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# A Narrative Inquiry: Case Leaders' Perspectives on Resilience in Hospice Care

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A NARRATIVE INQUIRY: CASE LEADERS' PERSPECTIVES ON  
RESILIENCE IN HOSPICE CARE

GAIL RENEE AHERN

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:

A NARRATIVE INQUIRY: CASE LEADERS' PERSPECTIVES ON RESILIENCE IN HOSPICE CARE

prepared by

Gail Renee Ahern

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

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## **Dedication**

I dedicate this work to my husband, Bob. The support, encouragement, and steadfast love that he gave during this process made this work possible. I also thank my children, Rob and Katelyn, Luke and Kelsey, and Marty, for their encouragement and support. My dissertation committee offered guidance, energy, and knowledge at every turn. I thank them for their wisdom and excellence in academia. I also dedicate this work to those in the field of hospice care. The people who do this work touch lives with ethical resilience, leadership, and meaning-making as the crossroads of living and dying meet with grace, dignity, and undeniable hope.

## **Abstract**

This study is a qualitative inquiry examining the perspective of team leaders within hospice organizations on resilience. The goal of this study was to examine how hospice leaders build resilience for themselves and within the interdisciplinary teams they lead. A framework of three key theories of leadership—servant, spiritual and authentic—was used to help in understanding the similarities and differences of the interviewed leaders and their key themes and practices. The eight leaders interviewed were from a range of hospices in diverse settings and all were directly responsible for leading interdisciplinary teams. In-depth phenomenological interviewing was undertaken until the study reached interpretive sufficiency or saturation. Research questions included: What methods do leaders use to intentionally create resilient interdisciplinary team members? Do team members experience that resilience or are they on the fast track to burnout and seeking other job placements? The eight nurses interviewed in this dissertation reflect ethically resilient practitioners who define themselves within the understandings of servant, spiritual, and authentic leadership. Key findings included the high level of commitment to this challenging profession among all the interviewed hospice leaders as well as the similar yet diverse and adaptive strategies used to cope with critical challenges such as stress and burn-out. Most participants identified humor, creativity, spirituality, compassion, confidence, excellent listening skills, ever-increasing proficiency and education in the field of hospice nursing, as essential to ethical resilience. Implications for current and further research, and for hospice leaders' and the author's own practice, are considered. This dissertation is available at AURA <http://aura.antioch.edu> and through Ohio Link ETD Center, <http://ohiolink.edu/etd>

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## **Introduction**

### **Introduction and Background to the Study**

The first topic on today's interdisciplinary team agenda at Mount Carmel Hospice in Columbus, Ohio, is Mr. Jones. Last evening, Mr. Jones sat too close to his electric heater while wearing his oxygen. There was a flash explosion. The table next to Mr. Jones' chair caught fire. The heater blew the circuit breaker. Mr. Jones and his caretaker are safe.

An incident report was completed. Oxygen safety was once again reinforced to Mr. Jones and his caretaker. The incident was reported to Mount Carmel Hospice Legal and Regulatory Committee as a sentinel event. The company that provides the oxygen also made a report for their records.

The interdisciplinary team (IDT) meets for two hours every Tuesday, Wednesday, and Thursday at Mount Carmel Hospice. Registered nurses, licensed practical nurses, chaplains, a physician, social workers, bereavement staff, clinical managers, nursing aides, students and interns from all of the disciplines listed above, and a pharmacist gather to discuss a small portion of our patient census. Each patient is usually reviewed by the interdisciplinary team every ten to twenty days. Events such as the fire at Mr. Jones' home are top priority due to the potential harm that such an incident could cause.

These IDT meetings address medication management, spiritual issues, psycho-social issues affecting both patient and family members, safety concerns (such as bed bugs, domestic violence, elder abuse, fire hazards, drug diversion, etc.), bereavement intervention that may need to occur before the patient dies, and a variety of issues that uniquely arise in new situations. Our team is skilled at working swiftly, with dignity and care. When a situation is too complex to deal

with in a few minutes, we have an “ad hoc” meeting scheduled immediately following IDT with appropriate team members present.

The IDT meeting is usually at the beginning of the day. The majority of the work of hospice teams occurs in homes, nursing care facilities, and hospital rooms. At a bedside, a nursing aide gives a bath to a confused and uncooperative Alzheimer’s patient. The chaplain is paged to the bedside of a dying person for a final prayer. A social worker has spent the last three days working on a Medicaid eligibility, only to learn that the patient she was working with died. A family is calling one of the nurses whose 30-something son has taken all of the morphine out of the house, leaving the patient in pain, with no medication to address the multiple symptoms of his pancreatic cancer. The physician just walked into a home with dog feces imbedded in the carpet and bed bug bites all over the patient. Today I (the bereavement coordinator) will lead one school group in a high school where a senior hung herself three weeks ago; I will see three hospice family members for grief counseling; and I will meet with Terri whose grandfather was shot last week at the transmission shop where he worked. Terri, age 14, was being raised by her grandfather because her mother died of an overdose when she was five years old. I will spend my evening with a grief support group of widows and widowers struggling to put life back together again. Welcome to a day at our hospice in the heart of the city of Columbus.

The call for resilient leaders is at the apex of this study, based on the daily challenges facing dedicated healthcare workers as they interact with patients and families with many physical, social, mental, spiritual, and emotional needs.

Although Hospice and Palliative Medicine (HPM) is now an American Board of Medical Specialties- recognized sub-specialty . . . and provides potential for a challenging and meaningful career, the practice of HPM involves unique challenges related to the frequent exposure to suffering and death. (Swetz, Harrington, Matsuyama, Shanafelt, & Lyckholm, 2009, p. 773)

Given this reality, resilient hospice leaders are those who can find a work-life balance (Swetz et al., 2009). According to Machin (2010), they are also leaders who share the following three elements: personal resourcefulness, which includes flexibility, perseverance, and courage; a positive life perspective, including optimism and a sense of personal motivation as well as goal setting; and social embeddedness, which involves the nurturing of social support and the willingness to access it.

