in decision-making, creativity, innovation and continual learning (R. A. Anderson & McDaniel, 2000). The future is no longer knowable but emerging through an intricate set of interactions. Leaders must be skilled in the facilitation of diversity, communication and interpersonal relationships. The health care organization can no longer be seen as predictable with multiple parts performing in isolation. It must be understood as a set of interdependencies (R. A. Anderson & McDaniel, 2000; Plsek & Wilson, 2001) where the fundamental importance of relationships and relationship building must be acknowledged.

**Relational Leadership**

Relational leadership is a relatively new term in the leadership literature having no agreed-upon single definition and a meaning that is still open to interpretation (Uhl-Bien, 2006). With the increasing focus on creating positive and life-affirming (Madsen & Hammond, 2005) organizations, communities, and societies, there is an emerging interest in leadership relationships. Vaill (1989) states: “All management is people management, and all leadership is people leadership . . . there is nothing that a manager or a leader can do that does not depend for its effectiveness on the meaning that other people attach to it” (p. 126).
We find the term, relational leadership, in the leadership literature; but its essence is rooted in the feminist psychology’s relational practice (Fletcher, 1998) and, more broadly, in the social science concept of social construction (P. L. Berger & Luckmann, 1966). It is also evident in numerous leadership theories such as servant leadership (Greenleaf, 1977), transformational leadership (Bass, 1990), authentic leadership (Avolio & Gardner, 2005); shared leadership (Pearce & Conger, 2003); distributed leadership (Gronn, 2000); complexity leadership (Uhl-Bien et al., 2008); and spiritual leadership (Fry & Slocum, 2008), among others. Concepts such as transformational leadership, emotional intelligence, authenticity, the learning organization, and leadership for the common good speak to the quality of interactions between individuals, groups, networks, organizations and/or communities. The question arises as to where relational leadership fits and what, in particular, allows relational leadership theory to be studied as a unique framework?

Within my review of the literature one approach seemed to best describe the concept of relational leadership with an overarching framework for the study of leadership “as a social influence process through which emergent coordination and change are constructed and produced” (Uhl-Bien, 2006, p. 654). Uhl-Bien clarifies the key aspects of relational leadership by contrasting this with the “more traditional orientation . . . can be called an entity perspective because it focuses on individual entities . . . consistent with an epistemology of an objective truth and a Cartesian dogma of a clear separation between mind and nature” (p. 655). She describes the relational perspective of leadership as “a process of social construction through which certain understandings of leadership come about and are given privileged ontology” (p. 654). This form of leadership is “socially constructed and socially distributed, recognizing that organizational phenomena exist in interdependent relationships and intersubjective meaning” (p. 664).
While the term relational leadership has only recently been introduced into the literature of leadership theory, there is a long history of relational concepts evident in the field of organization development. In 1918, Mary Parker Follett, a pioneer in the field of organizational behavior, spoke of the need for non-dominant leaders who do not dictate what others will do but who influence followers: “The person who influences me most is not he who does great deeds but he who makes me feel I can do great deeds make them feel as if they can do great deeds” (Follett, 1918/1998, p. 230). She also wrote of the need for employers and employed to study the ideal relation and attempt to actualize it in order to create a true community. Her early views suggest a deep knowledge and appreciation of leadership as influence, and, as well, the complexity of systems thinking. This is evident in her description of “relation in relation” (p. 129)—the notion that relationships are not just between two people but also in relation to other relations, that is, to society.

Nearly 100 years ago, well in advance of modern leadership thinking, Follett (1918/1938) understood that creative forces come not from the individual alone but from individuals participating in relationships with other individuals: “Creative power is evolved through the activity of the group life” (p. 3). Today this same thinking is taking hold in a new way within an environment of rapid change and increasing complexity.

Mary Parker Follett was ahead of her time in her understanding of the importance of relationships in organizational behavior. Although her work clearly brought focus to these concepts, they did not seem to take hold and did not resurface again in a meaningful way until the organizational behavior scholarship of the 1950s. This decade brought forth the view of leadership through the lens of task focus versus people focus (e.g., Blake & Mouton, 1964) and the organizational implications of these two approaches. The well-known framework of Theory
X and Theory Y, conceived by McGregor (1960), underscored the distinct ways that managers and leaders focused, whether on merely getting organizational tasks done versus motivating “the human side of enterprise” (the title of McGregor’s groundbreaking book). Since that time there has been a constant presence of relationship as a key component of leadership throughout the organizational and leadership literature. In the following pages, I will explore relational leadership as it has taken shape since the 1950s.

Although relational leadership concepts have not necessarily evolved along a definite chronological timeline, there does exist a continuum of mutuality, or relationship within theoretical leadership concepts. This continuum spans relationships from path-goal theory (House, 1971), which examined the motivational relationship between leader and subordinate, through groups and teams, distributed and participatory leadership, emergent leadership, and finally the leaderless organization (e.g., Brafman & Beckstrom, 2006). As I explore the history of leadership relationships and reflect upon the concept of relational leadership in today’s organization, I will stop short of examining the leaderless organization since it has little relevance to relational leadership in the context of healthcare.

The term, relationship, obviously implies the presence of an other with whom one is experiencing an interaction or encounter. When we begin to explore these interactions, the self tends to become prominent as well as self-awareness, insight, and reflection.

**Relationship with others.** Since the study of leadership has moved away from the heroic or “great man” theories (Borgatta, Bales, & Couch, 1954; Rost, 1991), the individual or entity perspective of relational leadership theory has become a common construct within the modern leadership literature. As opposed to the heroic leader gaining power “from their personage, aside from their tested capacities, experience, or stand on issues” (Burns, 1978, p. 244), the value we
place on leaders and leadership today lies in the ability of a leader to generate real change. This change is brought about through collective purpose, human interaction, satisfaction of human needs, fulfillment of expectations, and a demonstration of the relationship between moral principles and power. Burns defines this type of leader as a *transforming leader*, one “who recognizes and exploits an existing need or demand of a potential follower and seeks to satisfy higher needs . . . engaging the full person of the follower” (p. 4). According to Burns, transforming leadership “is a relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents (p. 4).

The evolution of thinking around organizational behavior and the value of relationship was also evidenced through Robert Greenleaf (1977) and his idea of the leader as servant. Greenleaf built on existing leadership concepts and the participatory involvement of followers in decision-making by defining a new way of being in relationship. He described the involvement of followers as not just another way of getting the leader’s ideas accomplished, but as a caring behavior that would enhance the growth of workers while improving the caring and quality of organizational life (Spears, 2010). Greenleaf (1977) described servant leadership as follows:

> The servant-leader is servant first. It begins with the natural feeling that one wants to serve. Then conscious choice brings one to aspire to lead. The best test is: do those served grow as persons: do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And, what is the effect on the least privileged in society: will they benefit, or, at least, not be further deprived. (p. 27)

The primary difference between Greenleaf’s (1977) servant leadership and Burns’ (1978) transformational leadership lies in the fact that, while transformational leaders and servant leaders both show concern for their followers, the overriding focus of the servant leader is upon service to their followers and the transformational leader has a greater concern for getting followers to engage in and support organizational objectives. (Stone, Russell, & Patterson, 2004, p. 354)
While Burns (1978) believed that transformational leadership and transactional leadership were at opposite ends of a continuum, Bass (1985) did not agree that it was either/or, but held that transformational leadership could augment the effects of transactional leadership. His study of leadership focused on the organizational goals and the way in which the relationships within the organization influenced positive outcomes toward those goals. Although Bass respected the need for leaders to establish effective relationships with both superiors and subordinates and to both enable and empower followers, his primary focus of those relationships, as with Burns, was to support organizational objectives.

In the years since Greenleaf (1977) brought the words servant and leadership together in a meaningful way and Burns (1978) and Bass (1990) developed theories of transformational leadership, many great leadership thinkers and scholars have continued to move those concepts into relevance for the 21st century (Rost, 1991). As will be discussed further below, we have seen significant theories and concepts build on the importance of the relationship between leader and follower in creating strong individuals, organizations, communities, and societies. It is valuable to look back to see how these groundbreaking leadership ideas evolved and explore the foundations upon which they were built.

**Early studies.** As noted above, Follett (1918/1998) expressed a deep passion for inclusion, participation, and collaboration early in the 20th century. United States industry did not embrace her ideas until the 1950s and early 1960s, when studies of leader behavior emphasizing people versus productivity began to emerge (Blake & Mouton, 1964; McGregor, 1960). While the Ohio State Behavioral Questionnaire (Stogdill & Coons, 1957) was being developed, Seashore (1954) was beginning to study the behavior of work groups and the
relationships, cohesiveness, and interdependence within those groups, work that he would continue well into the next decade.

The Ohio State study looked at two independent leadership behaviors: *consideration*, the degree to which a leader acts friendly or supportive towards his subordinates, and *initiating structure*, the degree to which a leader defines and structures his role and the role of the subordinate toward reaching goals. This research resulted in the development of the Leader Behavior Description Questionnaire (LBDQ) and the Supervisor Behavior Description Questionnaire (SBDQ). Both tools were widely accepted and widely utilized. Based on this usage, the feedback that researchers received through their continual and ongoing evaluation of the tools allowed researchers at Ohio State University (OSU) the opportunity to gather valuable data. Researchers utilized these data as an opportunity for ongoing analysis leading to the creation of valuable revisions and refinements of the tools.

While OSU researchers were working on the LBDQ and SBDQ, researchers at the University of Michigan were developing the Michigan Leadership Studies, focusing on task versus relational leadership behavior (Seashore 1954). Three characteristics of effective leaders were proposed: task oriented behavior, relationship oriented behavior, and participative leadership. Through these studies, an understanding of leadership as the combination of planning, scheduling and coordinating activities with a supportive approach to subordinates and the building of cohesive teams emerged (Bass, 1990). Both the Ohio State and Michigan Leadership Studies opened the door for others to explore the role of management within the context of people, participation, and collaboration.

In addition to these two key studies, Tannenbaum and Davis (1969/1978) were also exploring the role of manager on a “boss-centered/subordinate-centered” (p. 96) continuum.
They explored the range of behaviors along this continuum and also looked at factors that managers should consider when making the decision about how to lead. These included forces in the manager, forces in the subordinates, and forces in the situation. Tannenbaum and Schmidt (1958/1973) stated that “the strength of each of them, will, of course, vary from instance to instance, but managers who are sensitive to them can better assess the problems which face them and determine which mode of leadership behavior is most appropriate” (para. 37). From this perspective, the manager’s focused attention could include to value systems, confidence in subordinates, and awareness of one’s own leadership inclinations, and feelings of security in uncertain situations. Motivating forces in subordinates included their need for independence; readiness to assume responsibility for decision making; tolerance for ambiguity; interest in the problem; understanding of the organizational goals; and their level of knowledge and experience to deal with the problem. Relevant features of the situation included the type of organization, group effectiveness, the problem itself, and the pressure of time (Tannenbaum & Schmidt, 1958/1973).

The shift toward more inclusive and person-oriented leadership was slowly taking place. Scholars recognized the change and were interested in developing a deeper understanding of how leaders, followers, and organizations were evolving. According to Peter Vaill (personal communication, December 20, 2011), organizational behavior scholars were busy debating what they perceived as the most current and important issues facing organizations of the time.

**Unexpected cultural change.** Largely beyond the awareness of scholars during the 1950s, was the dramatic societal change that was slowly beginning to take place and that would, over the next decade, change U.S. culture to the core. A quote attributed to musician John Lennon was: “The thing the sixties did was to show us the possibilities and the responsibility that
we all had. It wasn’t the answer. It just gave us a glimpse of the possibility” (as cited in Wiener, 2010, para.1). The ideal of possibility found its way fully into the psyche of an upcoming generation and took on an interesting and powerful blend of individuality and community. One of the great challenges of leadership is to envision possibilities and determine how to share that inspiring vision and bring it to reality. Kouzes and Posner (2002) describe vision as not about what the leader wants but as an ideal and unique image of the future for the common good implying a choice of values and something that brings meaning and purpose to the lives of both leader, follower, and larger community (p. 125).

Although the baby boomer generation of the 60s is often referred to as the “me generation” (see Henderson, 2014), there also existed a strong sense of we. Worldviews broadened within that decade and with that came the harsh realities of the many divisions in our world (Rielly, 2003). Language began to change to incorporate this new reality with isms such as racism and sexism finding their way into the lexicon. The dichotomy was that along with the emphasis on me, the focus on differences brought with it a realization of the value of togetherness.

Evolution of leadership relationships. As U.S. culture evolved, so did the way in which leadership was perceived, studied, and ultimately carried out. Industry was becoming more global and beginning to employ more educated and knowledgeable workers. Organizations that had traditionally viewed their employees objectively and as all being virtually the same, found young employees entering the workforce calling attention to what was unique and subjective in people (Athos, 1970). These workers came to the job with an expectation of expressing their individuality, changing the relationship between the individual and the organization, and of
having their voices heard. The top-down hierarchy of typical U.S. organizations began to feel the first shudders of the walls coming down.

Leadership scholars understood the need to study the ways in which leadership might be changing, or might need to change, to meet the demands of the changing culture and prepare for the future. Athos (1970) and Athos and Gabarro (1978) advocated for learning from the new, young workforce: “The solution to the problem involves our growing and changing as persons, so as to integrate more of the views and values of the young. Such growth can then be expressed in changes in our behavior in our executive roles, as we explore how to renew our organizations skillfully and carefully” (Athos, 1970, p. 61).

Bowers and Seashore (1966) brought forward their “four-factor theory of leadership” (p. 238) detailing four dimensions to describe the function of leadership. Two of those dimensions were support—defined as “behavior that enhances someone else’s feelings of self-worth and importance” (p. 247); and interaction facilitation, “behavior that encourages members of the group to develop close and mutually satisfying relationships” address the specific issue of relationship in leadership (p. 247).

Blake and Mouton (1964) had already introduced the “managerial grid” (the title of their book), a tool to measure a leader’s orientation toward task versus touch or production versus people. Blake and McCanse (1991) later explained the grid: “The concern-for-production and the concern-for-people axes combine in various ways, with each way expressing how an individual thinks about achieving production through people” (p. 28).

Acknowledgement of the rising importance of recognizing the human being as essential to effective functioning of the organization was brought to the forefront of organizational behavior through the work of Bennis (1966). In the book Changing Organizations, he recognized
the rapidly changing social environment that would lead to organizations moving from a bureaucratic to a more inclusive structure. Bennis cited the increasing education of workers along with a growing sense of individuality that would require organizations to become more human and more collaborative. Increasingly complex work environments would make it impossible for one person to have all the necessary knowledge, resulting in participation and inclusion becoming the norm. Relationships between management and workers, and within work teams would create the difference between mediocrity and success.

Tannenbaum and Davis (1969/1978) entered the dialogue, describing human emergence as complex, related not only to an increased sense of individualism and social change but also to changes in technology and a growing sense of being part of a larger human system. Man could no longer settle for being treated as an object but to be treated as a person. Organizations would need to embrace values that moved away from the negative evaluation of individuals to confirming them as human beings. Rather than as inherently bad, people would need to be seen as inherently good, as a whole rather than just a necessary part, as emotional beings with unique knowledge, perspective, experience, and emotion. People would need to be trusted and engaged in meaningful collaborative relationships while being understood as more than simply a fixed object. According to Tannenbaum and Davis (1969/1978), people were moving, evolving, and “in process” (p. 67).

Understanding the changing social environment and the importance of engaging with workers as human beings—rather than unfeeling machines—raised the very pragmatic question of how to make that happen, specifically, how the process of relationships including between individuals, within groups, and within the hierarchical structure of organizations, are developed,
maintained, and nurtured. Interpersonal relationships, previously found mainly as a topic within the psychological literature, became a priority within the study of organizational behavior.

Athos and Gabarro (1978) brought not only the “what” and “why” of communication to the forefront, but also the “how.” Their groundbreaking book, *Interpersonal Behavior: Communication and Understanding in Relationships* was based on 20 years of teaching interpersonal behavior at the Harvard Business School. They spoke to such topics as verbal communication, body language, developing understanding, listening, and reflection. Through their use of personal experience and case study, Athos and Gabarro presented a comprehensive description of interpersonal relationships within organizational management. Their work also extended into the importance of self-knowledge and the value of that knowledge in entering relationships with others. Athos and Gabarro brought to the forefront the image of a manager as a person rather than merely an occupant of a role.

With this change came the acknowledgment of the need to continue moving beyond the leader-centric idea of leadership and truly embrace both the leader and the follower. DePree (1989) referred to people as the heart and spirit of the organization and asked, “Are the followers reaching their potential? Are they learning? Serving? Do they achieve the required results? Do they change with grace? Manage conflict?” (p. 12). He suggested as well, that “signs of outstanding leadership appear primarily among the followers” (p. 12).

Rost (1991) also emphasized the need for leadership scholars to move away from the focus on the “peripheries” (p. 3) of leadership such as traits, behaviors, personality, group facilitation, goal attainment, etc. and to focus on the nature of leadership as a process and a dynamic relationship with an understanding that the realities that leaders and followers face are extremely complex. He, along with numerous others, emphasized leadership as “an influence
relationship among leaders and followers who intend real changes that reflect their mutual purposes” (p. 102).

While the early evolution of leadership thinking did not necessarily emphasize the role of the follower over the role of the leader, the subsequent decades saw the focus shift decidedly to the right on the mutuality continuum. That movement toward understanding and valuing the mutuality of the leader-follower relationship, along with bringing a sense of humanity into organizational life, sheds light on some of the most profound leadership literature to date. This focus on the person as a vital and valued member of the organization, continues to significantly influence leadership thinking today. Within the pressurized environment faced by nurses and other professionals in the health care sector, leader behavior is a factor in perceived levels of self-efficacy and team-efficacy. Transformational leaders may help ensure employees’ job satisfaction and psychological well-being (Nielsen & Daniels, 2012; Nielsen, Yarker, Randall, & Munir, 2009).

The ability of the organization to function as a system within an increasingly complex environment, adapt effectively to change, learn from mistakes, and enjoy a successful future has been recognized by leading leadership scholars as an outcome of effective interpersonal relationships (Argyris & Schön, 1996; Burns, 1978; Schön, 1983; Senge, 1990; Vaill, 1996; Weick, 1969).

**Relationship with self.** Before further exploring how this profound shift from individual leadership to relational leadership has and will continue to affect organizational life, it is important to consider the components of interpersonal relationships—the individual and the self. There is common understanding of the individual as a specific person, but what constitutes the
self? How is this self created? What is the relationship between the self and the individual, or the self and the other?

Hosking (2011) inquired as to whether there is a “hard self-other” (p. 48) relationship, the traditional, western, Cartesian view of the individual mind and individualism; or a “soft self-other” (p. 47) relationship, the constructionist view of the social sciences where the self is socially constructed in relation to the other. The constructionist position considers the process of understanding as not mechanically driven by the forces of nature, but the result of an active, cooperative enterprise of persons in relationship (Gergen, 1985). The way in which one interacts within the world will change depending on past relationships and on which interaction or group within which they are currently participating (Lewin, 1939).

Our knowledge of human relationships and human development tells us that throughout life, an individual develops a personal identify or a sense of self. The self has been the subject of psychological and sociological discussion with one debate surrounding the existence of a stable self versus an ever-evolving self; this brings us back to the basic question of how the self is created. Capra (1996) describes living systems as having both structure and freedom, a fundamental, bound core as well as an ability to move and change because of interaction with the environment. His sees an organism as an inseparable network of relationships where, rather than the parts functioning like a machine and existing for each other, they exist by means of each other in the sense of producing one another.

This philosophy of mutual evolution of self can also be found in the 1930s writings of Martin Buber. In his beautiful description of the development a child, Buber (1923/1970) writes:

Man becomes an I through a You. What confronts us comes and vanishes, relational events take shape and scatter, and through these changes crystallizes, more and more each time, the consciousness of the constant partner, the I-consciousness. To be sure, for a long time it appears only woven into the relation to a You; but it comes closer and
closer to the bursting point until one day the bonds are broken and the I confronts its detached self for a moment like a You—and then it takes possession of itself and henceforth enters into relations in full consciousness. (p. 80)

Buber’s view that “extended, the lines of relationships intersect in the eternal You” (p. 123) shows his deep belief in the connectedness of all things and his conviction that, in order to become truly whole, individuals must not perceive themselves as separate from others.

This belief in the necessity of human connection and the existence of mutual growth also formed the basis of Carl Rogers’ work. In On Becoming a Person, Rogers (1961) describes his personal belief that it is through relationships that people grow, become knowledgeable of their self, and create meaning in their lives. This belief provided the basis for his practice of psychotherapeutic intervention and continues to influence many therapeutic relationships today. As a therapist, he believed that “if I am to facilitate the personal growth of others in relation to me, then I must grow” (Rogers, 1961, p. 51). He, too, refers to the separate self, possessed by both a subject and the other, and the need to fully understand and accept the separateness of both in order to enter into the connected self and move deeply into a relationship with the other. This mutuality of understanding as one enters a relationship with another provides the foundation for personal growth to occur. Rogers’s work began to change how we view the ostensibly expert therapist and his client—a change that would ultimately find its way into the field of organizational behavior.

The belief that this mutual growth is occurring as we enter relationships and engage our unique self with the self of another calls forth a question about the idea of self-knowledge. Formation and evolution of self does not just include the act of engaging in relationships with another, but incorporates the knowledge of self that occurs through the process of reflection. Leadership studies have emphasized the importance of self-insight utilizing concepts such as contemplation (Kouzes & Posner, 2002), self-awareness (Bennis, 2002; Day, 2001),
self-evaluation (Goleman, 1998) or self-knowledge (Heifetz & Linsky, 2002). The process of self-reflection is quite well represented within the leadership literature with a significant emphasis on organizational learning (Argyris & Schön, 1996; Vaill, 1996).

Schön (1983) wrote of the artistry that practitioners engage in as they approach their work through the lens of their individual experience and intuition. This intuition or “tacit knowledge” (Polanyi, 1966), according to Schön, is found not in books or in planning, but in the integration of a lifetime of experiences that an individual has encountered.

In her work with nurses in the clinical setting, Benner (2001) also identifies self-awareness, tacit knowledge and intuition as forces that delineate the distinction between a novice and an expert nurse. She describes a continuum of professional development that begins with education and technical knowledge and progresses over time into a deep level of knowledge that is created through many years of experience.

The work of both Schön (1983) and Benner (2001) provide examples of the importance of understanding the experiential processes that occur within an individual based upon their unique personal, professional, and life experiences. They also acknowledge the need for individuals to consciously engage in activities to deepen the awareness and appreciation of these processes. Through the practice of reflection, experience is integrated into one’s technical knowledge thereby creating a deeper level of professional intuition and competence.

**Relations within leadership.** Traditional, hierarchical views of leadership are less and less useful given the complexities of our modern world. Leadership theory must transition to new perspectives that account for the complex adaptive needs of organizations (Lichtenstein et al., 2006). Many leadership studies today are addressing the less traditional notion that relationships have the potential to move far beyond the achievement of organizational goals, building teams,
or creating positive work environments to where they can and must result in the emergence of creativity and new knowledge, enriching the individual and organizational capacity to adapt effectively to the rapidly complex and changing organizational, cultural, and societal environment (Drath, 2001; Heifetz & Linsky, 2002; Scharmer, 2009; Uhl-Bien, 2006; Wheatley, 2006). Expanding on our understanding of the natural world, leadership scholars are now viewing organizational, community, and societal needs through the lens of complexity science.

To better understand human interaction, scholars, psychologists, and philosophers have looked to nature where they have studied the science of complex adaptive systems. There has been a movement to translate the concept of complex adaptive systems into human behavior, assuming that the biological goal of the human organism is homeostasis. Viktor Frankl, in *Man’s Search for Meaning* (1959), disagreed with this assumption.

> I consider it a dangerous misconception of mental hygiene to assume that what man needs in the first place is equilibrium or, as it is called in biology, “homeostasis”, i.e., a tensionless state. What man actually needs is not a tensionless state but rather the striving and struggling for a worthwhile goal, a freely chosen task. What he needs is not the discharge of tension at any cost but the call of a potential meaning waiting to be fulfilled by him. (p. 127)

Although the strict application of the concepts of complex adaptive systems within the natural world to human behavior is unclear, there is strong agreement that human beings are indeed complex systems that function within larger complex systems of family, groups, communities, and societies. How an individual relates to their environment is dependent upon a unique relationship to the past, present, and perceived future (Gergen, 1985) and with the increasing rate of change calling for increasingly rapid and efficient adaptive responses to that change, one must conclude that a new vision of leadership must emerge.

As noted earlier, leader-follower or manager-subordinate relationships are one of the most studied of phenomena in the organizational literature (Sias, 2008). What we have learned
from that literature is that the more trust, respect, support, and feelings of positivity exist within that relationship, the more satisfied and productive the workplace (Uhl-Bien, 2006). In terms of scholarly research, leader-follower relationships have primarily adopted a postpositive approach assuming that there is an external reality of which people are conscious and that people act on this reality as self-contained individuals. A postpositivist theoretical approach would conceptualize relationships as real entities that exist beyond human perception and would include communication, attitudes, etcetera, that are indicative of outcomes (Sias, 2008).

Because it includes involves the entity or individual relationship, relational leadership, can be effectively evaluated through the postpositive approach. Yet this approach is only partially effective since relational leadership also includes the relational perspective, or a process focus. This process focus requires a constructionist approach since relational leadership, as constructionism, assumes a social reality, not separate from individuals. It is intimately interwoven where each per involved in the relationship is shaped by the other in everyday interactions and where knowledge is socially constructed. Effective study of relational leadership requires both postpositive and constructionist lenses, one to help us learn about the “what” of relational leadership and the other to learn about the “how” (Day & Antonakis, 2012, p. 292). Uhl-Bien (2006) describes this relational research strategy as follows:

Calling for a change in leadership research strategy that switched attention from leaders as persons, to leadership as process, Hosking (1988) argued, “we need to understand leadership, and for this, it is not enough to understand what leaders do” (p. 147). Instead, we must focus on processes—the influential acts of organizing that contribute to the structuring of interactions and relationships. In these processes, interdependencies are organized in ways that, to a greater or lesser degree, promote the values and interests of the social order; definitions of social order are negotiated, found acceptable, implemented and renegotiated. (p. 662)

The processes that “contribute to the structuring of interactions and relationships” (Uhl-Bien, 2006, p. 662) involve not only relationships outside the self but inside as well. As we
connect and interact with our environment we are changed in some way and that new self, through the ongoing act of connecting creates both internal and external change (Palmer, 2004). While we attempt to visualize an image of the space where continual interaction, connection, and change is occurring within both internal and external environments we can begin to appreciate the complexity and necessity of a relational leadership perspective.

As scholars continue to advance leadership into more and more complex and relational realms we are beginning to see a movement toward identifying the creation of an environment that supports “emergence” (Scharmer, 2009, p. 54) as one of the key responsibilities of leadership. Within this environment and through the inclusion of human spirit, new knowledge, new information, new ideas, and a new understanding of what it means to be part of a community can emerge.

These ideas integrate the leader-follower or leader-member exchange (LMX) theories (Graen & Uhl-Bien, 1995), with interpersonal relationships, group dynamics, and complex adaptive systems. They also incorporate a spiritual component that allows individuals, groups, networks, and communities to advance through this movement to a deeper and more thoughtful level of human interaction. We can see this expressed as “presencing” (Scharmer, 2000, p. 2)—blending sensing and prescience, and meaning to connect with the source of the highest future possibility of transforming the self or will (Scharmer, 2000, 2009; Senge, Scharmer, Jaworski, & Flowers, 2005), emergence—the power that is created through interconnections (Wheatley, 2005), or simply soul—the core of our humanity (Palmer, 2004).

It is this integration of leadership, relationship, and spirituality that I personally define as relational leadership, believing strongly that if we continue to move in this direction we are creating a powerful leadership philosophy that will allow us to look forward to our future and to
build workplaces that are life-affirming and successful. Exploring relational leadership as perceived and experienced by nursing leaders in today’s healthcare environment contributes an important layer to the body of leadership knowledge. According to the American Association of Colleges of Nurses (n.d.), nursing comprises the largest single component of hospital staff and are the primary providers of hospital patient care. Centering this study around health care generally and nursing specifically provides an opportunity to understand relational leadership through the lens of one group of professionals that practices relationship as a core component of day-to-day work.

**Nursing and Leadership**

One might assume that in the health care setting where human interaction forms the basis for care, a deep understanding of the purpose and value of relationships would be well understood and instinctively supported throughout nursing leadership. Certainly, the nurse-patient relationship has been well studied as nurses strive to understand the therapeutic necessity of this relationship in promoting healing, growth, and comfort, and empowerment (Halldorsdottir, 2008; Miner-Williams, 2007; Spence-Laschinger, Gilbert, Smith, & Leslie, 2010).

Koloroutis (2004) defined *relationship-based care* as comprised of three crucial relationships: the care provider’s relationship with patients and families; the care provider’s relationship with self; and, the care provider’s relationship with colleagues. Based on the vision that in the health care environment what matters most is caring and healing relationships, leaders inspire others through clarity of vision and purpose, confidence, and an ability to influence others to share that vision (p. 4).
Veronesi (2001) expressed concern about the increasing focus on technology in nursing detracting from the ability of nurses to engage in the nurse-patient relationship in ways they have done in the past. Political and economic factors as well as the pace of change in the health care environment challenge the concepts of nursing as a caring community—the traditional value on which the profession of nursing was founded. Supporting nursing practice within the complex health care environment in ways that support the relationship between the patient and the clinical nurse is an essential practice of nursing leadership (Cathcart & Fillipon, 2012; Rayman, Ellison, & Holmes, 1999).

Understanding the stressors in today’s nursing work environment and the projected strain on nursing related to workforce shortages, Wong, Cummings, and Ducharme (2013) performed a systematic review of studies to examine the relationship between nursing leadership practices and patient outcomes. Utilizing Donabedian’s (1966) structure-process outcome framework (SPO) they examined leadership processes such as “facilitating work conditions that promote optimum safe patient care, creating open communication with staff to support quality care standards, or promoting positive relationships with staff that promote work engagement” (p. 711). Exploring relationships in terms of quality measures is critical to understanding the key consequence of nursing leadership—patient outcomes.

Expanding the relational focus from patient to self, others, leaders, and vision begins to move the conversation about health care relationships toward organizational culture and leadership. Creating a caring environment for employees is a critical step in creating a high quality, safe and caring environment for patients. Nursing literature supports the importance of creating an environment of structure, support, engagement, meaning-making, and self-worth (Cummings et al., 2010; Gantz, Sorenson, & Howard, 2003; Veronesi, 2001; Wong &
Cummings, 2007). Critical to creating a caring environment is “enabling a caring philosophy that starts with nursing leadership” (Veronesi, 2001, p. 76).

Inspirational leaders who genuinely portray caring and support to create an environment of inclusion and trust do so within the relationships they form. Connecting with others authentically means understanding oneself in such a way that leader-follower relationships are formed on the basis of honesty, integrity, insight, trust and meaning (Avolio & Gardner, 2005; Avolio, Gardner, Walumbwa, Luthans, & May, 2004; W. L. Gardner & Schermerhorn, 2004; Shirey, 2009). The nursing profession sites authentic leadership as positively correlated with healthy work environments where performance is influenced in a positive way (Shirey, 2009; Wang, Sui, Luthans, Wang, & Wu, 2012).

Inspiration, trust, authenticity, connection, community, trust and meaning are all valued components of nursing leadership as evidenced in the literature. The importance of the nurse-patient relationship as well as the leader-follower relationship cannot be overstated in terms of promoting a positive work environment and positive patient outcomes. The nursing literature has seen a growing focus on spirituality as related to leadership.

Exploring discourse around spirituality and nursing leadership, Reimer-Kirkham, Pesut, Sawatzky, Cochrane, and Redmond (2012) found that nurse leaders were “cautious in integrating spirituality into leadership practices because of organizational and social influences” (p. 1029). They also found that spirituality and religion were sometimes considered interchangeably and that differences exist between faith-based and secular organizations.

Reimer-Kirkham et al. (2012) discovered an emerging interest in spirituality in relation to nursing leadership as well as differing opinions amongst nursing leaders as to the value and risk of its emphasis as a component of nursing leadership within health care organizations. While the
importance of acknowledging spirituality within the context of the patient care environment is a basic component of nursing practice, concerns were raised about spirituality being co-opted to serve corporate ideologies. Caution was raised about emphasizing corporate cohesion through means such as spirituality that could result in a cult-like culture and has the potential to reduce “the internal dissent that is essential to effective decision-making in complex organizations” (p. 1035). Further, Reimer-Kirkham et al. found “a paucity of quality evidence in relation to spirituality and nursing leadership . . . [and that within nursing the] integration of spirituality and leadership is remarkably contextual” (p. 1036). They concluded: “In an era where evidence, efficiency and outcomes are paramount in healthcare services, serious consideration needs to be given to whether primarily evidential or ethical grounds should be put forward for the integration of spirituality and leadership for nursing” (p. 1036).

**Spirituality and Leadership**

Workplace spirituality has been defined as recognizing the inner life of employees and the need for meaningful work within the context of community (Duchon & Plowman, 2005). Giacalone and Jurkiewicz (2003) add an emotional component through their description of a framework of organizational values within a culture that promotes employees’ experience of transcendence and the facilitation of their sense of being connected to others in a way that provides feelings of completeness and joy.

Spirituality has been heavily studied in the leadership literature and is generally found to have a positive effect on work attitudes and outcomes (Benefiel, 2005; Duchon & Plowman, 2005; Fairholm, 1996; Fry & Kriger, 2009; Fry & Slocum, 2008; Kazemipour & Amin, 2012).

Outside of nursing research, where leadership studies have evolved from the hierarchical to the relational, there has been a dramatic increase in interest around the role of spirituality in
leadership. The relationship between business and religion has a long and interesting history and has, in most societies, been integrally connected. “In spite of these interconnections, many mid-20th century management writers treated spirituality as incompatible with the rational, technical requirements of business” (Sinclair, 2007, p. 148). As interest in community, social responsibility, work-life balance and ethics has increased in the world of business, an interest in spirituality has followed (Conger, 1994; Fairholm, 1996; Garcia-Zamor, 2003; Giacalone & Jurkiewicz, 2003; Hawkins, 1991; Henson, 1991; Rost, 1995; Vaill, 1990).

As I began my search of the literature one of the challenges I found was that there is not a generally accepted definition of spirituality. Leadership scholars must choose from various definitions or descriptions of spirituality or adopt one of their own. Definitions vary from religion to love and from personal to communal. In Western culture, spirituality is generally associated with religiosity and defined in terms of the church. Merriam-Webster’s Dictionary defines spirituality as “something that in ecclesiastical law belongs to the church or to a cleric as such.” (Spirituality, n.d.)

The terms spirit and soul are often used interchangeably in the literature (Benefiel, 2003, 2005; Bolman & Deal, 2003, 2011; Sinclair, 2007) and refer to that place within us that connects to the universe, the divine, God, or whatever term an individual chooses.

Within the context of spirituality and organizational leadership, I am disinclined to employ a religious-based definition. The diversity that exists in today’s organizations brings with it an extremely wide range of religious and non-religious views.

Healthcare is an environment where we observe questions of spirituality regularly being asked (Cobb, Puchalski, & Rumbold, 2012). Health crises, whether personal or of a loved one, cause people to question the meaning of life. The role of healthcare professionals is to enter a
relationship within the crisis in such a way that physical, emotional, psychological, social, or spiritual healing will occur.

Healthcare leaders and care providers are increasingly challenged with attempting to balance the realities of decreasing resources for providing these healing services and the knowledge that the industry exists only for this purpose. Caregivers as well as patients are often in the position of questioning the meaning of work and of life. The challenge of balancing resources and care is immense and has compelled healthcare as an industry to explore creative ways in which the balance can be maintained. Both scholars and practitioners have grappled with these issues for years and will continue to be confronted by them for many years to come.

Pierre Teilhard de Chardin (1976) believed:

Ever since man reflected, and the more he reflected, the opposition between spirit and matter has constantly risen up as an ever high barrier across the road . . . this argument . . . in physics and in metaphysics, as in morals, in social science and in religion as the deep-rooted origin of all our troubles. (p. 23)

This division between what are considered hard versus soft leadership skills creates especially interesting reading in the current leadership literature. Prominent within this discourse is the relationship among spirituality, leadership, and work. Staying in touch with the deep center that is connected to the creative spirit of the universe serves to both clarify and sustain passion (Crosby & Bryson, 2005). If we can sustain our passion for the work that we do as leaders then we can engage in relationships with others that will feed their spirits and help them to find meaning in the work that they do. Peter Vaill (1996) expressed spirituality as:

A personal process, occurring over time and expressing at each moment the person’s sense of the meaning of life, of what the important questions are, of the significance of the persons and things around him or her, and of the direction that his or her journey is taking. (p. 180)

Understanding that each individual finds meaning in different things and in different ways, the leader’s role is to help people find meaning in the work that they do (Vaill, 1989).
Palmer (2004), in reference to the teaching profession, stated, “good teaching cannot be reduced to technique; good teaching comes from the identity and integrity of the teacher” (p. 2). The teacher must form a connection with the student, as the leader must form a connection with the follower. This connection requires intellectual, emotion and spiritual connections, depending on all three for wholeness. “They are interwoven in the human self and we need to interweave them in our . . . discourse as well” (p. 2).

Heifetz and Linsky (2002) brought the issue to light with the following questions: Why lead? If exercising leadership is this difficult, why bother? Why put yourself on the line? Why keep pressing forward when the resistance feels unbearable? Where can you find the drive to keep going? They propose that the only way you can answer these questions is by discovering what gives you meaning in your life. Their research found that the source of meaning most essential in the human experience draws from a yearning for connection with other people. They believe that leadership can give life meaning by allowing us to connect with others in a significant way. Heifetz and Linsky, along with other leadership scholars (Greenleaf, 1977; Kouzes & Posner, 2002; Palmer, 2004; Wheatley, 2006) describe this life-giving connection not as spirit, but as love. Vaill (2009) put it best when he said, “The nature of love, its power and importance, are widely perceived to be, in theory at least, the most desirable state of affairs among human beings” (p. 1).

There is concern among leadership scholars that spirituality will become a commodity, a fad, or simply another way to increase profits. We see this clearly in the spiritual intelligence literature where the act of measuring one’s spirituality or the ability to increase spirituality, dances on the dangerous ground of taking something that is deeply personal, unique, invisible,
and non-tangible, and putting it in the same toolbox that measures IQ, technical competency, or emotional intelligence (H. E. Gardner, 2000; Sinclair, 2007).

Spirituality is a learning process that requires a willingness “to enter into a process of dialogue about meaning, within one’s self and with others” (Vaill, 1996, p. 180). Vaill’s seven qualities of learning as a way of being, can bring about spiritual development. He described those qualities of learning: “That it should be self-directed and creative, be variously expressive and certainly involve powerful feelings of meaning, occur—on-line in the many walks of one’s life and continually throughout one’s life, and definitely provoke reflexive learning” (p. 183).

Healthcare, an industry built around the purpose of providing care, has historically maintained a focus on the person for whom the care is being provided, attempting to understand how to meet the physical, social, emotional, and spiritual needs of the patient. Healthcare leaders are moving more and more toward an understanding that employees, as with patients, will better respond to the pressure of their lives and their jobs if they feel that they, too, are being cared for.

Spiritually-based leaders believe that we are all part of an interconnected whole and create an environment that supports that belief. The basis for this is found in the idea of leadership and management as a sacred trust (e.g., Autry, 1991; Kerfoot, 1997) in which the well-being of other people is put into the leaders care during most of their waking hours.

Spiritual leadership embraces the concept of leadership as a sacred trust whereby the leader brings to work the values, attitudes, and behaviors that will instil a sense of deep caring in their followers. Spiritual leaders create an environment where people can find meaning and have a sense of making a difference in a workplace that recognizes that employees have an inner life that nourishes and is nourished by meaningful work (Duchon & Plowman, 2005; Fry, Vitucci, & Cedillo, 2005).
The Sisters of St. Joseph of Orange, in designing the mission outcome that every encounter is to be sacred (St.JosephHealth, n.d.-c) have committed themselves to the purpose of creating healthy, healing relationships throughout their organization. By defining attributes of dignity, care, connection, and compassion, they have lifted their religious and spiritual beliefs to the level of day-to-day operations within their organization. sacred encounters is not just a goal that is intended to sit on a shelf but is to be brought to life through relationships occurring the health care environment—between caregivers and patients, managers and subordinates, peers, co-workers, physicians—essentially every interaction within the health system.

Through review of the literature, this chapter has revealed that while substantial bodies of work exist on relational leadership, nursing leadership, and spiritual leadership, no studies to date have focused on understanding the interactions among the three in a specific health care context. In this dissertation, I propose to do just that by exploring how the mission outcome of sacred encounters is experienced by nurse leaders at one St. Joseph Health hospital. I will do this by employing the combined methodologies of narrative inquiry, thematic, and situational analysis, as discussed in the next chapter.
Chapter III: Methodology

Seeking to understand the lived experience of sacred encounters through the lens of nurse leaders in one faith-based, acute care hospital setting, this study examined how nurse leaders experience their leadership role in realizing a stated mission outcome that every encounter is to be sacred (Thies, 2012).

Choosing the Research Case and Setting

This study was performed at Mission Hospital, part of a large health system, St. Joseph Health, based in California and with hospitals in California and Texas. I was familiar with St. Joseph Health and selected this health system because leaders had specifically addressed a commitment to human caring through a stated mission outcome that every encounter will be a sacred encounter (St.JosephHealth, n.d.-c). I had previously met the Vice President of the Leadership Institute for St. Joseph Health so was fortunate to have access to him and to have the opportunity to explore the possibility of my research being done there. Through our initial conversations, he identified Mission Hospital as one of the hospitals within the health system that had been most intentional about sacred encounters. Through those early conversations, I gained an understanding of sacred encounters and the process the health system had undertaken to establish this particular mission outcome.

In qualitative research, it is important define the focus of investigation to a manageable topic that can be adequately explored within the time and space allotted for the research. When the focus is too broad, researchers may find it difficult to determine what method or methods are best in approaching the study. They may also have difficulty determining what information is important to the study and what information should remain outside of it (Walker & Lloyd-Walker, 2015).
I initially planned to focus my research on the leadership of the health system. Over time, I decided to work with the administration of one hospital rather than the overall health system. Realizing again that the parameters of my study were too broad and required further narrowing, my focus progressed to working with clinical leaders. Through further consideration I ultimately determined that my research would be specifically with nurse leaders.

This group of leaders could provide an important perspective on how sacred encounters transition from concept to practice and the role of the leader in that transition. This one professional area of practice could help to deepen the understanding of underlying social processes at work that contributed to positive outcomes in the implementation of sacred encounters as a strategic focus. An agreement was reached that I would perform my research with nurse leaders at one of the hospitals within the health system.

The Vice President of the Leadership Institute initially identified two hospitals as having had positive experiences with defining, designing and implementing practices supporting sacred encounters and as potential sites for my research. Together we selected Mission Hospital in Mission Viejo, California as the best site for this study. We chose this particular hospital for these reasons:

- The hospital administration’s commitment to sacred encounters;
- The willingness of hospital administration to accommodate my research (as someone outside of their facility);
- My prior familiarity with the setting; and
- Ease of travel to this location from the Midwest.

Mission Hospital is comprised of two campuses, one in Mission Viejo, CA, and the other in Laguna Beach, CA. Nurse leaders from both campuses were included in this study since both
hospitals fall under one administrative team and are therefore defined as part of a single nursing leadership body for purposes of this study. Participants for this study were defined as nurse leaders currently practicing at any level of nursing leadership—manager, director, vice president or other senior leaders.