How are hospice leaders resilient? How do they bounce back from challenges? How do hospice leaders function under tremendous stress? What do they do to take care of themselves and those with whom they work, love, and play? Throughout my studies, I examined leaders such as Mahatma Gandhi, Mother Theresa, Martha Stewart, and Nelson Mandela. I sharpened my definitions of leadership, ethical leadership, and resilience. Gandhi, Mother Theresa, and Nelson Mandela emulated this resilience throughout their lives, their careers, and the imprints that they left upon society and the world. H. Gardner (1995) tells the power of Gandhi's achievements as they spread far beyond the boundaries of India. He notes that it is Gandhi's writings and his "embodiment of personal courage" (p. 275) that empowered his movement as a liberator.

This kind of resilient, courageous leadership comes with both great sacrifice and great rewards. Gandhi's legacy in history is not only as a liberator of India, but also as an outstanding world leader tied to his core belief "that human beings belonged to the same species, that their frequent, often-violent struggles were fundamentally illegitimate, and that human beings needed to resolve their conflicts peacefully" (H. Gardner, 1995, p. 277).

I begin by outlining the ethics of leadership. Ethics is critical to the leadership models that I have chosen: servant leadership, authentic leadership, and spiritual leadership. Although

each of these leadership models has characteristics that overlap, they also bring distinct traits to the fore that will help to deepen understandings of how hospice leaders address resilience, why they have chosen their vocations, and how their unique gifts and talents embody these leadership models.

The concepts of team leadership and the social system of hospice will also be examined. A brief history of hospice and palliative care is included as well as the dynamics of interdisciplinary teams. How hospice leaders nurture resilience in their teams is critical to this study so focusing on building resiliency in teams is examined in the literature review. Resilience will be defined broadly, then particularly as it applies to those who work within the hospice settings.

### **Purpose, Importance, and Justification of the Study**

The purpose of this study is to examine the perspective of team leaders within hospice organizations on resilience. There may be many levels of resilience or possibly even no resilience created within interdisciplinary teams. Discussion of the support offered at the institutional level, such as employee assistance programs, organizational supports, and wellness programs provided by the larger institutions will also be included. There are currently many concerns, such as secondary trauma, that impact the well-being of nurses, social workers, physicians, aides, and chaplains who continually work with the populations of patients who are in hospice.

These concerns have been studied for more than 30 years. An article by Najjar, Davis, Beck-Coon, and Doebbeling (2009) reviewed 57 studies to explore compassion fatigue among healthcare workers who care for patients with cancer and terminal illnesses. The authors traced the term “compassion fatigue” back to Joinson (1992) who first coined this term relating it to

those who work in emergency departments. Joinson suggested that those who work in emergency departments may absorb some of the traumatic stress of those they serve. This becomes a secondary traumatic stress disorder. Najjar et al. (2009) noted the same secondary trauma is possible with healthcare professionals working with the terminally ill.

An article by Medland, Howard-Ruben, and Whitaker (2004) examined burnout and the need to foster psychosocial wellness among oncology nurses. Examining the state-of-the-art hospital at Northwestern Memorial in Chicago, Illinois, these researchers found that the turnover rate among oncology nurses was 40% compared to the hospital average of 14.2 %. Upon taking a closer look the researchers identified a number of issues that contribute to this stark disparity. Challenges among the oncology nurses in the Medland study leading to burnout and a need for fostering wellness include the following: a report of patient and family suffering, work overload, noises on the unit, a “spiritual dearth” reported by one of the physicians, difficult ethical decisions, an overwhelming sense of responsibility, ethical dilemmas, and the inability to separate their lives from work.

The Medland et al. (2004) study led to the development of “The Circle of Care Retreat.” This one-day overall plan was to address many objectives. One question asked was: Did you choose oncology or did oncology choose you? A sense of calling and other reasons that nurses chose their positions revealed the purpose of their passion for the calling of their vocations. Managing losses, stress management skills, strategies such as relaxation techniques and journaling were introduced. A session entitled “All Gifts Differing” gave attendees an opportunity to artistically express themselves with fashion, clay, and other art venues.

Circle of Care Retreats are now continual practice at Northwestern Memorial Hospital. Evaluations of staff burnout, stress, and turnover are ongoing. Identifying those who are at

highest risk for burnout and assisting them in developing interventions has also been implemented. Stress management sessions, self-care behavior, bereavement support groups, skill-building, coaching, and individual counseling when needed are all offered in addition to the Circle of Care Retreats. These all assist in addressing the burnout and staff retention at Northwestern Memorial Hospital.

The effects of stress, burnout, and the reactions that accompany these realities have an impact on all who are providing care in hospice settings. This stress may or may not be associated directly with patient care. It can also be related to understaffing, tension among co-workers, lack of necessary resources (such as current drug shortages), poor communication, and difficult dynamics within the interdisciplinary team. According to Ablett and Jones (2007), “Workplace stress has serious implications for both the physical and psychological health of staff, for patient care, and for organizations” (p. 733).

Some studies of hospice nurses contradict the notion that this is stressful work. Running, Tolle, and Girard (2008) noted: “Hospice nurses understand that all of their patients will die. Hospice nurses view what some might interpret as an emotionally draining, even aversive career, as a gift to be treasured” (p. 303). This study coincides with the concept that “death is a sacred transition” (Running et al., 2008, p. 304); however, even Running et al. pointed out that hospice nurses are at risk for burnout and compassion fatigue. Some of the greatest strain for these nurses comes when a patient is young, when a death is traumatic, when the nurse feels inadequately trained to handle the patient or the family, or when there is inadequate support from supervisors or other staff members (Running et al., 2008). This observation is also made if the nurse relates closely with the patient; for example, if the patient is a 35-year-old woman with young children

who is dying of breast cancer, the nurse may closely relate as a 30-something mother herself. This becomes a painful journey that the nurse and patient may take together.