My primary contact at Mission Hospital for the study was the Vice President of Mission Integration (VPMI). There was a small hospital-based team established to support my research and to ensure that all hospital rules, regulations and processes were followed. Along with the VPMI the team was comprised of a PhD Nurse Research Scientist and a nursing supervisor.

The role of the VPMI at Mission Hospital is to extend the healing ministry of Jesus in the tradition of the Sisters of St. Joseph of Orange and to ensure the integrity of the spirit and intent of the mission, philosophy, vision and values of the hospital and health system. The VPMI also provides leadership and strategic development for creating a culture in which others experience every encounter as a sacred encounter thus was identified providing primary oversight of my research.

Early in my conversations with the Vice President of Mission Integration, I was informed that it is unusual for Mission Hospital to have someone from outside of the organization do a research project within the hospital. There is a robust nursing research committee at the hospital that oversees all research begin done by internal staff. The Nurse Research Scientist chaired that committee and was assigned to my team to ensure that my study met all research requirements of their institution.

The nursing supervisor assigned as my hospital partner acted as my guide throughout the process. She was working on her Master’s Degree in Nursing and would use her experience working with me as part of her master’s degree work. She was identified by the VPMI and
Nurse Research Scientist to be part of my team because of her work on her MSN and also because she was known and trusted throughout the hospital.

She assisted me in numerous ways throughout the time that I was on-site such as making introductions and helping me find my way around the community and the hospitals. In addition, her assistance was essential in the identification of study participants. She was the only person along with me who knew the names and roles of the participant group. Throughout the entire process, this small team became critical in my ability to effectively carry out my research.

The research process can potentially create tension between the goals of the research and rights and privacy of the participants. The protection of human participants is imperative. As their study beings, researchers must fully consider all ethical implications of the research (Orb, Eisenhauer, & Wynaden, 2000). In preparation for this study an ethics application was approved by Antioch University to ensure full consideration and understanding of research ethics and the privacy and protection of participants (Appendix A). A study proposal was also submitted to the Mission Hospital research council for review; Mission Hospital’s agreement and support letter is in Appendix B.

My aim was to explore the nurse leaders’ perceptions and experiences of sacred encounters at Mission Hospital. Building upon existing leadership literature, I sought to explore the interaction between relational leadership, spiritual leadership and nursing leadership. This deep exploration of nurse leaders’ experience of sacred encounters within the culture and environment of a faith-based hospital setting provided an opportunity to gather, analyze and synthesize data leading to the discovery of emerging theory and adding to the existing body of leadership knowledge.
The Researcher and the Research

Consideration of a research method must be selected in relation to its strengths, weaknesses and alignment with the research question and the researcher’s paradigm (Byrne-Armstrong et. al., 2001). As important as accurately choosing a research method that is supported by the research question, is selecting an approach that speaks to the interest of the researcher. Corbin and Strauss (2008) noted commonalities among researchers who are drawn to qualitative methodologies. Qualitative researchers tend to enjoy the fluid and evolving nature of the work as well as the joy of serendipity and discovery. They do not seek distance between themselves and their participants but want to connect with them at a human level. There is a natural curiosity found in qualitative researchers and they enjoy making order out of seeming disorder and thinking in terms of complex relationships. “For them, doing qualitative research is a challenge that brings the whole self into the process” (Corbin & Strauss, 2008, p. 13). In this research study, consideration of both the personality of the researcher and the aim of the research itself resulted in the clear choice of a qualitative methodology.

It is also important that the researcher considers both ontological (being) and epistemological (knowing) assumptions when choosing a research method including “a variety of assumptions regarding the nature of knowledge and the methods through which that knowledge can be obtained” (Morgan & Smircich, 1980, p. 491). Epistemology informs methodology through consideration of the nature of knowledge including how it can be known and validated. Stanley and Wise (1990) argued that epistemological issues must be considered since it is not possible for researchers to have “empty heads” (p. 22) or for research to be “untainted by material experiences in the heads of theorists” (pp. 22–23).
I entered the researcher/participant relationship as a registered nurse who had worked in the healthcare environment for over 30 years. My experience has been in both faith-based and non-faith-based organizations. Personal values that I brought to the research environment included a strong belief that nurses generally choose their profession because of a desire to work and care for people. I believe that individuals grow and change because of interactions that they have with others. My many years in leadership positions taught me that relationships are paramount throughout both the vertical and horizontal relationship continuums.

Discovery has been a constant factor in my personal practice of leadership. My career path has comprised numerous opportunities to enter a disrupted environment with the goal of making order out of seeming disorder. A natural curiosity about complex situations and relationships and the desire to seek emerging knowledge through increased understanding is the lens within which I enter this research.

My role at the time of this study was as a senior leader in a large health system in the Midwest. In comparison with my prior experience in hospital operations, this position provided the opportunity to examine health care organizations from a new perspective— at the level of the health system versus individual hospital. My responsibilities spanned the continuum of entry-level employee through senior leadership and include both nursing and non-nursing staff training as well as clinical, non-clinical and leadership skill development.

The perspective from which I approached this study came from my broad experience in health care over many years. In addition, I was familiar with Mission Hospital through a family member’s prior employment at another unit within this health system, and by having been a patient there many years ago. While my experience of receiving care at Mission Hospital was positive, I had not been familiar with the institution’s specific commitment to sacred encounters.
at the time, and the hospital was not in my community, so I did not know any individuals there, as I embarked on my research.

An understanding of the risk of researcher bias must be considered in qualitative research (A. A. Berger, 2015; Mays & Pope, 1995; Shah, 2006). Even when the researcher is not conscious of personal bias there is the potential that unconscious bias could enter the research process. Due to my general familiarity with both the hospital, and my long experience as a nurse and leader, I needed to be aware of the potential for bias. Utilizing the process of continual reflection or reflexivity (A. A. Berger, 2015; Charmaz, 2006), I maintained an awareness of the thoughts, feelings and perceptions I brought to this study throughout the research process.

Charmaz (2006) defined reflexivity in the following way:

The researcher’s scrutiny of his or her research experience, decisions, and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher’s interests, positions, and assumptions influenced inquiry. (p. 188)

Clarke (2005) also reminded: “We cannot help but come to almost any research project already ‘knowing’ in some ways . . . we are, through the very act of research itself, directly in the situation as are studying” (p. 2). Specific to nursing research, Green (2013) notes that nurse researchers “must recognize the subjective reality inherent in the research process and embrace it” (p. 68).

Morgan and Smircich (1980) presented an ontological description of a subjectivist to objectivist approach to social science along with the implications for epistemology based on the researcher’s assumptions along the subjectivist-objectivist continuum. The highly subjectivist view of reality as an open system would “favor an epistemology that emphasizes the importance of understanding the processes through which human beings concretize their relationship to their world” (p. 493). In contrast, the objectivist’s understanding of a closed system has “an
epistemology of extreme positivism, derived from a mechanical conception of the universe as a closed structure” (p. 493).

Research is always performed by an individual with unique life experience, personality, and social context “that affect the research from the choice of a research question or topic, through the method used, to the reporting of the project’s outcome” (Bentz & Shapiro, 1998, p. 4). Consideration of where one is positioned on the continuum can provide clarity on approach for the researcher.

Based on my personal life experience and epistemology, I structured this qualitative study so as to facilitate a deep understanding of the experience of the nurse leader. This was a constructivist approach that assumed human beings, through interpretation of their environment, create reality and enact a meaningful relationship with the world (Gergen, 1985). This allowed the research to unfold in such a way that information, observation, and data I gathered, guided the research and allowed new knowledge to emerge.

The Research Method

Qualitative research methods facilitate the study of issues in depth and in detail without the constraints of predetermined categories of analysis (Patton, 2002). A qualitative research approach is dictated by the research question and whether the question lends itself to a methodology that allows the researcher to explore the inner experience of participants, determine how meanings are formed through and in culture, and discover rather than test variables (Corbin & Strauss, 2008; Stake, 2010).

The first consideration in choosing a method for this research was simply the focus of this study—the lived experience of nurse leaders. Van Manen (1990) approached lived experience from a phenomenological perspective “aimed at gaining a deeper understanding of
the nature or meaning of everyday experiences” (p. 9). According to van Manen, the purpose is to explore “the way that a person experiences and understands his or her world as real and meaningful” (p. 183). He also recognized the concept of relationality in that individuals live in relation to other human beings (pp. 104–105). Through this study, my desire was to gain a deep understanding of nurse leaders’ experience of sacred encounters—an interaction between two or more individuals—and how they (nurse leaders) within the environment of today’s health care setting perceive their relationships with others. In gaining this deep understanding of the perceptions of nurse leaders, I sought to build on current research and to discover new knowledge about nursing leadership and the spiritual and relational characteristics of sacred encounters. To this end, I identified narrative inquiry as the most fitting methodology for this study.

**Narrative Inquiry**

Narrative inquiry embraces narrative as both the method and the phenomenon to study (van Manen, 1990). It is intended to enlarge the vision of a particular experience and provide the researcher a means to gain understanding of the lives of others as expressed through lived and told stories. These stories take place in the context of the participants’ lives and involve the reconstruction of a person’s experience in relationship both to the other and to a social milieu (Connelly & Clandinin, 2006). Narrative is particularly useful in nursing providing a solid knowledge base for nursing through reflection and openness. It assists in the demonstration of human context and response (Vezeau, 1994).

Narrative inquiry has been explained and defined in numerous ways. For purposes of this study I use the definition put forth by Connelly and Clandinin (2006):

People shape their daily lives by stories of who they and others are and as they interpret their past in terms of these stories. Story, in the current idiom, is a portal through which a
person enters the world and by which their experience of the world is interpreted and made personally meaningful. Viewed this way, narrative is the phenomenon studied in inquiry. Narrative inquiry, the study of experience as story, then, is first and foremost a way of thinking about experience. Narrative inquiry as a methodology entails a view of the phenomenon. To use narrative inquiry methodology is to adopt a particular narrative view of experience as the phenomena under study. (p. 477)

My interest in gaining an understanding of nurse leaders’ perception of sacred encounters and how they perceive their leadership, lent itself well to the methodology of narrative inquiry. Nurse leaders at Mission Hospital each bring a unique experience and frame of reference to the study. They participate in their work environment individually and perceive their work through a very personal life lens. Narrative inquiry encourages the telling of stories and is based on the premise that listening to the stories of others provides an opportunity to make sense of their experience and to gain an understanding of how they might construct meaning within a broader social context (Polkinghorne, 1988). To expand my understanding of nurse leaders’ experience both personally and within the broader context I incorporated situational analysis into my study and explored the environment of Mission Hospital and of the nurse leader.

Creating meaning from these stories requires an analysis of the information gathered. Thematic analysis (Bazeley & Jackson, 2013) focuses on the content of the stories and, through an inductive process of data review, creates groupings, themes and categories from the data. My approach to thematic analysis included initial line-by-line coding of the transcribed interviews. From that process, themes emerged. Through thematic analysis I was able link the various stories together in such a way as to uncover common understandings, concepts and meaning related to nurse leaders’ experience and their leadership of sacred encounters. Bazeley and Jackson (2013) remind us that thematic analysis must go beyond descriptions of codes and categories. Truly effective analysis “requires using data to build a comprehensive,
contextualized and integrated understanding . . . of what has been found with an argument drawn from across the data that establishes the conclusions drawn” (p. 191).

By using narrative inquiry, situational analysis and thematic analysis in concert, then, I was able to build a model for understanding how nurse leaders moved sacred encounters from idea to practice.

Seeking to understand the phenomena of sacred encounters through the lens of nurse leaders at Mission Hospital, I had the privilege of entering the lives of 11 of them. From their telling of very personal stories with personal reflection and introspection, I experienced the deep emotions associated with their experiences. Approaching this study through narrative inquiry allowed me this special opportunity.

Connelly and Clandinin (2006) derive “three commonplaces of narrative inquiry” (p. 479) that provide the researcher with a conceptual framework within which to approach their work: temporality, sociality and place. Temporality refers to the notion that all events are in process or in transition. Sociality reminds us that there are conditions within which the participant exists. These include personal conditions, such as hopes and desires, and social conditions such as the environment, external conditions and forces. Place refers to the actual physical space where the inquiry and events take place. Particularly useful in this study were sociality and place although temporality was also a useful reminder of how people, places and events are in a state of constant change. Sociality defines the value and purpose of performing an in-depth situational analysis.

With the changing health care environment, it is important that participants’ experiences and stories are understood within the context of the health care industry, Mission Hospital and the immediate environment of the nurse leader. Place became an interesting component of this
study as I observed numerous signs and symbols of the mission, vision and values of the organization throughout the hospitals. These served as reminders to patients, family members and employees of the purpose and religious foundation of Mission Hospital.

Deep in narrative inquiry and the stories that people tell, is a need for people to paint a picture of their lives where they can discover a sense of meaning in their experiences. Narrative allows individuals to reflect on their perspectives of life events and develop stories that make sense of their lives. Yet narratives need not be seen only as individual chronicles of personal accounts of events. Using thematic analysis, the researcher weaves individual participants’ stories together to gain a deeper understanding into groups, events and cultures (Polkinghorne, 1988).

By listening to the stories of others, narrative inquiry provides an ability to make sense of their experience and to gain a deep understanding of how they construct meaning within a broader social context (Polkinghorne, 1988). The stories told by participants for this study, were insightful and very moving. Having volunteered to take part in this project, nurse leaders came to interviews open and willing to tell their stories. They were reflexive and provided unique perspectives on events related to sacred encounters. Going beyond the nurse-patient relationship, participants spoke of relationships between physicians and nurses and between leaders and followers.

These stories, woven together, created insights that moved my understanding beyond any single perspective. The combination of perspectives and the integration of thoughts, ideas and events culminated in an understanding of the organization and the people and processes within that organization—going far beyond where any one story would have taken me. This
Constructivist approach included interpretation of the relationship between storied events and the weaving together of descriptions and emotions that ultimately created the richness of this study.

Constructivism moves beyond the dualism in empiricist and rationalist schools of thought and places knowledge within the process of social interchange (Gergen, 1985). It assumes that there is no one true reality to be understood and that actors and researchers construct and interpret their realities through unique situated perspectives. Constructivist inquiry refers to a research paradigm recognizing that those experiencing it construct reality. Research becomes the process of reconstructing that reality (Birks & Mills, 2013, 2015; Clarke, Friese, & Washburn, 2015; Reason & Bradbury, 2008).

Situational analysis enhances the research by:

- Acknowledging the embodiment and situatedness of the researcher, grounding qualitative analysis in the broader situation of inquiry, attending carefully to differences, complexities, and range of variation in the data and including discourse data and taking nonhuman elements . . . into account. (Clarke et al., 2015, p. 12)

Clarke (2015) argued that everything in the situation should be considered, as every aspect affects most other things in the situation. Her situational maps allow the researcher to articulate and examine elements of the situation and the relationships among them. She identified social worlds/arenas maps as frames through which the researcher can analyze the meso organizational level, analyzing collective actors (social worlds), their work, and discourses in those arenas. Social worlds assume multiple collective actors and, according to Clarke, shifting theorizing “from social process/action to social ecology/situation” (p. 89).

Clarke (2015) indicated that the inclusion of humans is not enough and that the researcher must take the nonhuman explicitly into account. Clarke refers to the need for inclusion of the whole situation as follows:

- Fresh methodological attention needs to be paid to nonhuman objects in situations, things of all kinds. These may include cultural objects, technologies, animals, media,
nonhuman animate and inanimate pieces of material culture, and the lively discourses that also constitute the situations we study—from cups and saucers to lab animals to TV programs. (p. 91)

One can begin to see how enhancing understanding of the context and environment through utilization of situational analysis paired with the personal insights gained from narrative inquiry can result in rich and comprehensive research. Situational analysis extends narrative inquiry by grounding the analysis “deeply and explicitly in the broader situation of inquiry” (Clarke, 2015, p. 195). It includes the exploration of nonhuman elements in considerable detail based in the belief that the human and non-human factors and the relationship they share constitute the world together. This process of co-constitution and co-construction can be studied through using the situation as the local of analysis and explicitly including all pertinent nonhuman elements along with the human in situational maps.

Clarke (2005) conceptualized a concrete situational matrix making it clear that in an analysis of a situation, nonhuman factors do not just frame or contribute to the situation, they are the situation. Situational mapping can include such maps as human and nonhuman elements, functional arenas, political and economic elements, or others as determined meaningful through the emergent interview process.

The situation in this study was explored by starting with the macro-environment of the healthcare industry. Factors affecting the hospital included effects of the Affordable Care Act (Patient Protection and Affordable Care Act, 2010), technology, demographics, disease, economics and resources. The situation also emerged through the research process as aspects of the non-human environment in the hospital setting were discovered. Evidence of the faith-based values of the hospital was apparent throughout the hospital campuses in posted signage, pictures, wording, and displayed religious objects. Language of the organization became part of the situation and assisted my understanding of the overall culture and environment within which the
employees worked. In addition, hospital metrics were utilized to deepen an understanding of the representative hospital and establish foundational knowledge about the goals, objectives and outcomes related to practices associated with sacred encounters.

Relevant to this study, two maps, following Clarke’s (2005) approach to portraying situations, were used to situate the research in the broader environment. The first situated Mission Hospital in the larger health care industry setting (Figure 4.1 in Chapter IV). The second identified internal elements of Mission Hospital relevant to the nurse leader experience of sacred encounters (Figure 4.2 in Chapter IV)

The Research

A semi-structured interview process was utilized in 11 interviews with 10 nurse leaders. One nurse leader was interviewed twice—an initial interview and a second time to revisit some of the principal emerging themes. Two open-ended questions were asked of each nurse leader to start a dialogue about their experience in implementing the mission outcome of sacred encounters.

• As a nurse leader here at (Mission Hospital or Laguna Beach Hospital), will you describe your personal experience with sacred encounters?

• How do you, as a nurse leader, create or enhance the opportunity for sacred encounters to occur in your area(s) of responsibility?

Study participants. Study participants consisted of a purposeful sample of nursing leaders at Mission Hospital who held a position of leadership within the hospital. Participation in this study required the potential participant meeting two criteria:

• Participants held a position of supervisor, manager, director, vice president, or senior leader as approved by hospital administration
• Participants would have had identified themselves as having had experience with
  sacred encounters through completion of a brief online survey provided to nursing
  leaders. Two yes-or-no questions were asked and both needed to be answered
  affirmatively:

  o Would you like to participate in this study?
  o Do you feel that you are familiar with sacred encounters as it is defined by
    Mission Hospital?

  The Vice President of Mission Integration e-mailed an invitation, on my behalf this
  study, to all nursing leaders. I prepared an “Invitation to Participate in a Research Study”
  (Appendix C) which was attached to the Vice-President’s email and included a brief description
  of the study and the two questions for participants.

  The nurse supervisor serving as my partner and guide followed up with nursing leaders
  to ensure they received the email and to encourage participation in the study. If questions came
  up about the research she directed those individuals to me so that I could accurately answer their
  questions and provide clarification where needed. Prior to participation a consent form was
  provided to each participant (Appendix D). All procedural and protocol questions were
  answered and information clarified prior to the participant signing the consent form.

  **Data collection and analysis.** The 10 interviews were conducted face to face at Mission
  Hospital over a specified period of five days. The study was designed this way to allow for face
  to face interviews. Travel across the country was required for me to do the interviews, with the
  caveat that follow-up interviews would be conducted via telephone or Skype if needed. The
  limited timeframe required that reflection and analysis be done between each interview so that I
  could identify additional areas of exploration, clarification or explanation.
The setting of the interviews was a small office in a quiet hallway near the office of the Vice President of Mission Integration, but separate from her administrative space. Participants were scheduled at a specific time and, to protect their privacy, were not required to check in anywhere prior to coming to the interview. Each interview was scheduled for one hour with 30 to 60 minutes between interviews to allow me time for reflection and to avoid participant overlap. No interviews exceeded the 60-minute limit and there were no instances of participants crossing paths approaching or leaving the interview room.

Initial data collection began with an interview with a nurse manager. The interview process could have started with any level of nurse leadership within the organization. The manager position was selected due to the assumed proximity to patient care and the practice of sacred encounters. From this initial interview, next steps for a progressive and systematic method of data collection were determined by availability of study participants.

I started each interview with an overview of the study, then a reminder that participation was voluntary and that the session would be recorded. In each interview, I reviewed and then requested signing of the consent form and made a reminder that the participant could choose to stop the interview process at any point. I introduced the two research questions and reaffirmed their willingness to participate. Following this introduction, I asked the first open-ended question: “Can you tell me about your personal experience with sacred encounters?” Then, I listened intently to their response. Keeping an awareness of time and ensuring not to interrupt the flow of the conversation, I determined the most appropriate time to move the interview from the first question to the second: “In your role as a nurse leader, how to you what is your experience in creating or enhance the opportunity for sacred encounters to occur here at Mission Hospital?”
During the interview process I maintained an acute awareness of how the participant was responding to the interview and looked for any signs of reluctance or distress. I found that the topic of sacred encounters created an emotional response in some participants (sadness, tears) as they were telling stories of their own, often intense experiences. If I perceived reluctance or distress I paused the interview process to ensure that the participant was comfortable proceeding. Although emotion in the form of sadness or tears was common in the interview process, none of the participants reported sensing a level of discomfort that made them unwilling to proceed. On the contrary, they generally indicated comfort in expressing their emotions in the interview setting.

The emergent and iterative characteristic of the inductive interview process allowed me to add new pieces to the puzzle while the research was taking place, thus following leads that emerge throughout the process until patterns emerge (Bentz & Shapiro, 1998). The iterative process of interview, data gathering, and analysis, determined each subsequent step in the process.

I found this progression interesting and effective in that the interviews were all slightly different as I gathered new data and explored that data in subsequent interviews. One example was the concept of a daily story about care provided on one of the care units was distributed and read with staff during time set aside for a daily huddle on each of the nursing units. Utilization of this story was expressed as a way to reinforce sacred encounters and the importance of the work that they do.

It’s educating the people on who we are and what we are and on . . . one person in the hospital, a different person every day. It’s a little insight about them and what they do in their daily work. It actually brings people together. (Interview #2)²

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² Direct quotations are attributed by code-numbered interviews to insure anonymity of the participants.
This daily huddle story was encountered several times in early interviews; so, in subsequent interviews, I specifically asked about the practice, gaining new insights and perceptions from additional participants. This process revealed additional insight into the daily huddle as a means of reinforcing the practice of sacred encounters: “There is a story of a different unit or a different individual who is being recognized for their sacred encounter or their interactions with people” (Interview 20-018).

Throughout the interview process I made a conscious effort to remain open to what the data was telling me and to the direction of my research. This process of ongoing analysis allowed me to identify codes and themes that informed upcoming interviews. After each interview my perception of the data changed as new information was combined with old information gathered through the interview process. Charmaz (2006) stated that coding is both work and play and that we “play with the ideas we gain from the data . . . becoming involved with our data and learning from them” (p. 70). This iterative process allows the researcher to discover meaning within the data and begin to unify ideas and theoretical meaning.

The analysis of qualitative data includes a systematic yet flexible guideline for the collection and analysis of qualitative data to gain understanding of the behaviors, words and actions of those under study. Bazeley and Jackson (2013) further describes analysis as,

laid on the foundation of our understanding about how the world works, and what makes it, what it is (ontology); and of how we, as human beings, can understand and learn about that world and especially about the world of people (epistemology). (p. 1)

Data analysis in qualitative research follows a simple path. Corbin and Strauss (2008) describe this process as follows: First, the researcher breaks the data into manageable pieces. Second, those pieces of data are explored for the ideas they contain. Third, the researcher gives those ideas conceptual names that stand for and represent the ideas contained in the data. This coding requires the researcher to put aside preconceived notions and expectations and letting the
data and interpretation of the data guide the analysis using words that best describe what the researcher believes is indicated by the data.

Categorized themes were identified as data was gathered and coded. During this process, I wrote numerous memos to document thoughts, questions and ideas that I had during the process. These memos were essential to my thinking deeply about each interview where the data might be taking me. It assisted me in formulating questions for upcoming interviews and beginning to see essential concepts emerge. Emerging concepts were then tested in subsequent interviews guiding my thought process and, again, the direction of the research.

An example of the effectiveness of this process was when I saw a theme of leader as teacher emerging. I had categorized data around informal teaching and role modeling as teaching. I tested that theory in a subsequent interview and, with new data, adjusted my approach from using the term, teaching, to language more meaningful in the research environment: facilitating and coaching. This change did not markedly affect the direction or conclusions of my research but provided me with a perspective on language that I would not otherwise have had.

The methodology used throughout the interview process involved a continuous cycle of collecting and analyzing data. Data are analyzed utilizing thematic classification that is continually analyzed within the context of the data that are being collected. As gaps in the data are identified, the researcher determines the next appropriate step for data collection, thereby allowing exploration of similarities and differences until a new theme emerges. Utilizing the concept of saturation, as originally developed in grounded theory methodology (Charmaz, 2006), I focused on relevant data collection until it was no longer generating new information.
The systematic yet flexible approach to this study using narrative inquiry, situational analysis and thematic analysis, provided rich data that, through analysis, resulted in the creation of a model of practice that reflects the movement of sacred encounters from idea to practice. Charmaz (2006) described this rich approach to qualitative inquiry in the following way, “We try to learn what occurs in the research settings we join and what our research participants’ lives are like. We study how they explain their statements and actions, and ask what analytic sense we can make of them” (pp. 2–3).

**Quality control and data management.** Throughout the research process the highest ethical standards of managing confidential data was maintained. Participant names and departments were kept confidential to all but my Mission Hospital research liaison. The participants’ roles in the organization are part of the study data.

Two external coding partners, affiliated with Antioch University, were included in the research process for coding validation. One coding partner participated in line-by-line coding for the first several interviews to ensure multiple perspectives in validating the coding process. The dissertation committee methodologist reviewed initial interview and coding data to ensure appropriateness of interview method and coding process. Subsequently the initial partner then proceeded with line by line coding for all interviews for comparison and validation of my code identification. Dedoose software was utilized to aid in the coding process and data analysis. This is a proprietary application self-described as “a cross-platform app for analyzing qualitative and mixed methods research” (Dedoose, n.d., para. 1). The choice of this software selection was based on product quality and ease of use. Throughout the coding process, the software was utilized, along with regular conversations with the coding partner, for coding comparisons and agreement of point of data saturation.
All data, notes and transcription were kept in a secure, locked place during the research process and are to be destroyed in a confidential manner on full completion of the dissertation, following standards approved by Antioch University.

**Timetable.** The following outlines the chronology of events in conduct of this research:

- May 2016: Proposed study approved by Mission Hospital Research Council;
- May 2016: Written approval provided to researcher/Antioch University by Mission Hospital;
- July 2016: Initial survey sent to potential participants;
- July 2016: Participants selected in collaboration with Mission Hospital administration or designee;
- July 2016: Initial interview scheduled;
- July 2016: Site visit;
- August 2016–March 2017: Subsequent interviews held as needed;
- March–April 2017: Data analysis, final write up, research approved;
- (Date to be determined): Presentation of study to Mission Hospital.

**Study Limitations and Use**

The proposed study was intended to analyze Mission Hospital nurse leaders’ experience with sacred encounters. As with most qualitative research it was intended to be generalizable outside the single organization but, instead, to develop a deep understanding of how a singular aim—making each encounter sacred—was brought into effect. Results of the study will expand the literature around relational leadership in nursing. Equally important, Mission Hospital’s administration may gain knowledge and insight about the sacred encounters in and as practice.
**Ethical Considerations**

The following were the principles and procedures that were used to ensure that this study fully met standards of ethical research:

- participants understood in advance that their participation in this proposed study would be known by Mission Hospital along with the results of the study,
- all participation was voluntary and participants could opt out of the study at any time,
- strict confidentiality agreements were in place for all research partners,
- interview recordings and transcriptions were shared with research partners. However, no participant requested to review their interview transcript.

**Summary**

In qualitative research, rich insight arises by developing an understanding of the perspectives of participants who have diverse experiences of the phenomenon being studied. These unique perspectives allow for exploration of multiple dimensions of the process under study (Starks & Brown Trinidad, 2007). Within this constructivist approach to data gathering and analysis there is no predetermined lens through which data are collected or processed (Charmaz, 2006). The researcher simply follows the research. The addition of situational analysis to this study deepened our insight into the social arenas of Mission Hospital and of nurse leaders adding a rich dimension to the research.
Chapter IV: Results

All management is people management . . . there is nothing that a leader can do that does not depend for its effectiveness on the meaning other people attach to it.

(Vaill, 1989, p. 126)

The most powerful source of energy in an organization is meaning. Most people come to their work with a desire to do something meaningful. Leaders have an important role in connecting the individual to the work and encouraging the heart in such a way that meaning is discovered (Kouzes & Posner, 2002; Wheatley, 2006).

The purpose of this study was to gain a deeper understanding of nurse leaders’ experience at Mission Hospital in leading the practice of sacred encounters. Sacred encounters was one of three articulated mission outcomes (along with perfect care and healthiest communities) established by St. Joseph Health (SJH), the parent corporation of Mission Hospital (Thies, 2012). The Vice President of Mission Integration describes mission outcomes as an expression of the SJH mission: “It’s really about we’re doing this to extend the healing ministry of Jesus. That’s what it’s all about.” And specifically about sacred encounters: “And how do we know at the end of the day that we’re living out our mission? Well, because every encounter is experienced as a sacred encounter” (Interview 28-001).

Staff at Mission Hospital needed to transition sacred encounters from a concept into action. They needed to create meaning in the work of sacred encounters so that they could “remain grounded in the fact that is often the smallest acts that most profoundly affect the body, mind or spirit of both the cared for and the caregiver” (Thies, 2012). Mead (1934) proposed that human beings create meaning and a sense of self through interactions with other people. It is through that sense of self they construct actions that are then taken into the world. A nurse’s
sense of self as manager or as staff nurse, shapes interactions and relationships within the work environment and forms the basis for sacred encounters to occur.

Foundational to leadership is the relationship between leaders and followers and the ability of leaders to effectively create and implement a vision that empowers staff and creates an environment where work can be done in complex and changing environments (Casida & Pinto-Zipp, 2008; Graen & Uhl-Bien, 1995; Hollander & Offermann, 1990; Stogdill, 1974; Yoder-Wise, 2014). Knowledge of oneself and of other people is interdependent and becomes known in terms of the relationship that exists between them (Uhl-Bien, 2006). Health care, as one of the world’s most complex human organizations (Uhl-Bien et al., 2007) requires that leaders, challenged with a rapid pace of change, demonstrate skills in diversity, creativity and continual learning to meet the demands of the unknowable future (R. A. Anderson & McDaniel, 2000). The modern healthcare environment, in particular, creates challenges for leaders in building a unit-based culture that reflects the culture of the organization (Gifford, Zammuto, Goodman, & Hill, 2002; Kane-Urrabazo, 2006; Lok & Crawford, 1999; Yoder-Wise, 2014).

The first question, “Tell me about your personal experience with sacred encounters,” gave the participant an opportunity to talk about their individual experience with sacred encounters, either within or outside of their leadership role, and to reflect on that experience at a very personal level.

The second question was: “As a nurse leader at Mission Hospital how do you see your role in creating opportunities for sacred encounters to occur?” This question was designed to allow the nurse leader an opportunity to reflect on his or her personal leadership behavior as it relates to the realization of sacred encounters within their primary area(s) of responsibility or within the organization as a whole.
These two broad questions elicited rich responses from study participants. The interview process of asking the participant to reflect on personal experience with sacred encounters and then on their personal leadership behavior was done purposefully. The initial question allowed for the participant to essentially tell stories of personal experience. Although these stories at times stimulated strong emotions in participants they also served to build trust between the participant and the researcher. Use of intentional and well-defined interview practices helped to create an environment of support for the participant and allowed the interview to progress toward a deeper level of self-reflection (Kvale, 1996).

I found that participants were easily able to access personal experiences with sacred encounters ranging from being a patient, being a family member of a patient, or from providing care to a patient or family member. Describing their personal leadership behaviors to create opportunities for sacred encounters to occur proved to be a bit more difficult for participants to articulate. They easily noted the organizational practice of creating scenes that encourage a sacred encounter between the caregiver and the patient such as “Sweet Dreams” and “Thoughtful Goodbyes” (organizational practices that will be described later in this chapter—see Thies, 2012). Asking them to describe specific personal leadership behaviors they employ to encourage their staff to engage in sacred encounters on their unit(s) seemed to be generally more thought-provoking and challenging to answer.

**Setting the Stage**

When I initially became aware of St. Joseph Health and the identified mission outcome of sacred encounters I was intrigued that a large multi-state health system would articulate the expectation for all employees that “every encounter is a sacred encounter.” As interesting as I found the decision at the system level in articulating this expectation, I was even more curious
about how the nurse leader at the unit level within one of their hospitals would contribute to bringing sacred encounters to life. I narrowed my interest to one SJH hospital, Mission Hospital, that reportedly had embraced sacred encounters and had practices in place to ensure sacred encounters occurred within their organization.

During many years working in faith-based and non-faith-based healthcare settings, observing various leaders and leadership styles, I developed a strong interest in the value of relationships in leadership and also in the role that spirituality may play in the perspective of the nurse leader in carrying out his or her leadership responsibilities. Having been granted permission by SJH to work with Mission Hospital, I needed to design a study that would encourage participants to share their personal stories and perspectives. I decided to take a constructivist approach through narrative inquiry and thematic analysis with situational analysis (Connelly & Clandinin, 2000; Clarke et al., 2015) to explore the nurse leader experience with sacred encounters.

As often occurs in constructivist methodologies, my research took me to places I did not expect to go. I learned a great deal about relationships and spirituality but also about organizational culture and the perception of nurse leaders of their role as teacher, mentor, supporter and coach. I realized that sacred encounters occur not only in the interaction between the nurse and the patient but clearly between the nurse and his or her staff as well.

Health care organizations have a specialized and extraordinary purpose and are places where profound human experiences happen every single day (Koloroutis, 2004). These dynamic and complex systems bring together people from diverse backgrounds and life stories sharing their personal and intimate life experiences.
Every organization over time develops distinctive beliefs and values. Leaders at all levels of an organization have a role in creating, understanding, sharing and reinforcing these characteristics that ultimately become the culture of the organization. There is a “chicken or egg” phenomenon related to organizational culture questioning whether leaders shape the culture or are shaped by it (Bolman & Deal, 2003). From my experience in this study I believe the answer is that both are true. Nurse leaders at Mission Hospital were both shaped by the defined culture while at the same time being shaping the culture as they lived it and brought to life every day.

Even when an organization fails to articulate an identity people within the organization will come together and form a system of shared behaviors and beliefs. These shared beliefs may or may not correspond to the official organizational narrative yet the collective result forms the basis of organizational identity (Bolman & Deal, 2003; Deal & Kennedy, 1982; Gioia, Schultz, & Corley, 2000).

Organizational identity resides in a set of institutional claims—that is, explicitly stated views of what an organization is and represents—that are expected to influence its members’ perceptions of central enduring, and distinctive features of the organization by providing them with legitimate and consistent narratives that allow them to construct a collective sense of self. (Ravasi & Schultz, 2006, p. 435)

This sensegiving function provides a guide for how members of the organization should behave and what leaders do to influence behaviors supporting organizational identity (Ravasi & Schultz, 2006; Weick, 2001). Members of the organization will make sense of their environment through their personal and collective experience. Sensemaking is the process that underlies the social construction of organizational identities resulting in an identity, or culture, that may or may not reflect what the organization has put forward.

In 2006, leaders from SJH began a multi-year journey with sacred encounters. From 2006, when they had their first strategic summit related to sacred encounters, to 2012 when they
set expectations around system implementation, leaders sought to create a structure that would allow this concept to become action. Participating in the planning were mission integration executives from each of the SJH hospitals or “ministries.”

After . . . analysis and follow-up survey with more than 4,000 physicians, patients, staff and community members, four key concepts rose to the top: dignity, connection, care and compassion. Although we all understood it was entirely possible that the term “sacred” could have many definitions, the study clearly indicated that an act wherein these four concepts were present increased the likelihood a sacred encounter could be experienced. (Thies, 2012)

St. Joseph Health leaders created a succinct definition of sacred encounters, a strategy for implementation and piloted a methodology called scenography, later renamed as spotlighting that involved “examining key moments, or scenes, that could be redesigned and elevated to a sacred encounter for a broad representation of the patient population” (Thies, 2012, para. 9).

Thies (2012) described the essence of scene creation as follows:

Examples of such scenes are arriving in the admitting area, going to bed at night or leaving the hospital. Once a scene is chosen, the teams are encouraged to pour on the creativity. Everyone helps build the scene, working through a number of critical questions. For example, what is the emotion or tone of the encounter? Is it neighborly or motherly? What is the setting? Does the scene take place in the intimacy of the patient room or the celebratory area of a lobby or entrance way? What gesture will have an impact? Is it fluffing a pillow or greeting a patient at the door? (para. 11)

The core team, comprised of mission leaders representing each of the ministries (hospitals) across the system, articulated the following understandings of sacred encounters.

There are three realms of sacred encounters:

• an individual realm or personal response—experiences, feelings, thoughts;

• an organizational realm or culture—the spirit and experience of the local ministry;

• a societal realm or the experience of the sacred in pluralistic society;

There were also four key messages related to sacred encounters:

• the spectrum of sacred encounters is broad, not narrow;
• sacred encounters have always occurred on many levels throughout the SJH;

• sacred encounters means simply naming what is already there, and learning how to enable sacred encounters to flourish;

• St. Joseph Health is a ministry.

And the following describe the experience of a sacred encounter:

• when you discover an essential truth about being a human being,

• as a joyful experience of humility and awe about our ability,

• as searching for how to better honor the human dignity of a person in challenging circumstances, and

• as an experience of depth.

Finally, to foster the experience of the sacred, an inspirational statement was adopted:

To be a community that serves, that speaks, that celebrates and prays in such a way that others—regardless of their religious belief—encountering this community experience a revelation of life’s deepest truths . . . about human dignity, community, success, power, growth, sacrifice, love, suffering, debility, and death. Experiencing a harmony between their heart’s deepest resonances and this community’s character, persons go from this encounter more healed, more whole, more able to live, to love, to hope, to die. (Thies, 2012)

**Situating the Research**

Interviews with nurse leaders at Mission Hospital revealed a strong correlation between sacred encounters and organizational culture. They each had been formally introduced to the concept of sacred encounters through required leadership development work. Their interpretation, beliefs and understanding of the work was then, through their leadership, put into practice.

As I explored nurse leaders’ beliefs and their practice around sacred encounters, four distinct themes emerged: organizational culture, teaching, spirituality, and defined organizational
practices. A common thread through all was relationship, with the organization, with patients, with each other, and with the divine. To understand the experience of nurse leaders at Mission Hospital we must first understand the context, or social arena within which they carry out their work.

In seeking to understand one’s social world one must also comprehend the arenas in which that world participates (Clarke, 2005). For this study, to accurately capture the relevance of the data, one must understand the context of the research—the world in which the research takes place and in which the participants do their work. The work of the nurse leader takes place within the context of Mission Hospital, with all the complexities that go along with hospital life. In addition, Mission Hospital is part of a larger health system, St. Joseph Health that functions within the larger health care industry.

Although the immediate context of the hospital environment is most palpable for a nurse leader, their work is impacted by the larger health system and by aspects of health care industry overall (Shirey, 2009; Veronesi, 2001). For the purposes of this study I chose to include analysis of the social worlds of both the nurse leader and of Mission Hospital. The lens through which the social arenas map for Mission Hospital (Figure 4.1) was perceived included aspects of St. Joseph Health and relevant aspects of the health care industry overall. Finally, I explored the relationship between the two maps so that I could deepen my understanding of the context of the nurse leaders’ experience.

**The setting: Mission Hospital.** Participants in this study were all nurse leaders employed by Mission Hospital, and thus are, if not directly, then indirectly impacted by the larger context of the Mission Hospital situation (Figure 4.1). The importance of analyzing the social arena of Mission Hospital lies in the complexity of the hospital’s place within the larger
context of St. Joseph Health as well as its impact from factors associated with the health care industry overall.

Mission Hospital is part of an integrated, multihospital health system, St. Joseph Health. The American Hospital Association (n.d.) defines a multihospital health system as “two or more hospitals owned, leased, sponsored, or contract managed by a central organization” (para. 6). An integrated health system also seeks to link finances, people, technology and ideas into a system that delivers more cost effective and higher quality care. Shortell, Gillies, Anderson, Morgan Anderson, and Mitchell (2000) in Remaking Health Care in America, describe integrated systems as networks of organizations that provide a coordinated continuum of services to a population and are held clinically and fiscally accountable for the outcomes associated with provision of those services.

Figure 4.1. Social arenas map for the Mission Hospital.
At the time of this study St. Joseph Health was a 17-hospital health system divided into three regions—northern California, southern California and Texas. Along with its hospitals, St. Joseph Health also incorporated multiple medical groups, physician networks and home care agencies into its organizational structure. The organization had been constantly changing as new relationships were formed and as the health care industry evolved. Mission Hospital was located in the southern California region. All three regions had a local leadership structure but were governed by St. Joseph Health.

Health systems are typically integrated both vertically and horizontally offering a broad range of patient care and support services. Through ownership or formal agreements, they align programs and/or services to ensure a coordinated continuum of health care delivery (Conrad & Dowling, 1990; Lega, 2007; Wan, Lin, & Ma, 2002). Integration typically includes:

- Functional integration: financial management, human resource management information technology, strategic planning and quality improvement;
- Physician integration: organization of physician delivery systems including goals, purposes and shared objectives, and
- Clinical integration: coordination and delivery of patient care services (Shortell et al., 2000).

Enthoven (2009) accurately describes today’s integrated model of health care delivery as:

An organized, coordinated and collaborative network that: (1) links various health care providers, via common ownership or contract, across three domains of integration—economic, noneconomic, and clinical—to provide a coordinated, vertical continuum of services to a particular patient population or community and (2) is accountable both clinically and fiscally for the clinical outcomes and health status of the population or community served, and has systems in place to manage and improve them. (para. 1)
As part of an integrated health system Mission Hospital was impacted by numerous factors linked to the overall health care industry and other factors linked to St. Joseph Health. Through situational analysis it became apparent that many of the influences were attributed to both. The industry cannot truly be separated from St. Joseph Health in the context of the impact on Mission Hospital because much of the influence of the industry comes through the health system to hospital.

**The industry.** One of the most significant factors affecting the health care industry is the ever-changing economic environment. Examples of these changes include: decreasing payment for services, increasing percentage of workers with high-deductible plans, increasing cost of care, limited providers of insurance, increase in Accountable Care Organizations (ACOs), Congressional challenges to the Medicare budget resulting in decreasing payment, increasing number of people qualifying for Medicaid.

Regulatory pressures mount as the government and insurance companies implement measures to reduce the cost of health care. Outcomes around quality, safety and patient experience are public and payment is based on performance.

Technology is changing health care at a pace never before seen in the industry. Electronic medical records have changed the work of care providers; personalized health care is on the rise due to the availability of big data and the ability to more accurately predict patient risk; health care is being provided through telehealth and remote visits via phones, tablets or computers; innovation, such as robotics, is occurring at a rapid pace requiring care providers, patients and families to quickly learn and adapt.

Patient demographics are also changing with an increasing number of baby boomers expected to live longer, many with chronic conditions; acuity or the intensity of required care for
hospitalized patients is also increasing; new diseases are occurring; increasing diversity in the patient populations along with changing family structures bring diversity of values and belief systems.