N. Payne (2001) also notes a paradox in circumstances in which hospice workers are faced with various stressors and coping needs, “Despite the existence of some unavoidable stressors such as ‘death and dying,’ this sample of hospice nurses appears to utilize quite effective coping strategies” (p. 403). Interestingly, what this study reported as the “more stressful” components for hospice nurses were problem solving and more “pressure at work” (p. 404). N. Payne noted that these two issues could be addressed with further training or with nurses who had more training at the outset of their embarking on a vocation with hospice.

Keidel (2002) distinguished between burnout and compassion fatigue, defining burnout as a syndrome that includes physical and mental exhaustion, which she attributed to the hospice professionals. Keidel noted that burnout can include, “a negative self-concept, negative job attitude, and a loss of concern and feeling for the patients” (p. 200). She then assigned the term “compassion fatigue” to the family primary caregiver as a term she defined as having similar symptoms to burnout, while at the same time referring to a condition that is unavoidable as one cares for someone who is dying.

Keidel (2002) further observed that burnout is complicated for the hospice team as they also deal with a variety of social, economic, and medical issues including the challenging personal characteristics of patients and their families. A patient’s death is often understood as a failure of the medical system. “Family members may, or patients may have complicating problems such as alcoholism, drug abuse, depression or additional chronic illness” (p. 202). This list of challenges and problems can be as demanding and unique as each family, and patients with whom the staff members interact.

The interdisciplinary team (IDT) is critical in the day-to-day work life of the team members. The IDT leaders are called to prepare the teams and support, sustain, and troubleshoot with the teams as a multitude of issues occur with the hospice patient and family dynamics. Also important are the organizational structures that are in place to empower team members to grow, to reduce stress, and to encourage resilience.

This is the fertile ground for resilience. In a study by Gaydos (2004) depicting portraits of five hospice nurses, the author identified themes such as “endurance and resilience in the face of significant loss and grief and profound loss and grief before becoming a hospice nurse” (p. 20). It is the goal of the IDT leader to explore varieties of ways to enlist the team’s expertise, energy, creativity, problem solving, and leadership skills to meet each new and ever-changing challenge. Zerwekh (1995) observed another example of this endurance and resilience in situations in which a hospice death is difficult, noting, “With rare final agonal events, such as hemorrhage or extreme air hunger or acute pain, hospice nurse experts assume a calming and reassuring role while administering an armamentarium of palliative measures” (p. 42). It is the goal of the IDT leader to explore varieties of ways to enlist the team’s expertise, energy, creativity, problem solving, and leadership skills to meet each new and ever-changing challenge. It was my goal to discern how hospice interdisciplinary team leaders, in the midst of such challenges, create and sustain resilience with the teams with whom they serve. I asked how they define leadership and resilience, as well as how they apply these concepts in their daily work as leaders in place. I also asked them how they encourage team members to take advantage of organizational opportunities offered such as employee assistance programs, continuing education, and other opportunities for growth, enrichment, and health.

In my research I attempted to accomplish this through face-to-face, in-depth interviews utilizing a modified version of Seidman's (2006) phenomenological interview method with hospice interdisciplinary leaders. After a pilot study interviewing five colleagues at Mount Carmel Hospice regarding the use of one or two interviews 90 minutes in length I chose to use one interview. This pilot was completed on March 1, 2012. It contained only the following two questions: Would you be willing to complete two 90-minute interviews for this dissertation research? Or would you be willing to complete one 90-minute interview for this dissertation research? The five colleagues were unanimous that they would not be able or willing to give time for two interviews. But they would consent to the time for one interview. Due to the unanimous answers of this pilot study, I used one 90-minute interview to focus on the details of their experience in hospice leadership, particularly as it relates to their role as a leader who develops resilience within the interdisciplinary team. This interview also included the questions of meaning and the participants' understanding of resilience. As Seidman (2006) pointed out, "Making sense or making meaning requires that the participants look at how the factors in their lives interacted to bring them to their present situation" (p. 18).

The purpose of this study is to examine leadership at its most creative and sustainable apex in the hospice environment. I examine these leaders as they implement their understanding of ethical resiliency in their interdisciplinary teams and also the possibility that they may not see resilience as a part of their vocational purpose. How do they apply their leadership goals and resilience with their interdisciplinary teams? What can I learn from leaders as they relate to their teams? What is teachable to the broader hospice and palliative care audience about leadership, resilience, and interdisciplinary teams? It was my goal to glean the following from the in-depth interviews of hospice leaders in place: how they renew their own souls, remain resilient in their

own day-to-day leadership, and emulate, teach, and provide an environment of resilience for their interdisciplinary teams. My experience with the hospice leaders suggests that they are ethical and work from servant, authentic, and spiritual leadership models. Through the interviews, I inquired about leadership philosophy, understanding of resilience, and how models of leadership and resilience are lived out with their interdisciplinary teams.

This study is important for future hospice leaders and interdisciplinary teams. As the population of the United States continues to age the demands on our healthcare system also increase, as do the obligations for hospice and palliative care. According to estimates from the National Hospice and Palliative Care Organization (2012), 44.6% of all Americans who died in 2011, died while enrolled in a hospice. As we discover ways to create and sustain resilience within those who work with hospice, this study addresses not only stress and burnout, but also job longevity, joy in vocation, and the sense of calling that comes with this very unique work of helping people live quality lives until they die.

### **Research Questions**

After working for 26 years as an ordained Lutheran clergy person and eight years in a hospice setting as the bereavement coordinator I have spent my vocational life in service to others. Most particularly, while I continue my work at Mount Carmel Hospice, I watch many of my amazingly educated, wise, talented and gifted colleagues give of themselves in ways that are far beyond an eight- or ten-hour shift of punching a clock and putting in hours. The lives of hospice patients and their families touch the lives of hospice team members. M. Payne (2008) pointed out that families in hospice settings may experience a wide range of difficulties, which in turn means that the team members also go through these same difficulties. One team member usually experiences more of the adversity than others. Or, at times, the whole team experiences

the difficulties. Either way, the flow of adversity “generates different emotional reactions and engages different identities” from various team members (pp. 187–188).