Workforce changes can be seen across the continuum of health care from CEOs to care providers to service providers. CEOs are retiring at a rate of 20% per year and turnover of all staff is increasing. Worker shortage has continued over a number of years and is showing no signs of change. Traditional jobs are in demand but new roles are also emerging resulting in new jobs, new training and new relationships with academic partners. A recent survey of registered nurses found that 62% of nurses over age 54 are considering retirement and two-thirds say they plan to retire within the next three years. Other professions such as physical therapy also report workforce shortage trends. Technology changes such as telehealth, remote visits, and robotics, are creating shifts in where, when and how work is done (Zuckerman, 2017).

**St. Joseph Health.** St. Joseph Health (and thus Mission Hospital) was impacted by all of these industry changes. Table 4.1 shows this context of external and internal factors.

Table 4.1

<table>
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<tr>
<th>Social Arena Factors Influencing Mission Hospital</th>
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<tr>
<td><strong>Health Care Industry</strong></td>
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<td>Economic Environment</td>
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<td>Payment</td>
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<td>High deductible insurance plans</td>
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St. Joseph Health has experienced multiple mergers and acquisitions along with changes in physical plants and facilities to meet the changing demands of the market. How St. Joseph Health determines ways to adapt to this “permanent white water” (Vaill, 1996, p. 1) is guided by the beliefs and practices of its founders the Sisters of St. Joseph of Orange and defined by its mission, vision, and values.

**Nurse leaders.** Nurse leaders at Mission Hospital, although impacted by the larger industry and system worlds, have a unique context within which they perform their work. Through the interview process it was apparent that several aspects of the Mission Hospital social arena were also identified in the social arena of the nurse leader: technology, workforce, demographics, and regulations. Figure 4.2 shows the social areas map for nurse leaders.

![Social arenas map for nurse leaders.](image)

An overarching concept that continually emerged as a relevant factor in the social arena of the nurse leader and ultimately as the primary analytic theme, was organizational culture
Unique to the day-to-day world of the nurse leader were the social arena components of diversity—patient, staff and physicians; competing pressures; patient and family experience; teamwork; and transactional patient care. Their world is best understood through their own experience and in their own words.

**Diversity.** Cultural competence in health care is essential as patients, providers and caregivers become more diverse. A culturally competent health care system provides culturally appropriate services to ensure the highest quality of health care services can be provided (L. M. Anderson et al., 2003). Diversity at Mission Hospital is defined within the context of the organizational mission—to extend the healing ministry of Jesus. This was expressed by the Vice President of Mission Integration in the following way: “Jesus was radically inclusive . . . radically inclusive. He reached out to the margins. We treat everybody. Rich, poor, insured, uninsured, documented, undocumented” (C. Mueller, personal communication, July 28, 2016).

This sentiment was apparent within the stories told by study participants. One participant described a situation where she had to intervene with the estranged and angry father of a stillborn baby in the following ways:

Even as a trauma center, we’re not in the middle of LA, you know . . . they don’t typically see like gang-related stuff. I think the nurses just felt like they couldn’t handle it. Maybe we don’t need to be afraid of somebody who looks very different than you do” (Interview 25-002).

Staff and physician diversity was evident primarily in the context of religion and spirituality. One nurse leader stated, “I heard one time many years ago there was a staff person that said something like ‘I did not join this organization to be in church or whatever’.” She also identified diversity in her staff, “I would say probably 25 percent of my night shift is Muslim I have people who are Christian, Catholic and Muslim.” This nurse manager explained the difference between Catholic with a “big C” and Catholic with a “small C.” In her opinion the
big C refers to Catholicism specifically and small C “means that there is the universal tenets that hit all religions—like the Golden Rule” (Interview 20-018).

In reference to physicians and sacred encounters, one participant described physician behavior in the following way: “I think what they don’t get is translating into practice. They get the language, they get the expectation, but they still tend to act what they know, you know, behave as they always have. It’s very, very difficult for them to change their behaviors” (Interview 25-002).

**Competing pressures on staff and leaders.** Another factor of the nurse manager social arena was an acknowledgement of pressures on unit staff as well as on the leaders themselves. Nurse leaders were clear about those pressures and the responsibility they felt, particularly toward their staff.

Interviews demonstrated that nurse leaders feel a strong connection with their staff and are conscientious about ensuring that staff members feel that their leader supports them.

I have always been a patient advocate but now I am more of a staff advocate. I have kind of transferred that so that I consider them my team and my family and they know that. (Interview 28-003)

I feel as though I am their protector, I am their advocate yet I have to be firm with expectations on their behavior and their performance as well. (Interview 27-004)

I am hoping that I instilled in the employee the sense that I will cover his back or her back—whatever it is I will be there for you. I will stand beside you and we will face it together. (Interview 27-002)

There was probably some fear and some anxiety on their part. But I think . . . it was more important to demonstrate compassion towards him when I knew the staff was safe. I mean, he didn’t have weapons on him. (Interview 25-002)

When specifically asked about sacred encounters moving beyond the nurse-patient relationship, one nurse leader gave this example of a sacred encounter within the leader-follower relationship,

I feel like we should never hear . . . that we were not kind or respectful, you know. And I get that sometimes we have to tell our employees tough stuff. But if the employee walks
away wounded, that to me is the opposite of what should’ve happened. I’ve terminated people who have said, you know, ‘I love you’ at the end of it (laugh). Had a nurse say, ‘I’d go to hell for you’. (Interviewee 25-002)

Participants discussed the pressures that they, as nurse leaders experience. One nurse leader described her environment as,

continually changing. Sometimes you hear nurse leaders throughout the organizations saying the change just keeps coming. That’s part of like we just have got to be there for each other because I have not seen a stop in change since I have been here. There is something new on the horizon all the time. (Interviewee 27-002)

In describing an interaction with her director during a stressful time she described the support that she felt she received:

Sometimes I wear my emotions on my sleeve. She challenges me to remain . . . a calm tone, to remain for your staff . . . in the midst of change. She said, ‘I could tell you are uptight because your voice is a big higher. You are talking a little faster. If I saw your face I know I could tell on your face’. So that’s a good challenge to me. It’s nice to have someone who will do that with you. (Interview 27-002).

**Patient and family experience.** The patient experience can be interpreted as an economic issue where hospital revenue is tied to the experience of the patient and where data related to patient surveys are made public. Although participants were aware about patient satisfaction scores and aware of the importance of those scores when discussing sacred encounters the perspective of nurse leaders at Mission Hospital was not about dollars. It was about ensuring that experience of the patient and their family during hospitalization was perceived as positive and, in some cases, sacred.

One nurse manager described the patient experience as “healing the spirit” (Interview 28-003). Others used phrases such as “recognizing the positive impact that the nurse is having on the patient” and “bringing your whole self to the bedside” (Interview 25-002). Other descriptors included such things as providing comfort, advocating for the patient, showing you care, recognizing and dealing with frustration, and personalizing care. Challenging patient
experiences such as difficult patients or family members, suffering and distress were acknowledged as a part of the staff nurse experience. Nurse leaders recognized their leadership role in providing support and assisting their staff in managing through these difficult situations. The world of nursing requires that nurses work under challenging conditions. The role of a nurse leader is to recognize when these conditions occur provide appropriate, caring support to their team to enable to best care to be provided.

**Teamwork.** Teamwork is an essential component in the provision of care in a health care setting. Nursing education emphasizes the importance of the care team and of the essentiality high performing teams in ensuring high quality healthcare (Kalisch, Lee, & Rochman, 2010; Fewster-Thuente, 2011). The team is not limited to nurses but includes multiple disciplines including nursing assistants, support staff and physicians.

Nurse leaders and staff nurse experience with sacred encounters cannot always be considered as an individual effort. There are times when the relationship or encounter is solely between the nurse and patient. Certainly, interactions in the health care setting are often person-to-person and can be controlled by the individual. The presence of a team may not affect a unique interaction but affects the broader environment and experience of the players involved. For example—a nurse may enter an interaction with a patient who has just had a difficult experience with a physician. A nurse manager may have an interaction with a nurse who had just tried to calm an angry patient and family member who had not been served a meal on time. Encounters can also be affected by positive interactions that occur within a team.

Nurse leaders at Mission Hospital expressed the importance of building strong teams and of being a valued member of a team. One participant described the support of the team in helping a member gain a certification in her area of practice (Interview 27-004). Another
participant discussed the feeling of being wanted, part of a group, included (Interview 27-002). There were also descriptions of difficulties within teams such as perceptions of team member not pulling their weight or physicians not taking time to communicate effectively with the patient or team members.

**Transactional patient care.** Much of care that nurses provide to patients can be interpreted as transactional. *Transaction* means an exchange or interaction between people. This exchange happens in nursing every day—medications are administered; dressings are changed; patients are bathed; meals are served. Other essential activities related to these transactions include answering call lights, writing on communication boards and documenting care. A nurse’s day is filled with transactional activities.

In discussing their experience with sacred encounters nurse leaders noted that essential transactional activities could be seen as barriers to staff engagement in sacred encounters. This was true when the nurse leader perceived sacred encounters as separate from day to day activities. One nurse leader specifically cited her use of transactional activities to reinforce sacred encounters with her staff. The example she gave was coaching a nurse on how to engage in a meaningful way with a patient while assisting him with putting on his socks. She pointed out that it was possible, in those few moments, to engage with the patient in such a way to make him feel cared for, heard, respected and valued.

It is important to understand the context within which hospitals exist and nurse leaders lead. The evolution of United States health care, technology, the workforce and changing social structures will result in a continuously changing environment for the practicing nurse. Leaders can play a positive role in supporting the practice of nursing and the experience of the patient by
helping to create an environment where values, structures and behaviors are clearly defined and organizationally supported.

Also essential was understanding the full situation of inquiry (Clark, 2003) including the complexities associated with the hospital and the nurse leader. The individual voice of the participant in the interview is central to this study but that voice is better understood in the context of the environment in which it exists. Situational analysis supplemented the narrative inquiry by adding elements of the situation, human and non-human, that deepened the understanding of the nurse leader experience. It allowed me to dive deeply into the “situation” of today’s health care environment framing my perspective on creating organizational culture and the challenges associated with working in health care today.

**The Interviews**

I began with Peter Vaill’s (1989) statement that “all management is people management . . . there is nothing that a leader can do that does not depend for its effectiveness on the meaning other people attach to it” (p. 126). Mead (1934) suggested that both meaning and the sense of self are formed through interactions with others. It is through that sense of self that they construct actions that are then taken in the world. This concept of attaching meaning, is one of the challenges Mission Hospital and its leaders faced in moving sacred encounters from a concept into action. The meaning a nurse leader attaches to her role as leader, determines how she perceives role and how she chooses to interact with others. At Mission Hospital, this sense of self also determined the meaning they placed on sacred encounters and how they chose to bring sacred encounters to life. It is important to remember that the participant group in this research was made of only nurse leaders who had acknowledged having had experience with sacred encounters.
Multiple themes were identified through the process of data analysis. The four core themes that emerged were:

- *organizational culture*,
- *teaching*,
- *spirituality*, and
- *defined organizational practices*.

The most prevalent theme category was organizational culture. Numerous themes related to organizational culture emerged that were significant to understanding the experience of nurse leaders with sacred encounters. Aspects of organizational culture such as mission, vision and values, the practice of reflection during meetings, and expected behaviors were discussed. More important was the discussion about specific attributes of sacred encounters and of organizational culture as part of the nurse leader’s thinking, actions and leadership behavior.

Second to organizational culture was the concept of teaching described as formal teaching—those practices put in place by the organization to ensure understanding and expected behaviors around sacred encounters; and informal teaching—practices identified by nurse leaders as things they do every day such as coaching, mentoring, facilitating, providing feedback, modeling behavior.

The third core theme identified was spirituality. This was brought forward as personal belief systems, diversity and inclusion around staff, physician and patient belief systems, and the role of spirituality in caring or healing. The interjection of spirituality into the study brought a richness within the interviews that was enjoyable, gratifying, and at times overwhelming. Participants exhibited broad understanding and deep emotions about their personal experience
with sacred encounters and their spiritual connection to the work. Emotional responses were experienced in the form of tears, expressions of feelings of empathy or feelings of gratitude.

Finally, the data analysis revealed the theme of nurse leaders’ understanding and use of defined organizational practices, specific behaviors that create everyday purposeful ways for sacred encounters to be enacted.

Overlaps and interfaces occurred within and between each of the four themes. Through constant data gathering and reflection these integrated relationships became apparent and sometimes making it difficult to categorize certain elements of the data. As I continued through the cycle of reflexive data gathering and analysis the four core themes emerged. I have provided a thorough examination of each of the themes and, as inherent in thematic analysis, explored the relationship and interfaces between the themes in order to gain a deeper understanding of the data.

In addition to the core themes noted above, numerous other matters came forward through the process of data analysis that I consider to be comparatively minor factors. These are factors that arose a few times but not to an extent that I considered them highly relevant to the current study. I discuss them within the context of the study if they added to the understanding of the analysis.

**Core theme 1—Organizational culture.** Foundational to leadership is the relationship between leaders and followers and the ability of leaders to effectively create and implement a vision that empowers staff and creates an environment where work can be done in complex and changing environments (Casida & Pinto-Zipp, 2008; Graen & Uhl-Bien, 1995; Hollander & Offermann, 1990; Stogdill, 1974; Yoder-Wise, 2014). This vision is the basis of an organizational culture. One can argue that leaders do not actually create an organizational
culture but that instead, a culture emerges from the collective interactions of the group (Weick, 2001). Because St. Joseph Health defined one of the realms of sacred encounters as the organizational realm, the spirit and experience of the local ministry (Thies, 2012), in this study, organizational culture was found to be defined by SJH leadership but created—at least in part—by the words, behaviors and actions carried out every day by Mission Hospital employees.

The modern healthcare environment creates challenges for leaders in creating a unit-based culture that reflects the culture of the organization (Gifford et al., 2002; Kane-Urrabazo, 2006; Lok & Crawford, 1999; Yoder-Wise, 2014). Health care, as one of the world’s most complex forms of human organization, requires that leaders challenged with a rapid pace of change possess numerous skills such as diversity and continual learning to meet the demands of the unknowable future. Inherent in these skills is a basic knowledge of oneself, of other people and of the relationship that exists between them (R. A. Anderson & McDaniel, 2000; Uhl-Bien, 2006; Uhl-Bien et al., 2007). One nurse leader in describing employees’ response to implementation of actions associated with sacred encounters noted: “We do things differently here. I think they take things very well when it makes sense to them” (Interview 20-018).

I began to see aspects of organizational culture as a core theme, emerging early in the interview process through participants’ description of their experience with sacred encounters: the four attributes of sacred encounters; organizational mission, vision and values; and use of reflection as an expected behavior.

*Four attributes of sacred encounters.* As noted earlier, sacred encounters, as a mission outcome for St. Joseph Health and all its entities, was well defined and purposefully implemented through a lengthy and rigorous process (Thies, 2012). Within this process SJH
leaders performed a survey of over 4,000 employees, patients and physicians to ultimately settle on four attributes of sacred encounters: dignity, connection, compassion and care. As I interviewed nurse leaders, it became apparent to me that they not only had thorough knowledge of these four attributes but could also, through examples, articulate ways in which the attributes were reflected in staff and leader behaviors. Dignity rose to the top as the most visible and articulated attribute so I will begin there.

*Dignity.* This key attribute has been explained by SJH as follows:

If we close our eyes we could think of a face that might cause us to question whether all human persons deserve to be treated with dignity. They may have done something that would be considered inconceivable. Yet our tradition and our desire for Sacred Encounters tell us that our worth, our dignity, and that of others, is innate. As we attempt to make every encounter a sacred encounter, our tradition tells us that we must practice seeing the other as one who deserves to have their dignity honored, to even inquire about how that dignity is best honored from their perspective. (Sacred encounter attribute, n.d., p. 2)

One nurse leader expressed understanding of sacred in the following way:

When I think of sacred encounters I think of dignity to another person. To me, that can be displayed in many ways. I think one of the best ways to have a really sacred encounter is to be a good listener, to be truly present. We may walk down the hallway, just say hello and don’t even pay attention to if they responded, didn’t respond. (Interview 27-004)

Another, speaking of the care provided for patients on a nursing unit, stated:

Being with . . . Mother Theresa. What does she do? Sat at the bedside of the lowest of the low caste and cleaned them up. We do the same for the homeless. We treat them the same as we do anybody else. We give them a bath; we’ll help them get into their bed. We try to respect their dignity. (Interview 26-001)

In describing a difficult patient situation, a nurse leader described taking the time to understand how dignity could be honored from the perspectives of the patient, the visitor and the staff.

They’d call me to—the family’s really upset, that person’s really upset. He’s a gang member, don’t let him in. But one in particular that’s just coming to mind now for whatever reason was the patient was a young woman who had just experienced a
miscarriage. The visitor-to-be was her—the father of this baby and the boyfriend who had just gotten out of jail shortly ago. He was extremely hostile. He was an active gang member. He was really, really, tough. And the girls were—the nurses were afraid for the patient, afraid for themselves. This was a lot of fear. So they asked would I go talk to him. My job sort of, you know. So I went out and I met him and he was angry and he wanted to see his girlfriend and he wanted to know about the baby and he wanted to know about all these things and he was a, you know, he basically had been kept in the dark. So I said, “Okay, a couple of things. Let’s talk now. I’m going to come back out and talk to you. I want to go talk to the patient first.” I went and talked to her, “What do you want him to know?” You know, kind of went through that kind of thing. And I said “Well, what if he asks me to visit you? What do you want?” And she said, “I’d actually like to see him.” I said, “Okay, well let’s see what I think of that after I meet him a little more.” So I went back out and I talked to him respectfully and I said to him, “You know, I just need to explain a couple of things to you, you know, one of which is you’re getting ready to come into the ICU. I have to tell you, some of my nurses are a little afraid of you because of your history and your tats and the way you’ve been yelling and the language and what have you.” I go, “So you know, do you have it in you to sort of behave? You know, be a gentleman?” And he said, “Yes.” And I said, “Okay, let’s do a little bit of a trial then. You know… your girlfriend would like to say ‘hi’ to you and I know you’re grieving parents of a baby that you’ve lost. How about you come in the room and I stay in the room with you for about three minutes, five minutes? Let’s come in and, you know, just talk with her.” So he came in and talked and he was fine. And I looked at the patient and I said, “I’m going to step outside for the next five or ten minutes. Here’s your call light. You know, leave the curtains open. You call me if you need anything.” I gave them maybe 15 minutes together and went in and in and in, “I’m going to ask him to leave just because I didn’t know all the ramifications.” But I will say both these young people, who I know…I don’t know if he’d ever been treated kindly. I honestly felt like he had never been given respect. He’d never been given—because he just looked like a bad guy. (Interview 25-002)

Dignity, as a descriptor for sacred encounters, was often paired with respect. The concepts of dignity and respect came up repeatedly in participant descriptions of their personal views of sacred encounters, “the dignity, respect, the caring of being around that make sure that we shine in God’s light in everything we do and every interaction we have… that we have respect, dignity, and caring” (Interview 26-001). And, “to me sacred encounters means that everybody is treated with respect regardless of your background, your job position and where you are in your life” (Interview 27-003). Finally, the nurse leader who had experienced the difficult situation with the patient who had miscarried, reflected on her personal behavior with the patient’s boyfriend in the following way:
And in that moment when I could give him respect, he left giving me a hug, crying, telling me thank you. You know . . . it was treating him with dignity he did or didn’t deserve. That didn’t matter to me because guess what? I’m not in charge of who deserves dignity and who doesn’t. (Interview 25-002)

*Connection.* SJH has described this key attribute of sacred encounters, as follows:

Through the connecting act of healing and touch, profound and lasting relationships can flourish, as demonstrated by the restorative work of Sister Henrietta. Connection through providing care and healing “binds” us to one another, as Jesus bound himself to suffering individuals. Ultimately, this healing connection can be transformative for both patient and care provider. ([Sacred encounter attribute, n.d., p. 7](#))

Participants described *Connection* through use of language and through descriptions of specific instances where a connection palpably occurred. One nurse stated,

> I see simple things that they have suggested like sitting on the bed for a few minutes with the patient, giving them that eye level . . . simple things like that can make a huge difference in how a person sees their stay and what their relationship is with that nurse. (Interview 28-003.)

Another leader talked about what she heard occurring between one of her staff and the patient, “I hear my staff talking to patients, they connect. And you hear them laughing and telling stories. I think that is how somebody needs to be treated” (Interview 27-003). One participant simply stated, “This connection between the nurse and that patient at that moment is a sacred encounter” (Interview 25-002).

Within the attribute of *connection*, I also discovered an element of *mutuality*,

> And she’s telling me about how she knew she met her husband because years before she had a dream about him. And she knew what he looked like, and when she actually met him . . . there he was. And it’s neat things like that that leave with me. (Interview 27-001)

This participant further described the mutual interaction that happens between nurse and patient,

> I felt that it was an experience that you had with a patient or somebody else that really, you felt that you made the connection, that . . . this sounds cushy now, but it really is transformation. Because when you have a . . . when you spend time with your patient, and you come home . . . feel that impressions . . . or that made me feel just as good as I hope I made them feel. And it makes that experience worthwhile and validates the reason why you become a nurse. That is why we have these sacred encounters, and you have
these memorable experiences that form your future, or how you see your work.
(Interview 27-001)

Compassion. As one of its four key attributes, SJH has explained the meaning of compassion as follows:

Compassion is a practice, a presence, a receptivity, an ability to enter into the chaos of another. It is directed to our neighbor, the “dear neighbor.” This practice is important to us because it is discovered at the birth of our SJH ministry. It is found in the example of a group of women dividing up the city and attending to the needs of the people. Whether the dear neighbor is our self, a colleague, or a patient, we are called to practice compassion in our journey to foster sacred encounter. (Sacred encounter attribute, n.d., p. 4)

Compassion was evident in many ways throughout the study. One nurse leader described how she supported a staff member who was not in agreement with the outcome of a discussion about how a patient should be treated. The staff member felt there was an issue of patient safety involved and expressed their opinion. After a review through the chain of command the original care plan remained. The following conversation between staff member and nurse leader ensued,

But what if you don’t feel it’s right? What if you feel your license is in jeopardy? I said in this point of view of the physician, as a leader and my director is the leader, I feel that this is where we should go. We should follow our same techniques. I will be there any time you want to discuss it but we need to go back to the same chain of command that the ruling came down on. I will never leave you alone 24/7. I am here. We will go back up the chain of command. (Interview 27-002)

Nurse leaders expressed compassion for their staff through their acknowledgement of the pressures facing nurses today. They talked about the pressures of family life, of heavy patient loads, of staying on time and of the level of illness of patients. One nurse leader described how she addressed issues with staff who were not performing up to expectations,

When I bring someone into my office and first meet up a warm welcome meeting, a compassionate understanding in every encounter I have with them. I tried to understand the person not there in the job role, but outside of their job role. (Interview 27-002)
Compassion between caregiver and patient was a frequent topic raised in interviews in describing the organizational culture. It was well portrayed by one study participant who worked in palliative care:

I think compassion is where we need to meet them, meet each person. And maybe that does describe sacred encounters that I’m willing, you know, that we’re going to meet them at that point of compassion trying to understand a little bit of what they’re going through. It’s the seeking to understand, it’s all of those things. It’s what’s most important to them, you know. It is—I mean, usually bodily, physical healing’s not going to happen but emotional healing, spiritual healing, all those things can still happen no matter what your body is doing. Because I think again, compassion is one of those things that is bringing yourself with it. That . . . compassion is to suffer with when you look at the word. (Interview 25-002)

She went on to describe her experience with a 48-year-old patient with advanced cancer who had 10-year old and 13-year-old children:

And you know, what can I give her? What can I do for her? . . . how does she say goodbye to her children? You know, how does she prepare her children to say goodbye to her? And that was her biggest concern, you know. She wasn’t ready to give it up. She’s got a few more tricks she hopes before she leaves the earth. But it was one of the things, it’s very difficult, it’s just difficult. But I wanted to be there with her. You know, I wanted her to know that she’s not alone. You know, ‘This is hard but I can give you words to talk to your children. We can make sure that we—your husband knows what you want. We can leave a legacy through pictures or videos or, you know, let’s work on some of those things together,’ so that she has some tools to help her say goodbye to her family. (Interview 25-002)

Care. This key attribute has been described by SJH as follows:

Providing care is often the human response to an experience with one who is suffering. Care requires companionship and compassion. Compassion calls us to “suffer with” those who are in need of our care. Providing care for patients is mandatory in our ministries, but the ways in which we provide care and envision ourselves as care providers is an essential area of reflection. In the Christian tradition, providing care and offering healing is an opportunity to restore relationships among patients and families, patients and health care providers, and between patients and God (Sacred encounter attribute, n.d., p. 5)

As with compassion, the attribute of care was evident between nurse and staff and between staff and patients. The above description from one participant as “suffering with” as she reflected on her experience in palliative care; the story about the young mother and her boyfriend
who lost their baby; and the nurse leader who was thoughtful about her interaction with an employee who had not met expectations are all examples of compassion and of caring. It is difficult to separate the two. Even within the SJH description of the attribute, Caring, is compassion. The act of caring was also expressed as actions that occurred outside of the care environment,

But a gentleman was leaving and he looked lost. And I said can I help you. And he said he felt comfortable coming to me because I smiled. And I walked him. And he needed to go to the emergency room parking lot and was not sure where it was at. So I walked him out. (Interview 27-003)

Unique to the attribute of caring is the concept of healing a relationship with God. One participant talked about her interaction with a woman whose husband was dying:

We got her on the phone for the doctor . . . and I heard the doctor saying, “Oh, you’re not close by and you need to call somebody to come and get you.” This was the middle of the night about 2:00 or 3:00 in the morning. He said, “That’s okay. Do you believe in God?” She must have said yes. He said, “Well, if you believe there is a God, you know, that God is taking care of this and you’ve been with your husband all the time. Right now, he’s not doing too well. I don’t want you to come now because you’re tired . . . it’s in God’s hands right now. He calmed her down and she said, “Okay, I’ll come in the morning then.” His interaction with her . . . letting her know that God was in control and God would take care of it and giving her peace with the fact that her husband was going. That to me, it made my night. (Interview 26-001)

This nurse leader further recalled when a family was in the emergency room facing a serious drug overdose of their son:

I remember one night we had a Muslim family come in and their son was going to be intubated . . . he was a drug overdose. They had just celebrated a wedding anniversary, I think 24 or 25 years and they were quite angry because they were called out of their dinner and then they found out he had a drug problem. They were upset that he had taken an overdose and they were upset because they had told him this would happen to him if he continued with his problem. I remember taking them aside, the Chaplain wasn’t there yet . . . I remember taking them aside and just saying, “We didn’t know why this happens to one child other or another, one faith other than another.” I knew they were Muslim because she was wearing her cultural clothing and I said “would you mind if I prayed with you? The Chaplain is not here yet.” They said, “Oh please.” (Interview 26-001)
The nurse leaders’ response to the interview questions and reflection on their personal and leadership experience exhibited a high level of familiarity of the four attributes—dignity, connection, compassion and care—but also had a deep understanding of how those attributes were present in staff nurse and nurse leader practice.

**Mission, vision, values.** Participants in the study recognized that sacred encounters were related to the mission of the hospital and connected the work of sacred encounters as supporting the organization’s mission, vision and values. Understanding participants’ experiences and perspectives on sacred encounters is dependent on knowing how the health system articulates mission, vision and values. They are provided here for context.

*Our Mission*—Why we exist. To extend the healing ministry of Jesus in the tradition of the Sisters of St. Joseph of Orange by continually improving the health and quality of life of people in the communities we serve.

*Our Vision*—What we are striving to become. We bring people together to provide compassionate care, promote health improvement and create healthy communities.

*Our Values*—What we believe in. Our values are the guiding principles for all we do, shaping our interactions with those whom we are privileged to serve.

*Dignity*—We respect each person as an inherently valuable member of the human community and as a unique expression of life.

*Service*—We bring together people who recognize that every interaction is a unique opportunity to serve one another, the community and society.

*Excellence*—We foster personal and professional development, accountability, innovation, teamwork and commitment to quality.

*Justice*—We advocate for systems and structures that are attuned to the needs of the vulnerable and disadvantaged and that promote a sense of community among all persons.

(St. Joseph Health, n.d.-a)

Throughout my experience with Mission Hospital I was struck by the presence of the Sisters of St. Joseph of Orange and the organization’s Mission, Vision and Values throughout the facilities. The cross of the Sisters of St. Joseph of Orange could be seen hanging on walls in
offices and hallways and public spaces. To respect the parameters of this study and patient privacy I did not go into a patient room to personally observe the environment but a staff member mentioned that the crosses were placed in all patient rooms as well.

In addition, the history of the Sisters of St. Joseph of Orange was celebrated along hallway walls through photos, stories and murals. A large stone structure at the entrance to the hospital welcomed visitors and staff with a prayer written by Mother Bernard Gosselin, CSJ, Foundress of the Sisters of St. Joseph of Orange, “I pray that you might find light, joy and consolation, to assist and serve the Dear Neighbor with an Orientation toward excellence” (transcribed from a monument in the lobby at Mission Hospital).

In various places throughout the hospitals such as lounges, waiting areas, hallways were signs and symbols representing the organization’s core values. Participants reported that people do recognize something different at Mission Hospital and attribute it to the organizational mission. One participant shared the following insight,

    I have had stories that they have told me about the family members that have been cared for in other hospitals and have been cared for here. They talk about the difference, the better experience that they have at this ministry versus another hospital based on the very nature of the people, that work here, and the culture, and our mission. (Interview 20-018)

Another talked about how the values aided her in directing staff and encouraging behaviors consistent with organizational expectations, “It is reminding them what our priorities are, our values, our pledges, our vision which is all tied to human, the community. It’s all about our community” (Interview 27-001).

I also discovered that there was a intentional process designed to select leaders who would best fit the culture of Mission Hospital. The Vice President of Mission Integration interviewed each leader at the level of Director and above as part of the selection process. One participant described the experience this way,
She meets with every new leader. She is part of that interview process. She will start that journey, start those questions. She recognizes that people do not necessarily have the language that she is kind of trying to figure out what kind of person are you? Would you be able to, I guess really . . . do you have the capacity to really learn this, adopt this? What kind of person are you already. (Interview 20-018)

I personally experienced nurse leaders in this study as having both an understanding of the organizational mission, vision and values and, as well, a commitment to personally living the mission and expecting others to do the same,

I think that mission, vision and values are not options. They are who we are. And if you are working here, you are obliged to behave—have behaviors that demonstrate those values . . . Dignity, justice, service, and excellence. (Interview 25-002)

Reflection. Reflection provides a way for people look back on experiences or events in order to gather new knowledge, learning and understanding. It provides time for contemplation and for sensemaking. It is essential to leadership in that it furthers continual learning and self-knowledge (Barbour & Hickman, 2011; Koloroutis, 2004; Kouzes & Posner, 2002; Vaill, 1996; Weick, 2001). At Mission Hospital reflection is built into the fabric of the organization through established processes, structures and expected behaviors.

Reflection as an expectation at Mission Hospital was articulated throughout the interview process:

Well at the very beginning I was not used to, actually, kind of being in a meeting where there was a reflection. It really kind of . . . depends upon the person. Some are reflections. Some are kind of more—some reflections are kind of more universal; and kind of like more . . . I mean, you hear reflections from Buddha, or from self-actualization, or Marianne Williamson, or whatever. It is all good as long as it makes you reflect upon something that is sacred or compassionate towards another human being. Or something that is going to help you grow and reflect on something. (Interview 20-018)

Reflection is seen as a relevant part of the journey of sacred encounters and of organizational expectations:

In our staff meeting we have a reflection of some kind, something that kind of prepares us for whatever we’re doing. I was doing a meeting on that and I had a little reflection
ready even though there were just three of us. I had the reflection to start because I think it starts on the right foot. It is the expectation. Then I wondered about it and I said, okay, why do we really do that? It really isn’t a Catholic tradition the way I grew up. This is different. Why do we do that, what is the meaning of it, why is it important to do that? That’s when I started realizing the sacred in everything that we do. (Interview 26-001)

A daily practice at Mission Hospital is having a reflection on each unit during the time of the daily huddle. Huddles happen twice each day, once on each shift. The purpose of the huddle is to get staff together to listen to a story about care at the hospital and to take a moment out of their busy day to reflect.

Mission Hospital began distributing a reflection every day to be shared with all staff during the daily huddle. The reflection is often in the form of a story about something that occurred on one of the care units. People are invited to submit their stories for use in the daily huddle so that everyone within the organization can benefit from each other’s experience. It is seen as a way to promote positive interactions and to share what may be sacred encounters. Leaders are welcome to share the common story or to encourage their staff to share experiences of their own. Beginning the daily huddle in this way ensures that there is at least a moment on each shift for the staff to reflect together on their work and on the work of others.

This appreciative approach follows the concepts of participatory and appreciative action and reflection and, as discussed by Ghaye et al. (2008), focuses on:

- encouraging the development of insight and building on a positive present,
- collective learning through interconnectedness and appreciate sharing,
- understanding human experience, and
- use of reflective learning.

Describing the daily huddle and her interpretation of her staff members’ response, one participant stated:
Whatever time it is, they take that break for three minutes. They may have had a horrific trauma but they go to a huddle for three minutes and just not think about anything else. I think they love it because it honors someone every day. It has that reflection that you’re racing into work and if it’s the beginning of the shift they’re having it . . . you’ve left your family at home, you had a problem getting the babysitter . . . there’s all kinds of things. They hit every light on the way in but you’ve got to stop for a three-minute huddle. It gives them time to just stop and be present in the moment and have nothing else to worry about except just that huddle. And finish on a positive note . . . we’re encouraged to finish on a positive note so that you’ve got positivity there. It makes us reflect and think away from the ordinary daily life. (Interview 26-001)

Sacred encounters, as an expression of organizational culture, was prevalent throughout the interview process, particularly as it related to meetings and daily huddles. I have highlighted the main areas where organizational culture was expressed—the four attributes of sacred encounters, the organizational mission vision and values and reflection.

Core theme 2—Teaching. Another unexpected core theme that emerged through data analysis, was teaching or, more specifically, the leader as a teacher. As I moved through the interview process I began to hear nurse leaders discuss concepts related to teaching. Various descriptions of leadership behavior presented as themes that ultimately developed into the core theme of teaching. Themes ranged from required formal leadership education such as formation work to informal methods such as coaching, mentoring, role modeling and simply recognizing a sacred encounter in the moment. It is interesting that during theoretical sampling, the term teaching, did not resonate with the Mission Hospital Vice President of Mission Integration (VPMI). She felt it did not reflect how she perceived the work, relating it more to concepts of facilitation or coaching. I respect her insight and it helped me to better understand her perspective on the work. Another important insight was that components of teaching overlap with the core theme, reflection, where the daily huddle was also explained as a way to teach and reinforce sacred encounters: “But from the framework of what is our mission? Then with our sisters and so forth. One of things that they have hardwired is the huddle process in the morning
and in the evening” (Interview 20-018). I will explore, in the following subsections, the core theme of teaching beginning with the formal and then to the informal.

**Formal teaching.** I found that understanding formation in the context of this study was most easily gained by listening to the words of leadership at St. Joseph Health. One of the participants in this study was the Mission Hospital VPMI. The role of the VPMI in Catholic health care is to ensure integration of the Catholic mission—continuing the healing ministry of Jesus, into all organizational work. The VPMI described formation as the work of the soul, stating,

> Through the work of the soul, we become transformed and what is transformed . . . we see the world in a different way. We have a different way of being in the world. Something shifts in us and I think everyone of us can stop to think about times when our point of view or our perspective shifted and we understood in maybe a deeper way. (Interview 28-001)

She expressed her feelings that formation work is not something accomplished in a day or in an event. It is “a lifelong journey” that required her to remind herself regularly that “everybody is at their own personal journey and their own faith journey . . . their own spiritual journey and God is active in that. We can’t go ahead of grace.”

Formation work is not what one would consider as traditional education. It requires participants to look inward at self and, through reflection, gain a deeper understanding of their personal beliefs and experience. In the Catholic tradition, they reflect on the healing ministry of Jesus and how they can further that work. Every leader at Mission Hospital was expected to participate in formation as part of their job. Through a program called “Mission and Mentoring” they learned about the history of the founders of the health system, The Sisters of St. Joseph of Orange, about the mission, vision and values of the organization, and about their role as a leader.

Formation was ongoing so that leaders continued to learn about themselves and their work through the changing and challenging evolution of their environment. When the mission outcome, sacred encounters, was established formation work began around
leader personal perception of sacred encounters work and ways they would begin to build sacred encounters into their daily lives, the lives of their staff and of their patients, “Well, my first exposure to really understanding sacred encounters was when as a new leader to the organization. I was the commitment they made to me by putting me through what is called Mission and Mentoring, which is a yearlong program where they go over Catholic social teaching. They go over the real, the framework of working at St. Joseph Health and working in Mission Hospital. Sacred encounters . . . was a significant portion of what it meant. How we incorporate that into every encounter. That was my exposure to it. (Interview 20-018)

Another participant described when she first understood formation,

Actually, that was just recently that I understood formation. The Catholic community apparently, they don’t use education when they’re doing anything like Mission and Mentoring. What we have here is an in-depth program to teach about the Catholic faith and to teach about how they live, their doctrine and their vision and purpose. It was mandatory for me to go to it and I thought it was just education. It is education but they call it formation. (Interview 26-001)

Formal teaching was also utilized in creating scenes or spotlighting sacred encounters. This will be discussed in the section describing the core theme of defined organizational practices, but is important to mention here as a fundamental component of formation work at Mission Hospital.

**Informal teaching.** Participants discussed formation specifically around the work of the leader at Mission Hospital. In terms of their role with their staff, leaders described several ways in which they impacted sacred encounters through interactions with their staff. These interactions most often were in the form of what I call informal teaching—coaching, mentoring, modeling and providing feedback.

**Coaching/mentoring/providing feedback.** I decided to combine coaching, mentoring and providing feedback as one theme because of the way in which participants talked about their work. They did not necessarily differentiate among the three but used descriptions that I believe reflect this way of teaching. One participant stated that she was always coaching her staff. Another talked about her role in helping to develop new nurses through constant feedback. Still
another spoke about correcting behavior, “I always do it privately. I do not believe in sharing stuff in public. It’s just disrespectful to me” (Interview 27-003). Related to the work of encouraging sacred encounters one participant reported,

I would say it out loud. Because I think they need the language . . . sacred is not familiar work. Encounter may or may not be a familiar word. So I think putting the two of them together can be really unfamiliar. It’s been my kind of challenge all along to put it together. (Interview 25-002)

She also described a moment when she decided to move feedback from informal to more formal due to the situation she had encountered with her staff member:

I think there is a time to be more formal either in a debrief or I think times when we’ve had ethical challenges and maybe they’re experiencing some moral distress. You know, they’re like they wouldn’t have picked the same thing the family picked or a choice like that. So then you can say to them, “Well, let’s get together and talk about how this family came to this conclusion. (Interview 25-002)

One participant described the leader’s role in supporting sacred encounters:

You help make it real in those moments. They may not connect the dots themselves but you can gently support the concept by pointing it out to them. In our meetings . . . I would gently might say something or say . . . “that was a sacred encounter. Did you know that? That was a sacred encounter. Thank you for doing that.” (Interview 26-001)

In describing their role, nurse leaders also described their staff’s interest in learning.

Nurse leaders talked about staff asking questions and for clarification to further their own learning. As part of their informal teaching leaders took the time to answer these questions and in the process pointed out to staff how patients and family members come to decisions, or express their feelings, or respond to illness in ways that may not be predictable—all lessons that could enhance the staff member’s potential for sacred encounters to occur.

Modeling behavior. Nurse leaders used their position to model behaviors they felt would help staff understand sacred encounters and to have improved interactions with their patients. They show them by example, demonstrate ways to pray with a patient, take on difficult situations that staff are reluctant to take on. One nurse leader described a situation where she went to a unit
where a patient was waiting to be transported to another area. The staff were not assisting the patient but were sitting and talking.

I actually got involved in it and I included them in it and show them that I as a leader... can push the patient up. ‘Let’s get the monitor on the patient and let’s get him up to the floor’. I think that’s kind of the way I motivate people and encourage them to assist and not reprimand them for doing what they’re doing but to show them by example. (Interview 26-001)

**Core theme 3—Spirituality.** Workplace spirituality has been defined as recognizing the inner life of employees and the need for meaningful work within the context of community (Duchon & Plowman, 2005). Giacalone and Jurkiewicz (2003) add an emotional component through their description of a framework of organizational values within a culture that promotes employees’ experience of transcendence and the facilitation of their sense of being connected to others in a way that provides feelings of completeness and joy.

Healthcare is an environment where questions of spirituality are regularly asked. Health crises, whether personal or of a loved one, cause people to question the meaning of life. The role of healthcare professionals is to enter a relationship within the crisis in such a way that physical, emotional, psychological, social, or spiritual healing will occur.

The concept of spirituality came through the interview process in several ways. Being inclusive of all religious beliefs and honoring other faith customs was a common theme. One example was given that illustrates a participant’s view of religious inclusion:

Both employees and patients religious beliefs and view are respected. They honor their culture whatever they are, whatever they need. We sit with them and we allow them to tell us why they want this done or not done and the doctors will stop and take the time to ask them... a lot of the doctors will ask them why and we will honor what they do... their customs. (Interview 26-001)

Another participant described her perspective in this way: “I think our spirit of care people are very well educated on how not to offend other religions. So, the prayers that they have shouldn’t be offensive (Interview 27-001).
Along with inclusion of all religious beliefs, other aspects of spirituality were evident in the interviews. Some of these were the use of prayer, the concept of a higher power, the importance of supporting patients’ spiritual beliefs, emotional and spiritual healing, and the importance of considering the whole patient—mind, body and spirit. Work as a ministry was also mentioned the importance of providing spiritual support to patients and staff.

The most prevalent topic around spirituality that came out of the interview process was the nurse leader’s personal belief system and the importance of their work matching those beliefs. Participant reflection on their personal belief system impacted their choice in a place to work was a common factor. “I was born and raised Catholic so I knew that coming to a Catholic Hospital at least they’ll have support there for nurses” (Interview 26-001). “I appreciate what life God has given me. I appreciate that my parents sacrificed and they brought us here from Mexico . . . I am a nurse and I work for Mission Hospital. That is a blessing” (Interview 29-001). Another explained: “My upbringing being Catholic, a cradle Catholic, it always made me feel great to be able to be a Catholic in my workplace” (Interview 27-001).