Given these realities, hospice teams are critical. The team environment, the team process, and team management all contribute to the formation of resilient teams. M. Payne (2008) went on to cite four characteristics to successful teams: clear objectives, high participation, commitment to quality, and support of innovation. As I inquired about teams and their leaders, I listened for keys to resilient teams in the places and among the people who were telling me their narratives.

My research asks interdisciplinary team leaders about their leadership and the organizations within which they work. How do these leaders define “resilience?” Beyond that, the core question of my study is: What levels of resilience do hospice interdisciplinary team leaders in place create and sustain within their teams? Is this resilience grounded in ethics? Do they create and sustain resilience at all? Are there leaders who do not create resilience? Ancillary questions are: How do they cope with the difficulties interdisciplinary teams have with burnout and stress? How do they apply their knowledge and their understanding of both the challenges and resilience? How are organizational structures, continuing education opportunities, and health and wellness programs utilized and made available to interdisciplinary team leaders and members? How is this resilience created in the face of a caring situation where every patient’s trajectory is to die?

## Definitions

**Hospice.** There are a number of terms that need to be defined so that clarity can be established as this paper continues. First among these is the word, “hospice.” For the purposes of this study, “hospice” will be defined utilizing the definition of the National Hospice and Palliative Care Organization’s understanding. This is stated as:

Hospice provides support and care for those in the last phases of a life-limiting illness; recognizes dying as part of the normal process of living; affirms life and neither hastens nor postpones death; focuses on quality of life for individuals and their family caregivers. (National Hospice and Palliative Care Organization, n.d., para. 7)

Further, it is important to note that hospice includes patient/family-focused care that is interdisciplinary in nature including a physician, pharmacists, nurses, nursing aides, social workers, counselors, chaplains, and volunteers. Case review is an essential part of hospice care, required by Medicare within every two weeks for every patient. Medical equipment, medical supplies, medications, and teaching both patient and caretakers are included in hospice benefits. Grief support before, during, and after the death of the patient is also a part of hospice service.

Hospice can be care that occurs (and usually occurs) in the patient’s home. Kastenbaum (2009) noted, “*Hospice* too often suggested a place, not a program care” (p. 147). The goal of hospice care is to identify the goals and desires of the patient and to honor these as best the family and hospice team are able; however, hospice can also occur in assisted living facilities, nursing homes, hospitals, and independent hospice houses.

**Palliative care.** Palliative care is another dimension of the work that is growing in familiarity. Palliative care is often juxtaposed against curative care. Mount (2003), a Canadian physician, defines palliative care as evolving from the Latin term *pallium* meaning “cloak.” The contemporary meaning of palliative is to aid in reducing suffering. Although hospice and palliative care are not one and the same, palliative care patients often transition into hospice

patients. Depending on the healthcare system, these two ideologies may work hand in hand for continuity of patient care.

**Interdisciplinary team or interdisciplinary group.** The interdisciplinary team also known as the IDT or the IDG (interdisciplinary group) includes all of the members noted above as the interdisciplinary concept was explained. The case manager (also known as the IDT team leader) leads the meetings, which occur as often as is needed to cover the census of the hospice over a two-week period. For Mount Carmel, we have six team meetings in a two-week period. Each meeting lasts about two hours. This is fairly standard for a hospice with a census of 200 patients and families.

**Leader in place.** The leader in place is often a RN Case Manager however, this leader in place may also be from a variety of other disciplines represented on the team. Licensed Independent Social Workers, Licensed Professional Clinical Counselors, RN Nurse Practitioners, and Medical Physicians, may also be leaders in place, depending on the hospice or the palliative care site. There are also trans-disciplinary team leaders as discussed in Otis-Green, Ferrell, Uman, and Baird (2009). This trans-interdisciplinary team member is defined as being trained in more than one discipline so that she/he understands the approaches of hospice and palliative care across disciplines. This organizational structure has also proven to lead to continuity of care when one team member follows the patient from admission through death.

**Resilience.** Resilience refers “to a class of phenomena characterized by good outcomes in spite of serious threats to adaptation or development. Research on resilience aims to understand the processes that account for these good outcomes” (Masten, 2001, p. 228). This basic definition will be expanded in terms of the individual leader in place, the interdisciplinary team, and the social system of the team.

**Burnout.** Also important in this study is the opposite of resilience, burnout.

Burnout has been well described among physicians in general as well as oncologists and other subspecialties. According to the most accepted definition, burnout encompasses three areas: feelings of emotional exhaustion, cynicism or depersonalization, and a low sense of personal accomplishment. (Swetz et al., 2009, p. 773)

Burnout can lead to poor personal health for the healthcare professional, poor communication with others, and less quality care for the patients. All of these compromise not only the careers of the healthcare professionals, but also the care given to those in their charge.

**Ethics.** Price (2004) defined ethics as “the study of right and wrong, good and evil, and virtue and vice” (p. 462). Ethical leadership expands a sense of right and wrong to be inclusive of much more. Price also noted that this ethical leadership transforms people from who they are to whom they ought to be. This transformational leadership is moral and in the words of Burns (1978), “‘lifts people’ to their better selves” (p. 462).

**Servant leadership.** Servant leadership is defined by Greenleaf (1977) as “leadership bestowed upon a person who is by nature a servant” (p. 21). Servant-first and leader-first are two extremes of the leadership types. “Between them there are shadings and blends that are part of the infinite variety of human nature” (Greenleaf, 1977, p. 27). Greenleaf is clear that for one to truly be a servant-leader these “mostly intuition-based concepts” must start with a willingness to assist others first.