Yet personal belief systems were not limited to Catholicism: “[sacred encounters] is a beautiful term because it connotes spirituality, ministry, spiritual presence and a higher power, like a reason for being” (Interview 27-001). “You think of your job as your mission and your calling. To me . . . you don’t take a job unless it is your calling” (Interview 27-002). This participant went on to say,

I felt that a sacred encounter was when my relationship with God requires me to deal with every human being. Since we have now, this is one of our goals, it really helps me feel free to experience that and to share with people, just to care for them as I would expect Christ would care for me. (Interview 27-002)

Another participant described the importance of the work environment and Christianity, Sacred encounters to me . . . being a Christian and coming to Christianity late in life, it’s extremely important for me to have my work environment a place where I can share my
faith. That doesn’t mean pushing my faith on somebody else but it means being there, being present for people. (Interview 26-001)

Finally, a theme that was heard many times in many ways is reflected in these words:

So that is just a blessing . . . my faith is very strong and every morning I have a nurse’s prayer . . . I just ask the Lord to help me be your hands, your ears your eyes, your mouth to say healing words. (Interview 29-001)

Core theme 4–Defined organizational practices. In creating the mission outcome of sacred encounters Mission Hospital leaders not only engaged in a rigorous process of defining what is a sacred encounter, they also utilized an inclusive process to determine ways in which the concept would be translated into behaviors. This process was called “spotlighting.” Spotlighting was a process by which staff members identified a patient situation or experience that they believed could become a sacred encounter. The VPMI describes the early process in this way,

We had a little steering committee of which I participated on and one of the very first things they did was they did focus groups of patients. What they wanted to know . . . what were those moments along the hospital stay in which you experience the sacred? They had different ways of articulating that in the focus groups, I don’t recall exactly how. They came away with I think with 17 moments in a patient’s journey in which the potential for the sacred was evident. Some of those moments were when a patient arrives in a unit . . . Warm Welcome, or when a patient is in bed alone at night and all their family and visitors have left and now they have to go to sleep in a strange environment . . . Sweet Dreams. We have one about discharge, oftentimes feeling when the patients are fearful about going home or maybe they’re very happy . . . they’ve just had a baby . . . those transitional moments. We came away from those moments and they helped us develop a methodology based on this human centered design that we call our Sacred Moments Scene Designs. These scenes are meant to be generative and iterative, not scripts but really how do you . . . when you are welcoming somebody let’s say on your unit, how do you insure that the four attributes are in place? That dignity is honored . . . they design the scene based on those four attributes. (Interview 28-001)

It was apparent through the interviews with nurse leaders that they had an understanding of this process. They had not all implemented scenes in their area of responsibility but were aware that they were being utilized in other areas. Some nurse leaders had designed scenes in their areas and readily shared their experience:
Now you are saying goodbye to your patient and the scene that we hone in on is just before they leave the hospital. What can we do to make that transformative? Like if it’s cool outside, put a blanket over them so that when they’re waiting outside for their care to come around, that they’re comforted that way. Or when they get their discharge instructions, let’s do it eye to eye, same level, not standing, and looking down on the person, but sitting down right next to them and sharing those discharge instructions that way, and bringing in the family. And having a gift to give to them. So we actually have little gift bags that have hand-sanitizing lotion. (Interview 27-001)

Another leader described their unit’s practice of Sweet Dreams:

Yeah, we’ve had Sweet Dreams for a while. Sweet dreams basically is at nighttime. The focus is on making sure that the patient feels they are being made ready for sleep and quiet. They are given an eye mask, and lotion, and a little prayer book, so a lot of different things. There is also a sort of little memo book so that people can write down their concerns and questions. (Interview 28-003)

Spotlighting or scene design was developed to allow for staff to individualize the experience in a way that made sense to their unit and their patient population. Staff are specifically trained on how to develop a scene. Various examples of how different units designed and carried out Warm Welcomes, Thoughtful Good-byes, and Sweet Dreams, were brought forward through the interview process. What I noticed is that the design of the scenes maintained a sense of spirituality and also of inclusion. In describing the Sweet Dreams cart on her unit, the nurse leader stated, “it has little cards on it, maybe a verse from the Bible, maybe something from Buddha, Dalai-Lama or something like that depending on the patient” (Interview 26-001).

Leaders also talked about the two-minute sit down, an approach designed to help staff connect more fully with their patients. It entails the nurse or staff member sitting down with their patient for at least two minutes once a shift. During that time, they are expected to put down their electronics and to be totally with the patient. What they do in that two minutes is up to them—they can talk about medications or how the patient is feeling, or they can pray with the patient, talk about family, or just be present. The nurse and patient determine what is most
comfortable and useful in that situation. In describing the two-minute sit down one participant stated, “Simple things like that can make a huge difference in how a person sees their stay and what their relationship is with that nurse” (Interview 28-003).

Summary

In a complex and changing health care environment nurse leaders face major challenges in ensuring that staff are supported and that patient care is delivered in a safe and caring manner. Situational analysis of Mission Hospital and the nurse leaders revealed many factors in the environment of care that could possibly impact patient care. Nurse leaders at Mission Hospital faced potential influences from the larger St. Joseph Health system—mission, vision, values; mergers and acquisitions; population health—and of the health care industry overall—economic conditions; regulations; technology. Along with these environmental conditions, within their specific work environment nurse leaders could also be impacted by competing priorities, patient demographics, and teamwork. Within this changing social arena, nurse leaders expressed a commitment to ensuring that, in their area of responsibility, patient care is delivered in ways that demonstrate the values of the organization.

To reiterate, four core themes emerged from analysis of the interviews: organizational culture, teaching, spirituality and defined practices. Although separate, none of the themes stands alone. Spirituality is steeped in the organization’s culture. As a faith-based health system, St. Joseph Health consciously created a culture based in the beliefs and practices of Catholicism. The stated values are inclusive of all religions and belief systems as is the mission outcome, sacred encounters. I found the concept of dignity predominant as both a value and an attribute of sacred encounters. The stated value, dignity, refers to “each person as an inherently valuable member of the human community” (St.JosephHealth, n.d.-c, para. 1). As an attribute of
sacred encounters, dignity identifies an innate worth in every person regardless of one’s perception of their deservedness (Thies, 2012).

Teaching was identified as the way nurse leaders assisted their staff in understanding the four attributes of sacred encounters and ensuring that behaviors were in place that would bring those attributes to life. Participants described numerous defined practices that were designed purposefully to move sacred encounters from concept to action: scene creation (such as Sweet Dreams, Thoughtful Goodbyes, Warm Welcomes), the two-minute sit down, and reflection during the daily huddle. These practices are taught to employees and reinforced by nurse leaders through feedback, coaching and modeling behaviors becoming the manifestation of the organization’s culture and mission outcome, sacred encounters.

I began this study with an interest in relational leadership and the expectation that through the exploration of nurse leaders’ experience with sacred encounters I would find a meaningful intersection between relational leadership, spirituality and nursing leadership. Through thematic analysis of data in a narrative inquiry, recurrent ideas emerge from the data as the study unfold. My initial expectations provided a framework for my questions and for the research but, as often happens, the data took me to another place. Relationships and relational leadership were underlying features of the participants’ experience but what emerged as central was the culture of the organization and the process by which culture was transitioned to action through the behaviors of nurse leaders. In the next chapter I will go beyond the data and elaborate on my thoughts and observations about what this means to nursing leadership.
Chapter V: Discussion and Implications

Background

As a nurse leader having worked in diverse aspects of health care over many years, I was curious about the hospital-based nurse leaders’ perception of their role in the changing health care environment. Having long worked as a bedside nurse when patients stayed in the hospital for many days, when the same nurse cared for the same patient day after day and a backrub was an expectation for bedtime care, I wondered about the evolution of the nurse-patient relationship. So many changes had occurred over the years such as shortened lengths of stay, increased use of technology, twelve-hour shifts, and increased acuity of the patients. With all those changes, was it was still possible to establish a therapeutic relationship with the patient? And if so, what role should the nurse leaders play in making that happen? My personal belief is that an essential part of the nurse’s role in promoting healing is through their relationship with the patient. I believe in the mind-body-spirit approach to healing and that all three dimensions can be influenced by an affirming nurse-patient connection.

I have not been at the bedside for many years but my work has always indirectly impacted the bedside nurse. I have been leader over operational areas, developed programs designed to address the professional practice of nursing, and been responsible for clinical nursing education and for the development of nurse leaders. I have seen the challenges facing the profession today. I have also witnessed the changing role of the nurse leader and heard the concerns being raised as new pressures arise. Nurses are trained to bring their self to patient care. Our education includes understanding the therapeutic relationship that exists between the nurse and patient and the importance of that connection in the healing process. Nurse leaders,
faced with countless competing priorities, struggle to find ways to support their staff so that they can support their patients’ healing.

There have been a wide array and huge number of studies about the nurse-patient relationship and the importance of that relationship in promoting patient health (Fleischer, Berg, Zimmermann, Wüste, & Behrens, 2009; Shattell, 2004). A positive relationship can promote healthy outcomes where a negative relationship may result in patient vulnerability and potentially harmful encounters (Angel & Vatne, 2017). Peate (2016) described the role of the nurse:

An integral part of the patient pathway, striving to make that journey as seamless as possible, helping people to navigate a complex and frequently unfathomable service. The nursing presence is often invisible to the patients and to other disciplines in the provision of high-quality, safe and effective care, making this the uniqueness of nursing—the power of nursing. This can only come about when the therapeutic nurse-patient relationship is apparent and allowed to flourish, working with the patient to identify their true needs, engendering trust that is based on established, solid, relationship and giving special to the patient’s self. (p. 783)

Peate (2016) also expressed concern that “this delicate, intimate demonstration of caring and empathy is increasingly on the brink of collapse” (p. 783), indicating that it is often not the fault of the nurse but of the system in which the nurse has to perform; the implication is that nurse leaders must stand up for the nurses they lead.

In 2009, I was introduced to the CEO of a large faith-based health system, St. Joseph Health, that had recently introduced a mission outcome that every encounter will be a sacred encounter. I was immediately fascinated by the concept and wanted to know more. My journey culminated in this study: exploring the experience of nurse leaders in realizing the strategic mission outcome of sacred encounters.
Brief Overview of the Situation

There are two social arenas explored in this study—the arena of Mission Hospital and the arena of nurse leaders practicing at Mission Hospital. Its social arena was depicted in Figure 4.1 in the previous chapter. Mission Hospital functions as part of a larger health system, St. Joseph Health that provides direction and oversight for the hospital. The health system is responsible for the mission, vision and values of the organization. It makes decisions about mergers and acquisition, physical facilities, and use of technology solutions. St. Joseph Health, and subsequently Mission Hospital are situated within the larger health care industry, thus are affected by the economic environment (payment structures, increasing costs, Medicare, Medicaid); the regulatory environment (government policy, insurance, quality, safety, patient experience); technology (access to care, equipment, physician relations, electronic medical records, innovation) and changing patient demographics (aging population, diversity, changing family structures, chronic disease, new diseases).

The social arena of the nurse leader (see Figure 4.2) is impacted by all of the above. Nurse leaders are also faced with managing competing priorities, workforce issues and direct patient experience, creating complex leadership challenges. In the hospital setting, these factors are constantly considered by nurse leaders as they manage patient care and the day-to-day work of their staff.

A Story of Sacred Encounters

Mission Hospital nurse leaders interviewed for this study champion the Sisters of St. Joseph of Orange mission, vision and values to create a care environment wherein attitudes and behaviors reflect their desired mission outcomes. They are committed to understanding, adopting and modeling behavior supportive of the health system’s clearly defined mission
outcomes—perfect care, healthiest communities and sacred encounters. This study focused on nurse leaders’ experience with one mission outcome—sacred encounters.

In today’s integrated health system, new leadership behaviors must emerge in order to adapt to the complexities of the current and future state of the environment (Brass et al., 2004). Evidenced by deliberate planning, design and implementation of sacred encounters, St. Joseph Health leaders imagined a different culture, a culture where all interactions would reflect the mission of “extending the healing ministry of Jesus in the tradition of the Sisters of St. Joseph of Orange by continually improving the health and quality of life of people in the communities we serve.” They then brought the mission statement to life through articulation of the three mission outcomes. To fully appreciate the culture St. Joseph Health leaders were trying to create through the mission outcome of “sacred encounters” one must experience it through the words of someone involved from the very early stages of the work, Mission Hospital’s Vice President of Mission Integration.

It was just a week earlier that mom and I had “the talk.” Mom, God forbid anything should happen to you, but what would you want in terms of life support should you become gravely ill? Her decision informed the decision I had to make. We wouldn’t be putting her on life support. The ER staff made her comfortable, dimming the lights . . . a warm blanket . . . the staff closed the door so we could be alone with mom. We cried, we prayed, we talked to her and held her hand, not wanting her to go and yet knew that this is what she would want rather than the heroics we often sometimes experience. I asked for the chaplain and when . . . I arrived at the threshold and fell into her arms. She was so lovingly attentive to mom, me and my family . . . She took the lead as we held our hands in prayer around my mom’s bedside . . . It reminded me of the suffering of Jesus as his mother stood by. How many times had mom stood by my side when I suffered in life? Lots.

Mom hung on. We expected her to go any minute in the ER but she’s a tough old bird, a New Englander. It was decided it would be best to transfer her to Three West and continue comfort care. Her nurse . . . met us at the door of the room. I could see the concern in her face and she greeted me with a warm hug. She helped the transporter bring mom’s gurney into the room and as we crossed the threshold she said, “Look.” She directed my gaze to the window which was framing the most beautiful sunset. I couldn’t believe how symbolic it was at that moment for me, us, mom. We all paused and took in the beauty of God’s creation . . . the yellows, the reds, unbelievable. I knew God was
present with us in the here and now. A sense of peace floated like a feather into my heart and rested there. In that moment my faith was affirmed . . . and all it took was someone to pause and point out the sacred within the ordinary. Our nurse could have easily attended to the transfer . . . asking us to leave for a few minutes . . . but she didn’t. She was attuned to the sacred that was right there within our midst waiting, wanting to be noticed, revered. The transfer would wait until we took our notice of Him, for this was to be a Holy space, the space where mom would enter Heaven. This was our sacred moment.

She didn’t die then. She has since passed away. We used this story as reflection because I think it really points out a couple of things. One is a lot of things that we do in nursing are transactional things so the part of the story about getting mom a warm blanket, dimming the lights, closing the doors, allowing us to be alone in the ER . . . are really acts of great service. It wasn’t the transformational moment. It was stopping, pausing, and acknowledging the divine that is here and present in the ordinary. It took a moment . . . to and it meant so much to me. It was like . . . aah . . . this is what we’re talking about because in my heart I could feel my heart truly reach a sense of peace that mom was okay, that God was a part of this process and it just took attentiveness to that particular moment for her to notice a beautiful sunset.

I share that story a lot to try to point out that the difference between acts of great service and what we’re talking about and fostering sacred encounters so that every encounter will be experienced as a sacred encounter. It’s really acknowledging the sacredness and the holy spaces in our lives, stopping to notice whether that is a prayer . . . it doesn’t have to be a religious thing. It doesn’t have to be a prayer . . . something about God’s expression in nature.

It is in telling the story and what I find as a leader who has a responsibility around integrating our sacred encounter mission outcome into the culture, it’s very easy for . . . I’ll say for nurses and for everyone . . . and yet that’s not exactly what we’re talking about. There’s a differentiation and it’s really based on a theological tradition and spiritual tradition of the Sisters of St Joseph and out of our Catholic faith tradition that God is here and present in the ordinary. It’s just up to us to notice the divine’s revelation that he becomes revealed to us however we describe the divine or the sacred within. It’s really based on a theological foundation and that’s what we try to express and try to put into words so that nurses understand there is something deeper here that we’re talking about. (C. Mueller, personal communication, July 28, 2016)

The importance of this story is that it clearly demonstrates the experience that leaders at St. Joseph Health were trying to engender by the mission outcome of making every encounter sacred. The clarity with which the VPMI could articulate her personal insight revealed the distinction that had been made between the typical tasks of the nurse and a sacred encounter. St. Joseph Health leadership through sacred encounters defined a set of behavioral expectations that
reflected the organizational mission, vision and values that if implemented successfully would change the culture of the organization.

**Brief Overview of the Findings**

I approached this study with two questions in mind:

- How does relational leadership theory inform nursing leadership practice in a large healthcare organization?

- And how did nurse leaders at Mission Hospital experience their personal leadership in realizing the mission outcome, of every encounter, a sacred encounter?

In exploring these, I would gain a deeper understanding about the intersection of relational, spiritual and nursing leadership and make an important contribution to the field of nursing leadership.

Through interviews with nurse leaders at Mission Hospital it became apparent that the participants in this study were committed to ensuring that, within their area of responsibility, patient care would be delivered in ways that demonstrate the values of the organization, specifically through behaviors associated with sacred encounters. It is important to restate that one of the eligibility criteria for participation in this study was that the nurse leader must have had experience with sacred encounters. I did not specify what type of experience or whether the experience was positive or negative. The criteria simply required that the participant had experience with sacred encounters.

I also began this study with an appreciation of the complexity of the health care environment and the challenges that creates for nurse leaders. I was familiar with the stated mission outcome of sacred encounters and was curious about the role of nurse leaders in the transition of sacred encounters from concept to practice. I set the stage for the study through the
literature review (Strauss & Corbin, 1998) focusing on relational leadership, spiritual leadership and nursing leadership theory.

Four themes emerged from the interviews with multiple subthemes associated with each. I found that the experience of nurse leaders with sacred encounters revolved around:

- The culture of the organization expressed through its mission, vision and values, the relationship with the Sisters of St. Joseph of Orange and the four attributes of sacred encounters;
- The value of teaching sacred encounters through formal leadership and staff training (formation, classes) and through informal training performed by the nurse leader through coaching, mentoring and modeling sacred encounters;
- The strong place that spirituality holds in sacred encounters expressed as part of the organizational culture and personal belief systems, seen as a foundational component of interaction with others and in the way, staff are encouraged to engage in sacred encounters with their patients; and
- The centrality of defined organizational practices.

Nurse leaders talked about specific behaviors that the organization has defined that encourage sacred encounters. Examples are spotlighting behaviors such as Warm Welcomes, Thoughtful Goodbyes and Sweet Dreams. They also mentioned the practice of reflection during daily huddles and the “two-minute sit down.”

It became apparent through the interview process that the four themes were inseparably entwined (Figure 5.1).
Of the four core themes, organizational culture was the most prevalent in the interview process and in the experience of the participants. Over the course of interviews and data analysis my understanding of the how participants understood organizational culture was clarified. It became clear to me that organizational culture is the overarching concept perceived by participants as the driver or purpose of sacred encounter work. Nurse leaders often used the term “organizational culture” interchangeably with mission, vision and values. They spoke of “living the mission” or values of the organization while framing experience through the lens of their spirituality, religion and/or belief system. The themes were strongly connected with implementation of defined behaviors when they were teaching others.

This work came to life in three different ways—through spirituality, teaching and defined organizational practices (Figure 5.2).
Organizational culture was expressed as mission, vision and values and expressions of sacred encounters. St. Joseph Health defined the organizational cultures through the charism of the Sisters of St Joseph of Orange. A *charism* is a particular grace given by the Holy Spirit to an individual or a group for the good of the whole church and is a call to share the mission of Christ (Geagley, 1987). Founded in the 17th century, the Sisters of St. Joseph of Orange have described their charism as follows: “To assist and serve the dear neighbor and by dividing up the towns into various sectors, to find out what disorders exist in each sector so that they may remedy them through their own efforts” (Geagley, 1987, p. x). It forms the foundation of the St. Joseph Health culture and during this study was experienced throughout the physical hospital settings and the interview process.
The health system defined specific expectations related to its mission through three mission outcomes: perfect care, healthiest communities, and sacred encounters (St. Joseph Health, n.d.-b). This study focused on one of those outcomes, sacred encounters.

St. Joseph Health leadership provided a clear framework within which its mission would be carried out. Sacred encounters lived within this framework and came to life in three different ways—defined organizational practices, teaching and spirituality.

Defining and carrying out specific practices were seen with the work of sacred encounters such as “Warm Welcomes, Sweet Dreams, [and] Thoughtful Goodbyes” (Thies, 2012, para. 16), reflection during the daily huddle, and the two-minute sit down. These were not all-encompassing, but provided leader and staff with some concrete ways to bring sacred encounters into use. Leaders communicated these behaviors, along with a philosophical understanding of sacred encounters, throughout the organization, using both formal and informal teaching. Teaching was evident along the entire continuum of organizational hierarchy beginning with the most senior leaders teaching other leaders through front line nurse leaders teaching their staff.

Various methods of passing on sacred encounters (teaching) would occur depending on the audience and the topic. Formation work was a mostly formal process of learning and reflection and typically occurred between a senior leader and other leaders. Bedside employees engaged in formation work but in a more limited way. Role modeling, coaching and mentoring most often happened in the moment and occurred often between nurse leader and staff. Nurse leaders also were involved in formal teaching through their work of scene design and assisting staff members in their understanding of the defined organizational practices associated with sacred encounters.
The Four Themes Arising from Nurse Leader Narratives

**Theme 1: Culture of the organization.** Within a faith-based health care setting organizational culture can be defined and translated into practice through intentional design and through teaching that occurs at all levels of leadership. Mission Hospital culture was moved from words on paper to specific bedside behaviors through the formal and informal teaching practices. Unique to this culture was its spiritual foundation and the role nurse leaders played in weaving spirituality into practice.

To understand the transition of culture from concept to practice, it is first important to describe how this study informed my personal beliefs about organizational culture. Every organization has a culture. Some people believe that cultures are something organizations have while others insist that organizations are cultures (Bolman & Deal, 2003). The role of culture in an organization is to help people make sense of themselves and of each other through attitudes, actions and artifacts (Vaill, 1989). Sometimes culture is strong, clearly articulated and exhibited in behaviors of its employees. At other times it is fuzzy, fragmented and emerges from within. Whether an organizational culture is weak or strong it has a powerful influence throughout every aspect of an organization and affects practically everything (Deal & Kennedy, 1982).

Numerous definitions of organizational culture have been presented over the years. Because of the inclusion here of the concept of teaching, I refer to Schein’s (2010) definition of culture:

A pattern of shared basic assumptions that a group learned as it solved its problems of external adaptation and integration, that has worked well enough to be considered valid and therefore to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (p. 18)

Where my experience with Mission Hospital challenges me to depart from Schein’s (2010) definition, is with his belief that a group’s problem solving has worked well enough to be
taught to new members. Leaders of St. Joseph Health understood the need to articulate clear, consistent and shared values during a time of continual and rapid change. The “permanent whitewater” (Vaill, 1996, p.1) of industry change created immense challenges for the provision of care. Leaders envisioned a specific way of being together that they wanted employees and patients to experience. They intentionally defined, designed and implemented a process to create that experience. Teaching what the organization holds as the best ways to perceive, think, and feel, occurred simultaneously with group learning. In other words, the organization was in the state of continual learning while defined behaviors were being introduced and implemented within the hospital.