**Spiritual leadership.** To understand the nature of spiritual leadership, it is important to define what is meant by spiritual. Okon (2005) defined it as follows: “‘Spiritual’ is from the Latin *spiritus*, meaning breath. It may be understood as nonmaterial or metaphysical, hence pertaining to sacred things or the soul, or more broadly, the intellectual and moral aspects of life” (p. 392). Expanding from here to define spiritual leadership Gehrke (2008) noted, “Effective spiritual leadership includes values, beliefs and behaviors necessary to motivate the self, and

others to foster a sense of spiritual survival, which consists of transcendence, or calling, and social membership or connection” (p. 352). The spiritual leader is thus one who may rely on the sacred, moral, or metaphysical entities of the soul and have a sense of calling or deeper identity as a leader that is grounded in beliefs or behaviors associated with a particular community or institution, such as the Roman Catholic Church.

**Authentic leadership.** Authentic leadership derives from the concept of authenticity defined as “The condition or quality of being authentic, trustworthy, and genuine, free from hypocrisy . . . Authenticity in leaders has important positive implications for others in the organization and in the organization’s culture” (Allen, 2004, p. 65). Integrity, a need for balance, congruence in beliefs and actions, self-awareness, and a moral/ethical perspective are essential to the authentic leader (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008).

**Team leadership.** Team leadership, critical to the interdisciplinary teams of hospice and palliative care work, is defined by Zalatan and Yukl (2010) in the *Encyclopedia of Leadership* as follows: “Effective team leadership enables members of a team to perform collectively to achieve objectives” (p. 1529). For the sake of this study the team leaders are members of the team. They also ideally share leadership and rotate leadership with other equally qualified and responsible team members. Zalatan and Yukl noted that a leader must have five primary contributions for the team to be effective. These include being goal directed, having adequate resources, encouraging a supportive climate, competent team members, and a plan for continuous improvement.

**Social systems.** Harter and Phillips (2004) define social systems as: “A grouping of people who work together interdependently for a common purpose . . . For every social system, there is a structure comprising people in some kind of relationship with another” (p. 1516). The

social system studied here is the interdisciplinary team of hospice. This team defined by the National Hospice and Palliative Care Organization includes a physician, an RN, a chaplain, a social worker, and a counselor.

**Religion and spirituality distinguished.** Two other concepts that arose in the interviews need definition. These are “religion” and “spirituality.” Some authors use these terms interchangeably (McIntosh & Newton, 2013). Dr. Bernard Spilka (1993) refers to spirituality as a “fuzzy” term. While others use these two terms to distinguish two very separate concepts (Pargament, 2013). Within the literature, many views are expressed for defining spirituality and religion.

It is important to note that many authors (Doehring et al., 2009; Geertz, 1966; Kirkpatrick, 2005,) work with a thesis that: “Spirituality is the core function of religion (Pargament, 2013). This meaning making, sacred search is imbued in every aspect of life (Pargament, 2013). As spirituality and religion are defined, this assumption undergirds the definitions of both concepts.

Pargament (2013) concludes that spirituality has a practical side of prayer, spiritual meditation, and meaning making. This definition of spirituality emphasizes that one can be spiritual and religious or spiritual and not religious. It is a flexible definition without the restrictions of an institution. This spirituality is functional and works for the perceived good.

Continuing this line of thought, Pargament (2013) defines religion as traditionally including an institutional expression. Religion includes a search for the sacred that is spiritual in nature, deeply faithful, and longing for transformation. Hood, Hill, and Williamson (2005) define religion as a sense of the divine; however, these theories can become very broad and obscured.

Finally, there is a third way. McIntosh and Newton (2013) test a mini-theory that delineates religion and spiritual from one another by behavior. They note, “What is religion in one context may not apply to religion in another context” (p. 263). By this they mean that religion and spirituality expand and contract in different contexts. The sense of the divine or the definition of “religious” or “spirituality” may change given a different time, place, person, or experience.

For the work of this dissertation, I assert that religion is the institutional practice of one’s faith. This includes participating in a church, synagogue, mosque, or community that supports and sustains one’s growth and faith. Spirituality is a more individualized journey of prayer, meditation and meaning making. Religion and spirituality are not mutually exclusive of one another. These concepts will be helpful through the remainder of this dissertation for the sake of consistency and in order to avoid any discrepancy in understanding meanings. These definitions were also given to participants in the study so that they were able to stand on common ground throughout the interview process. Definitions of resilience, servant, spiritual, and authentic leadership were given to participants in the form of Table 2.3. These definitions are discussed at length in the second chapter, as part of the literature review. Additionally, it was my goal to glean from each participant her own understanding of these concepts. In the fifth chapter, I present conclusions drawn from the participants’ interviews as themes arise, discord is noted, and hospice interdisciplinary leaders share how they view resilient leadership, how they embody resilient leadership, and levels of resilience that they create and sustain in the interdisciplinary team members.

## Nature of the Study

Data for this research consists of a narrative inquiry focusing on one 90-minute interview with each hospice interdisciplinary team leader chosen for the study.

Narrative analysis refers to a family of methods for interpreting texts that have in common a storied form . . . the analyst is interested in how a speaker or writer assembles and sequences events and uses language and/or visual images to communicate meaning, that is, make particular points to an audience. (Riessman, 2008, p. 11)

Narrative inquiry listens for the “how” and “why” of stories, listening for images that are used to communicate meaning, looking for gaps, understanding cultural context, and finding unique insights (Riessman, 2008, pp. 11–13).

A modified form of Seidman’s (2006) phenomenological interviewing structure was used as a process of acquiring rich data for research. The leaders were identified through purposive sampling. Nagy, Hesse-Biber, and Leavy (2006) noted that “Qualitative researchers are often interested in selecting *purposive* or *judgment samples*. The type of purposive sample chosen is based on the particular research question as well as consideration of the resources available to the researcher” (p. 70). This sample represents the variety of hospice choices available to patients in the Central Ohio area. Each person was interviewed for one 90-minute interview. Additionally, hospice interdisciplinary leaders were interviewed until the study reached saturation. According to Nagy et al. (2006), saturation is achieved when nothing new is found in the research data.

The data collected was in the form of interviews on site at the hospices where the interdisciplinary team leaders work. Intensive field notes and an audio recording of each session were made. All interviews occurred over a two-week period. A transcriptionist was hired to transcribe each tape. Both verbal and non-verbal actions were noted with transcription fluency

marks as defined by Ochs (1979). After the transcript of the tape recording was completed, I checked each transcribed manuscript against the recording for accuracy.

Once the data was collected and participants approved transcripts, I analyzed the results to identify the commonplaces and experiences of the hospice leaders in accordance with Connelly and Clandinin's (2006) concept of "Defining and balancing the commonplaces" (p. 482) and building "commonplace features" of the research into the study (Clandinin, Pushor, & Orr, 2007). This is one of the goals of narrative research text analysis and interpretation. A second goal in analyzing the research for the purposes of this study was to position the sets of three interviews within the context of "the social, cultural, and institutional narratives in which the individual's experiences are constituted, shaped, expressed, and enacted" (Clandinin et al., 2007, p. 29). A final goal was to define further research opportunities that may surface from this study.

### **Summary of Chapters**

The chapters of my dissertation are as follows. The first is the introduction, which includes the situation of the researcher, positioning interests, and my background as I began my research. It also includes the purpose and importance of the study, supported by research and the justification for this study. A brief discussion of the narrative inquiry and overview of the layout of the paper is also included in this chapter.

The second chapter is a literature review on leadership models used to address the hospice leadership arena. The chapter begins with a review of hospice leadership followed by critical discussions of the ethics of leadership, servant leadership, spiritual leadership, and authentic leadership. Usage of terms such as hospice, palliative care, resilience, and interdisciplinary teams is reviewed. This chapter also includes a critical discussion of the concept

of resilience. I conclude by linking leadership and resilience, power, values, and communication (Drinka & Clark, 2000) as a foundation for interdisciplinary teams to function within healthcare organizations such as hospice.

The third chapter is an in-depth look at research methods and procedures. Narrative inquiry is the research method chosen for this paper. In addition, phenomenological interviewing is used as a method for gathering data. The research approach and design, as well as the data collection methods and techniques, are noted. Researcher position, data management, and a summary are also included in this chapter. The rationale for forming questions is based on a modified version of Seidman's (2006) understanding of phenomenological interviewing. The chapter includes descriptions of the process for gathering, transcribing, and coding the data. Appendices serve as an additional source for information such as the research questions, Institutional Review Board (IRB), pertinent data collection, transcription, storing of data, and coding process.

In the fourth chapter I present the interpretation of research findings incorporating information from the literature review with the information gathered from the study. Analytical techniques are explained using a modified version of the phenomenological approach designed by Seidman (2006). This includes searching for "threads and patterns among the excerpts within those categories and for connections between the various categories that might be called theme" (p. 125). This can only come after all interviews have been completed and after the researcher has, in Seidman's words, "mentally lived with and rested with the data" (p. 128).

The fifth chapter summarizes and states the conclusions for those who work in the hospice and palliative care fields fully reflecting on the question of resilience for interdisciplinary team leaders and beginning to look forward toward the implications of this

study. I conclude with a discussion of what I have learned from this study and how this research will change my practice.

The sixth and final chapter reflects on the implications of this dissertation for leadership and change. This chapter brings the researcher back to the core of the Antioch PhD in Leadership and Change program. Those who began as reflective leaders in year one of the program close this work as reflective leaders. This chapter asks how did this research change the researcher? How has the process of exploring resilience, and interdisciplinary leaders in hospice settings through a modified version of Seidman's (2006) phenomenological interviewing process impact this researcher's present and future research and life work?

## Literature Review

The team leader's understanding of leadership is crucial to the study of leadership. In this study, hospice interdisciplinary team leaders were asked through the narratives of their experiences to explore resilience within themselves and their teams. The ethics of leadership is the overall paradigm for all leadership models discussed. Servant leadership, spiritual leadership, and authentic leadership will be viewed through the standards of ethics set forth in this study. In this chapter, several core principles for the hospice and palliative care team model will be outlined and compared to the models of servant, spiritual, and authentic leadership. Also addressed are issues such as formal and informal leadership, power, communication, and trust. These are all issues raised by Drinka and Clark (2000) in their work, *Health Care Teamwork*. Beyond these, leadership issues that impact the organization and its management environment are addressed. These include employee assistance programs, wellness programs, stress management for hospice teams, and other ways that IDT leaders and hospice organizations provide resilience opportunities for team building.

### **What Makes a Healthy Interdisciplinary Team?**

Healthy leadership within hospice and palliative care organizations may occur in teams. "The organization and the team share responsibility for assuring that the individual and professional practice components are in place and appropriate for the team's work" (Drinka & Clark, 2006, p. 12). The team must be aligned with the organization's mission. The team must also continue growing, learning, sustaining leadership and teaching each other new ways of patient care. Healthy teams have members who have roles defined by their specialties, for example, nursing, social work, chaplaincy, etc. (M. Payne, 2008, p. 188). Every team member

has the same goal of serving the patient and family with caring compassion as the patient reaches the end of life.

There are some nurses and other team members who have worked at Mount Carmel Hospice for twenty years. These men and women have learned to be self-empowered and to balance their life and work. They take responsibility for their own life functioning. Patients, families, and co-workers love them. There are also team members who are hired, work six months to a year, and leave. Turnover among hospice employees is significant. Monroe, Hansford, Payne, and Sykes (2007–2008), discussing the National Health Service within the United Kingdom, indicated that the hospice workforce, both in the care of children at places such as St. Christopher's Hospice and in hospices that care for adults, is a major challenge. Recruitment and retention problems facing the National Health Services are experienced at all age levels.