Vaill (1989) defined organizational culture as “a system of attitudes, actions and artifacts that endures over time and that operates to produce among its members a relatively unique common psychology” (p. 147). He also made the point that what management wants to do with an organizational culture “is powerfully influenced by the culture itself,” (p. 149), a concept that was clearly articulated within this study as leaders set out to change behaviors and attitudes within the organization. Vaill’s declaration that “it is not possible to just sit down with a clean slate and describe the kind of culture an organization ought to have” (p. 149) is where my experience with Mission Hospital causes me to take exception. From years of working in health care systems, I do understand the complexity of organizational culture, but, through this study, I found that leadership can sometimes actually just sit down and define the kind of culture it wants and effectuate change, as evidenced by the work at St. Joseph Health. Thus, I take issue with Schein (2010) and Vaill, for both see organizational culture as highly stable over time, resistant to even comprehensive change strategies. Short-term changes in attitudes and behaviors do not create or transform a culture in their perspective. But organizational culture is palpable, always
in creation through the day-to-day experience of the organization’s members. Wheatley (2006) stated:

> It doesn’t matter where you go, whom you talk to, or what that person’s role is. By observing the behavior of a production floor employee or a senior executive, you can tell what the organization values and how it chooses to do its work. You hear the values referred to even in casual conversation. You feel the values are real and alive. (p. 129)

**Theme 2: Leader as teacher.** I was surprised by the ways in which leader as teacher emerged within this study. From the beginning of the design and implementation of the mission of sacred encounters, teaching was part of the plan. Discovering the concept of teaching here should not have been too surprising since an essential component of implementation has been to shepherd sacred encounters to fruition. To make every encounter sacred required that knowledge be passed from health system senior leaders to leaders at each care site. What I did not anticipate were the many and various ways participants would articulate the practice and importance of teaching. The process of teaching—imparting knowledge—was described as formal and informal, done at specific times or in the moment. It often included the process of reflection and of assisting people in gaining a deeper understanding of themselves and their personal beliefs.

Participants also expressed the concept of teaching in descriptions of the work that they, as leaders, engaged in as they encouraged the work of sacred encounters in their day-to-day work. This was articulated through terms such as coaching, mentoring, providing feedback or more frequently as role modeling desired behavior.

Teaching others is a key component of the role of the nurse. Nurses teach patients, peers and students. Mentoring and preceptorship is also part of the daily life of a nurse. Nursing practice is often carried out through tasks such as changing a dressing, administering medications, documentation, teaching patients and family members about illness and care. There are frequent changes in processes, procedures, policies and equipment. Much of the teaching
associated with nursing and nursing leadership revolves around effecting changes in actions associated with tasks but much less about changes in thoughts, beliefs and associated behaviors.

Mission Hospital set clear expectations about the thoughts, beliefs and behaviors that would bring the mission outcome of sacred encounters to life so that every person who experienced Mission Hospital would experience an intentionally designed culture.

**Teaching sacred encounters.** The core theme of leader as teacher was enacted both formally and informally in the lived experiences that the nurse leader participants narrated.

**Formal teaching.** Formation is a practice that requires participants to look inward. Through reflection they gain a deeper understanding of their personal beliefs and experience. When the mission outcome of sacred encounters was established it was accompanied by a spiritually based plan for the transfer of knowledge from senior leadership to the entire organization. For leaders, this would occur through formation. The purpose was to assist all leaders at Mission Hospital in developing a cognitive understanding of sacred encounters but to not stop there.

Formation work deepened leaders’ personal perception of sacred encounters allowing them to move from head to heart—to truly understand sacred encounters as a spiritual connection between human beings and to expand the healing ministry of Jesus. They would discover ways that they might begin to build sacred encounters into their daily lives, the lives of their staff and of their patients. Participants sometimes used the term formation in describing their experience of learning and other times simply discussed the required, formal learning experiences they had engaged in as a leader at Mission Hospital. Whether using formation language or not nurse leaders described a consistent and intentional learning experience that was an expectation of their work as leader. This experience was not a single event but an ongoing process of reflection and
deepening personal understanding providing leaders a clear and consistent message about the organizational culture, the organization’s mission, vision and values and expectations about their role in ensuring those were brought to life.

Informal teaching. In addition to the formal teaching it seemed that informal teaching was a part of the nurse leaders’ daily lives. They reported taking advantage of situations whenever possible to teach the staff member about sacred encounters. Sometimes that came in the form of mentoring a staff member that a simple task had the potential of being a sacred encounter if the staff member entered the interaction with the belief that it could. A very plain example was the act of just assisting a patient with putting on socks. The nurse leader pointed out that the nurse controlled whether that was just a task or a sacred encounter by the way the staff member thought of and approached it.

Informal teaching also came in the form of coaching and providing feedback. Nurse leaders reported observing a situation that may have been better handled differently and providing feedback to the staff. Nurse leaders reported that the purpose of the feedback was to help the staff member see that in changing the way they approached a situation, the patient and/or family member could have a different experience. They also reported that they did not always use the term sacred encounter in these instances but simply redirected the staff member to have a more meaningful interaction.

Finally, and most frequently, the nurse leader reported modeling behavior as a way of teaching staff. There were numerous situations where a staff member was in the position of observing the behavior of the nurse leader. Sometimes it was the result of a staff member asking for assistance and other times it was simply because the nurse leader was engaging with a patient or family member in the presence of other staff members. Nurse leaders were cognizant of their
staff watching and learning from the leader’s behavior and reportedly engaged in modelling actions specifically to help their staff member see how they managed a situation. At times, they would then enter into a deliberate conversation to determine the staff member’s perception and to specifically acknowledge the purpose of the behaviors. As with other forms of informal teaching the nurse leader did not report regularly tying this back to sacred encounters. They still perceived their behavior as instilling behaviors in their staff that would reflect behavioral expectations for sacred encounters.

**Theme 3: Spirituality.** Common to and affecting all other themes, was that of spirituality. Participants acknowledged the spirituality engrained in the organizational culture as well as how their personal belief system aligned with the culture. They lived their spirituality through the defined organizational practices associated with sacred encounters and through their personal beliefs about how sacred encounters could manifest in their areas of responsibility. Leaders acknowledged spirituality in the work of formation as well as in day-to-day interactions with staff and patients.

I had anticipated spirituality being a prominent theme in this study, but was surprised by the depth at which participants were able to express such spirituality within the contexts of personal beliefs, patient and family experience and organizational culture. Most participants readily discussed their religious background and how their religious beliefs impacted their day-to-day lives. Some made the decision to work at Mission Hospital specifically because of their spiritual beliefs and their desire for a work environment where their beliefs would be respected. Some had worked in hospitals where they were unable to pray with patients or reference their spiritual or religious beliefs in the context of their work. The desire for meaningful work was connected to personal beliefs and the desire to bring peace, comfort and
healing to others. While all participants reported either a Christian background or no specific religious affiliation, every one of them expressed a desire to connect with others at a deep spiritual or emotional level with patients and families. They sought to help others find meaning in sometimes extremely difficult situations and to assist their staff in finding the meaning in their work.

In addition, nurse leaders communicated their desire to deepen the spiritual connection between themselves and others to support the process of healing. They recognized that human healing occurs at many levels—physical, emotional and spiritual, and that their interventions and those of their staff had the potential to impact healing at all levels. There was a notable appreciation for the diversity of the patient population and a conscious respect for those differences. Organizational expectations for sacred encounters were drivers to open discussion about cultural differences and how to best meet the needs of a diverse patient population. Throughout the hospital were signs of this global respect in the form of statements, symbols and artwork. There seemed to be an ease with which participants openly discussed the diversity within their organization and a sense of confidence in their personal ability and through their leadership in creating a culture of acceptance and support.

Spiritual leadership can bring vision, value, hope and love to the workplace. It can foster empowerment of individuals and teams creating an environment of fulfillment and commitment. Spirituality is a foundational component of nursing practice as nurses are trained to see a patient as a whole being—physical, psychological, social and spiritual. The nurse leaders in this study expressed an appreciation of the commitment made by Mission Hospital through the mission outcome of sacred encounters.
**Theme 4: Defined organizational practices.** In addition to the spiritual learning through formation, scene design, or spotlighting (Thies, 2012), was frequently cited as a way to involve staff in understanding specific actions that could result in a sacred encounter. In spotlighting the nurse leader and other key organizational leaders would guide staff in selecting and designing a scene that would move an everyday interaction to a sacred encounter. The work of scene design further required that participants consider the four attributes of sacred encounters—dignity, connection, compassion and care—and determine how to build those into a teachable and repeatable process that would encourage all staff on their unit to have a sacred encounter. Spotlighting engaged staff in a defined process for understanding how to create a meaningful connection with patients through specific behaviors and reflecting on that experience. The practice of reflection deepened the understanding of the intimate relationship between the task, offering tea during Sweet Dreams for example, and the sacred encounter, the connection with the patient. It provided a forum for the staff member to pause for a moment and reflect on whether their interaction generated a deeper emotional connection with the patient.

Not dissimilar was how staff perceived the two-minute sit down. This seemed to be a more recent behavior for staff but was reported on time after time in relationship to how leaders assist their staff in sacred encounter behavior. Nurse leaders at times had to convince their staff that simply sitting on the bedside with no electronic devices, no pre-determined agenda for two minutes had the potential of engaging in a sacred encounter. In many cases staff reported back that it was a transformational experience not only for the patient but for the staff member as well citing the stories that patients told or the prayers that they shared or the powerful feeling of being present but silent.
The implementation of reflection at the daily huddle was another way that Mission Hospital encouraged specific behaviors related to sacred encounters. A huddle is a process where on each shift on each unit the staff gathers for a three-minute reflection. The intent of the huddle according to participants in this study is to allow staff time to reflect and to ground themselves in the work that they do. A story from one of the units is distributed to all units for sharing and reflection. Each unit can choose to use that story or to tell on of their own. Telling stories is a way that people and organizations make sense of the world (Boje, 2008) and sense making is an important component of organizational culture (Vaill, 1989; Weick, 2001). Nurse leaders were charged with facilitating the reading of the story and the associated reflection. The leader could not assume that staff understood reflection so part of their role as leader was to teach their staff the value of telling the story and reflecting on what the story meant to each individual staff member and to the group as a whole.

Conclusions Regarding Themes

At Mission Hospital expectations around organizational culture were purposefully established at the top of the organization. Through specific, defined behaviors of nurse leaders the articulated culture could be translated into bedside practices. In this study, the component of culture being translated to practice involved deep emotional, spiritual and relational practices Teaching, both formal and informal by the nurse leader was the primary mechanism through which the transition from concept to practice occurred. Spirituality as a foundational organizational value formed a common language and common thread throughout the process.

Implications for Practice

In considering implications for nursing practice I go back to the beginning of this study and the description by Koloroutis (2004) of healthcare organizations as having a specialized and
extraordinary purpose and being places where profound human experiences happen every single day (2004). Those of us in the health care field understand the importance of the work we do and how we affect lives every single day. This study demonstrated that the practice of nurse leaders has a direct impact on organizational culture. Nurse leaders through their personal learning about the mission, vision and values of the organization can through formal and informal teaching bring the culture to life.

So often nurse leaders get caught up in the daily tasks and pressures associated with their jobs without taking time to learn, understand and reflect on the purpose and value of that work. When an organizational culture is clearly defined and articulated at the senior leadership level, it can become reality through the discipline of purposeful actions. At Mission Hospital, a faith-based health system, the espoused culture also aligned with personal beliefs of many of the nurse leader creating a deeper connection and commitment to the mission and the work. Through personal learning and passing knowledge through formal and informal channels, the nurse leader has the potential to create positive change in her life, the lives of her staff and the lives of the patients.

Limitations

This study was limited to the experience of nurse leaders in one faith-based hospital where religion and spirituality were at the heart of the organizational culture. I do not propose that results of this study are generalizable to non-faith-based hospitals although I do contend that any organization with a clearly articulated organizational culture could benefit from the learnings acquired through this study. I believe that the results are transferrable to other faith-based hospitals, particularly where faith and spirituality are predominant components of the mission, vision and values of the organization.
Limiting the focus of this study solely on nurse leaders provided a single perspective on sacred encounters and allowed us to see only part of the whole. Examining a single subset of the employee population at Mission Hospital excluded staff members, physicians, administrators and particularly patients. In addition, this study was limited to the practice of sacred encounters among nurses but did not capture the experience of sacred encounters among nurses as perceived by patients and other members of the hospital staff.

One of the selection criteria was that the nurse leader must have identified himself or herself as someone who had had experience with sacred encounters. I did not specify what that experience was but I did not include nurse leaders who did not articulate clearly that they had some experience. Another limiting factor of this study was the small size of the participant group and that the study was limited to one hospital.

**Implications for Future Research**

The focus of this research was specifically on the experience of nurse leaders in one hospital telling only part of the story of Mission Hospital and St. Joseph Health’s journey of sacred encounters. Throughout this study, I continually wondered about the perspective of the staff. What would they say? How would they perceive sacred encounters and their role in the mission outcome? How might they see sacred encounters as impacting their role as an employee at Mission Hospital or the care received by the patients? With every encounter a sacred encounter where do staff members experience sacred encounters occurring—between peers or in their relationship with their manager?

It would also be interesting to explore the perspectives of the broader leadership team at Mission Hospital. What is the experience of non-nursing clinical leaders such pharmacy or laboratory and of non-clinical leaders such as leaders in environmental services or hospital
finance? Another perspective that would help to put the full puzzle of sacred encounters together would be the physician. Physicians work side by side with nurses (Fewster-Thuente, 2011) and interact regularly with patients and family members. Finally, understanding the perspective of the patient and family members would add richness to understanding the realization of sacred encounters as a mission outcome.

Because the mission outcome, sacred encounters, was not limited to one hospital but part of a larger health system a broader study from the health system perspective would be valuable. Mission Hospital had embraced sacred encounters. What about the others? What happens throughout the health system? Are their different levels of acceptance and why or why not? Is the stated culture present throughout the system? What are the challenges that face large health systems today when trying to ensure a specific and well-defined way that people engage with one another? In this faith-based organization spirituality was at the forefront of much of the work and critically important to the realization of sacred encounters. Would this be true in other organizations?

Another valuable study would be with other faith-based hospitals and health systems. Do they have well-articulated expectations around organizational culture? If so what is the experience of leaders, staff and patients as it relates to those expectations? The same would be interesting in a study for non-faith-based hospitals and health systems. What are the practices there and how might they differ?

Health care is an extremely complex industry that is experiencing rapid and continual change. Relationships among individuals, groups and teams are an everyday part of the work in a health care environment and are essential for organizations to succeed. Life experiences are not constructed alone but in tandem with others whether one is a patient or caregiver. I believe
important data are waiting to be explored that will enrich the knowledge about relational leadership, spirituality and nursing leadership.
Appendix
Appendix A: Antioch University IRB Approval Letter

July 24, 2016

Dear Margaret Mark,

This letter is to confirm the following note you received on 28 June, 2016:

As Chair of the Institutional Review Board (IRB) for ‘Antioch University Ph.D., I am letting you know that the committee has reviewed your Ethics Application. Based on the information presented in you Ethics Application, your study has been approved.

Your data collection is approved from 06/28/2016 to 06/27/2017. If your data collection should extend beyond this time period, you are required to submit a Request for Extension Application to the IRB. Any changes in the protocol(s) for this study must be formally requested by submitting a request for amendment from the IRB committee. Any adverse event, should one occur during this study, must be reported immediately to the IRB committee. Please review the IRB forms available for these exceptional circumstances.

Sincerely,

ORIGINAL SIGNED BY

Dr. Philomena Essed, Ph.D.
Chair, Institutional Review Board
Antioch University PhD in Leadership and Change
900 Dayton St.
Yellow Springs Ohio 45387
Appendix B: Mission Hospital Letter

Cindy Mueller, RN, MN, MAHCM  
Vice President, Mission Integration  
Southern California Region and Mission Hospital

May 24, 2016

Dear Ms. Mark:

This is in response to your May 17th request to conduct a grounded theory study at Mission Hospital, where you will explore the nurse leaders’ experience in leading the practice of sacred encounters. Your request has been granted and we look forward to supporting you in this important nursing research.

It is our understanding that the study will entail on-site one-hour interviews with six to ten nurse leaders during the June-July timeframe. The study may also include the collecting of additional information related to St. Joseph Health’s mission outcome of “Every encounter will be experienced as a sacred encounter.” It is our understanding that all research protocols will be closely followed and study results will be shared with Mission Hospital at completion.

Mission Hospital will be able to support the study by providing consultation, oversight of the study, as well as locating and scheduling conference rooms for private interviews and ensuring that interviewees have appropriate tools, i.e. computers, telephones for their participation. We will assist in the identification of participants, scheduling of their interviews, and communication to potential participants.

It is our understanding that all personal expenses will be incurred by you and will include, but are not limited to, expenses related to travel, hotel, telephone, tools, equipment and time.

If you could please provide a copy of the Antioch University IRB approval once the review process has been completed. Mission Hospital will let you know of the study’s approval status once presented to the Mission Hospital Research Council. Once both approvals are in place we will schedule a conference call to begin the process of setting up the interviews.

We are very grateful for this opportunity to partner with you and support you, our nursing colleague in deepening our understanding of the nurse leaders’ role in fostering a culture in which each and every encounter will be experienced as a sacred encounter.

Thank you.

ORIGINAL SIGNED BY

Cindy Mueller, R.N., M.N., M.A.H.C.M.  
Vice President, Mission Integration  
Mission Hospital and St. Joseph Health, Southern California Region

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A Ministry founded by the Sisters of St. Joseph of Orange
Appendix C: Invitation Letter to Nurse Leaders to Participate in Study

Invitation to Participate in a Research Study

Dear Nurse Leaders:

My name is Peggy Mark. I am a registered nurse and a doctoral candidate in the PhD in Leadership and Change program at Antioch University in Yellow Springs, Ohio. I have been given approval by my university and Mission Hospital to conduct my final doctoral study at Mission Hospital and I am asking for your participation.

My qualitative study is titled, *Exploring Nurse Leaders’ Experience in Leading the Practice of Sacred Encounters: A grounded theory study of relational, spiritual and nursing leadership*. Through this research I hope to gain an understanding of how nurse leaders at Mission Hospital perceive their role as it relates to the goal of “sacred encounters”.

Participation in this study would include a 60-minute interview with me. I may ask for a brief follow-up phone call following the interview for clarification if necessary.

Your name, department and managerial level will be kept confidential to protect your privacy.

Having some experience with sacred encounters is an essential part of this study. Please answer the following three questions if you would like to participate in this research:

1) Would you like to participate in this research study?
   __ YES  __ NO

2) Do you feel that you are familiar with and have had experience with sacred encounters as it is defined by Mission Hospital?
   __ YES  __ NO

Approximately ten nurse leaders will be included in this study. If you have answered “yes” to both questions above you are an eligible participant. In a grounded theory research, study participants are selected based on information gained during the interview process. This means that depending on the research process, some participants will be selected to participate and others will not. If selected, you will be contacted between now and July 29, 2016 to schedule an interview.

If you are interested to participate in this study please copy and return your responses to questions 1 and 2 in this letter directly to me in an email at XXXXX@XXXXX.XXX

Thank you very much for your consideration.

Sincerely,
Peggy Mark, RN, MBA, Doctoral candidate
Appendix D: Study Participant Consent Form

Principal Investigator: Peggy Mark, RN, Doctoral Candidate
Antioch University PhD in Leadership and Change

Exploring Nurse Leaders’ Experience in Leading the Practice of Sacred Encounters: A grounded theory study of relational, spiritual and nursing leadership

I volunteer to participate in a research project conducted by Peggy Mark, a doctoral candidate at Antioch University PhD in Leadership and Change. The study is designed to gather information about the experience of nurse leaders in leading sacred encounters. I will be one of approximately six to ten nurse leaders being interviewed for this study. I understand that:

1. Participation in this study is voluntary.
2. I will not be paid for my participation.
3. I may withdraw and discontinue participation at any time without penalty.
4. While most interviewees in will find the discussion interesting and thought provoking if I feel uncomfortable in any way during the interview session, I have the right to decline to answer any question or to end the interview.
5. The interview will take place in one of the following ways: telephone, Skype, or face to face. Notes will be written during the interview. An audio and/or video recording of the interview will also be made.
6. I will not be identified by name or department in any reports.
7. My role in the organization (supervisor, manager, director, vice president) will be stated in reports and in the study.
8. This study has been reviewed and approved by the Institutional Review Board (IRB) for Antioch University PhD in Leadership and Change, Mission Hospital Administration, and the Mission Hospital Research Council.
9. Transcripts of the study will be maintained by the researcher in a secure and protected manner for an indefinite period of time to allow for future scholarly publications.
10. Findings of this study may be used for future scholarly publications.

Your contact at Mission Hospital for any questions about participation in this study is __________________________ who can be contacted at ______________ or ______________.

If you have any ethical questions, concerns or complaints about participation in this study, you may express them to:

________________________, Chair of the Institutional Review Board
Antioch University PhD in Leadership and Change
Yellow Springs, Ohio 45387
xxx-xxx-xxxx
Please sign two copies of this informed consent form indicating that you have read, understand and agree to participate in this research study. One copy will be for your records and the other for the researcher records.
I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.
Thank you.

____________________________  ______________________________
Name of researcher (please print)  Name of participant (please print)

____________________________  ______________________________
Signature of researcher  Signature of participant

________  __________
Date  Date
References


Center for the Study of Healthcare Management. (n.d.). *Applying complexity science to health and healthcare.* Minneapolis: Carlson School of Management, University of Minnesota.