Every patient's narrative ends in death. Some team members are not prepared for this. Even though they may intellectually know this going into hospice work this work is not for everyone. One of the lessons that I have learned working in this environment is that it takes a person who can balance life and work, develop resilience, connect thoughts and emotions, and understand themselves deeply. I have also learned that resilience in hospice care is an ever-deepening experience of growth, love of dignity within life, and death and respect for each human story.

I have learned that when teams are functioning as supportive, authentic, and integrative teams, they are resilient; however, if they begin to splinter, back-bite, lose sight of the mission and purpose of hospice, or lose their personal balance, the teams begin to disintegrate quickly

M. Payne (2008) defines a resilient team environment that includes the following four characteristics: “clear objectives, high participation, commitment to quality and support of innovation” (p. 190). Working with mental health teams Onyett (2003) defines a larger number of interventions to support a resilient team. These include: promoting clarity of roles for team members, making workloads manageable, keeping paperwork at a minimum, always being mindful of physical safety, encouraging contact between team members, advocating for gender issues, creating autonomy for professionals, advancing effective leadership, encouraging achievement of personal focus, making opportunities for peer consultation, and creating team meetings that work with excellence. All of these interventions encourage a team that is engaged with each other and communicating well. Team members from various disciplines respect their fellow team members. Power is a non-issue as team members are all involved in quality of care. Individuals within the team grow in their disciplines and both team and individual safety, effectiveness, resilience, and an environment of cooperation and excellence are promoted.

In her book, *High Performance Healthcare*, Gittell (2009) suggested that team building, teamwork, and team boundaries are critical to excellence in healthcare. An example set forth in her book illustrating the power of teams working together, is broadening patient rounds to include a team effort. Gittell noted, “Patient rounds are a type of cross-functional meeting in which physicians, residents, nurses and others responsible for the care of the patient get together to discuss the patient’s case either at bedside or in a separate conferencing area” (p. 162). This teamwork increases performance and relational coordination. These rounds are essential for communication pathways. Gittell continues by noting that there are financial responsibilities to convening the team on a frequent basis. Those costs are much less than the benefits of communication, goal sharing, knowledge, and mutual respect among team members.

## **Ethical Leadership**

The paradigm of ethical leadership is critical to the essence of this study due to its focus on end of life care. It is imperative that ethical leadership be at the forefront of this research. The first task is thus to define “ethics” both historically and in terms of leadership. Ethics is the overarching theory above the three leadership models presented in this study in that it is inherent in servant leadership, spiritual leadership, and authentic leadership. It is also imperative in all hospice interdisciplinary team leadership.

The *Encyclopedia of Leadership* (Goethals, Sorenson, & Burns, 2004) begins its discussion of ethical leadership with this definition of ethics: “Ethics is the study of right and wrong, good, and evil, and virtue, and vice” (p. 462). There has been a debate dating as far back as Plato over the degree that leadership can be unethical. Although it is clear that leaders can abuse power, nevertheless a philosophical discussion of leadership is an ethically grounded endeavor.

The view that true leadership is concerned with the good of the followers not the good of the leader finds 20th century expression in the work of James MacGregor Burns (1978). Burns goes so far as to deny that Adolf Hitler was a leader because “leadership, unlike naked power-wielding, is . . . inseparable from followers’ needs and goals” (p. 19), and because Hitler was “an absolute wielder of brutal power” (p. 27). This brutal, unethical power is not seen as leadership. Rather it is seen as wielding self-serving, unbridled power to harm humanity. Burns discusses power and motives moving toward the deeper concept of moral leadership for the greater good of all.

Northouse (2004) supports this view of ethics and leaders as he asserts, “Ethics has to do with what leaders do and who leaders are” (p. 302). Northouse continues by noting that the choices that leaders make and the ways that they respond to given circumstances are indicative of their character. He supports the five principles of ethical leadership set forth by Burns (1978), Greenleaf (1977), and Heifetz (1994). These include: “respect, service, justice, honest and community” (Northouse, 2004, p. 302).

An in-depth study on the nature of ethical leadership by Brown and Trevino (2006) identified a number of personal characteristics that are related to ethical leadership. These personal characteristics were discovered through interviews with open-ended questions about the behaviors and characteristics of ethical leaders. They then cross-referenced their findings with other research and compared ethical leadership to authentic, spiritual, and transformational leadership. They noted both similarities and differences among these three theories as compared to ethical leadership. For example, the leader’s honesty, integrity and trustworthiness are important values for the ethical leader (Brown & Trevino, 2006). They also emphasize agreeableness, conscientiousness, moral reasoning, principled decision-making, and fairness. What distinguished the ethical leader from an authentic, spiritual, or transformation leader in every case was that the ethical leader accentuates moral management (p. 598).

De Hoogh and Den Hartog (2008) define ethical leadership utilizing the concepts of Brown and Trevino (2006). It was the goal of their study to test these concepts against the traits of despotic leadership for the correlations between ethical and despotic leadership. This article reports on a multi-method and multi-source study. They found that ethical leadership had significant implications for organizational management and social responsibility (De Hoogh & Den Hartog, 2008, p. 308). Among the conclusions of this study they noted that “Ethical

leadership is found to be important for perceived top management team effectiveness and subordinates' optimism about the future of the organization and their own place within it" (p. 309). The link between the leadership traits of ethical leaders and the consequences for the organization is remarkable. When compared to the despotic leader, the ethical leader always has a vastly more positive effect on the organization and its members (p. 309).

The implications of ethical leadership as defined by Brown and Trevino (2006) and De Hoogh and Den Hartog (2008) for the population of this study are essential. Honesty, trustworthiness, fairness, moral management, and the like are critical as interdisciplinary team leaders set the tone for each member of the hospice team. As Drinka and Clark (2006) stated, "Because a team's growth is based on its ability to evaluate itself and to correct its mistakes, members of IHCT's (interdisciplinary healthcare teams) must be willing to trust all team members to observe the team's work and give honest feedback" (p. 144). Honest and trustworthy leadership are intrinsic to a healthy team.

Lincoln and Holmes (2010) discuss ethics from the viewpoint of decision-making. They suggested that "The process of ethical decision-making involves four distinct psychological steps: moral sensitivity/awareness, moral judgment, moral motivation/intention and moral action/courage" (p. 57). These four steps of decision-making are applied in their study. Utilizing a sample of 352 Navy chaplains, Lincoln and Holmes (2010) administered a two-part questionnaire that was adapted from the Canadian Department of Defense's Ethics Survey. Part one focused on ethical decision-making and how it is informed by philosophical approaches. Part two focused on moral awareness, moral judgment, and moral intention. In this study on moral intensity, the authors conclude that "Understanding the relationship between the process of ethical decision-making and moral intensity provides individuals with greater insight into what

affects their ability to make and act on moral decisions” (Lincoln & Holmes, 2010, p. 61). This process is critically true when the decision-making involves human lives, dying with dignity, and issues of quality versus quantity of life, including the end of life without pain.

It is important to note that ethical leadership is at the center of healthcare, hospice care, and palliative care. “Do no harm” is an oath that every licensed professional clinical counselor must take. For physicians, they subscribe to the Hippocratic Oath (Lasagna, 1964). In this oath, each medical doctor has special obligations “I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm” (Lasagna, 1964, para. 9). Every nurse and many other persons in healthcare professions have a similar oath of ethical and moral responsibility to seek the highest level of care for the persons with whom they serve.

Ethics in itself is an important aspect of leadership. Northouse (2004) reminds us that leaders have more power than followers. Due to this power differential leaders also have greater responsibility, more control, and must be more sensitive to how their leadership affects the lives of others. Northouse goes on to note that “ethics is central to leadership, and leaders help to establish and reinforce organizational values” (p. 306).

Ethics and leadership values are of particular interest within interdisciplinary team leadership on many levels. Hospice team leaders have continuous dialogue regarding the quality of life for hospice patients. According to Drinka and Clark (2006), “Differing interpretations of the concept of quality of life underlie difference in approaches to care” (p. 78). Ethics, values, and definitions of quality of life all inform decisions related to quality of life and level of care. Social environment, the patient’s ability to make decisions, resources, and problem solving also inform this central issue in hospice care (p. 79). Ultimately, decisions about maintaining quality

of life are made in collaboration with the physician, IDT leader, the team, and the patient and family. This is a highly individual and ethically sensitive subject.

The ethical leadership paradigm supports each of the leadership forms discussed above. Northouse (2004) asserted that servant leadership, spiritual leadership, and authentic leadership are labeled as more follower than leader oriented. “With its strong altruistic ethical overtones, servant leadership emphasizes that leaders should be attentive to the concerns of their followers and empathize with them; they should take care of them and nurture them” (p. 309). For spiritual leadership, “the embodiment of spiritual values such as integrity” (Reave, 2005, p. 656) calls forth the parity with ethics. For authentic leaders, Sparrowe (2005) argued that the leader must speak with his/her own voice. If one echoes words of another, this will suggest to followers that the leader is not credible and not trustworthy (Sparrowe, 2005, p. 420). Each of these leadership models is a refreshing view of honest, self-aware, introspective leadership that reflects compassion. Leaders who follow such paradigms emulate ethical leadership and resilience as described here.

For the purposes of hospice and palliative care, ethical leadership can be attributed to the founder of the hospice movement, Cicely Saunders (Twycross, 2007). The opening of St. Christopher’s Hospice in 1967 was the basis for Cicely Saunders’ commitment to compassionate care at life’s end (Twycross, 2007). The World Health Organization then embraced this same passion in 1980 (Sepúlveda, Marlin, Yoshida, & Ullrich, 2002). The keys to hospice and palliative care are: caring for the whole person, patient-centered (not disease-centered care), a partnership of empowerment for the patient and their family, open and honest communication, accepting death while enhancing life, improving the quality of life, concern with healing (not curing), and inter-professional teamwork as well as volunteers who support the patients and their

families (Twycross, 2007, p. 9). This kind of care embodies human compassion, and the gold standards of hospice and palliative leadership.

Twycross (2007) describes hospice as a “safe place to suffer” (p. 10). In order to provide such a safe place, hospice leaders must continually be mindful of their own life and work balance, their own resilience. A commitment to openness and honesty in leadership requires that each leader wrestle with their own mortality. They must be in tune with their spirituality and authenticity. The ethics they model and the resilience they emulate is important to evaluate and understand. This is the intention of my interview questions.

As H. Gardner (1995) was quoted at the beginning of this chapter, these leaders must employ “the embodiment of personal courage” (p. 275). The vision of leadership for the greater good, embodying personal courage and staying grounded in caring compassion leads to the resilient ethical leadership of hospice care. This is no easy challenge, but it is lived day in and day out at the bedsides of hospice patients throughout the United States and many other countries. According to the Worldwide Palliative Care Alliance (Connor & Bermedo, 2014), in 2011 approximately 136 countries or 58% of the 234 countries have a hospice or palliative care for patients and their families.

### **Servant Leadership**

Servant leadership is a calling (Couto, 2004). It calls for people to take responsibility for their values. “The servant leader invests in the human resources of a group or enterprise” (Couto, 2004, p. 1450). Greenleaf (1977) describes the servant leader as follows: “Leadership was bestowed upon a person who was by nature a servant” (p. 21). Such women and men may not aspire to leadership positions but rather they aspire to serve others. These servants have imagination and they allow others the opportunity to imagine and lead also. Servant leaders are

empathetic and accepting even of flaws and imperfections. Greenleaf (1977) observed that “The leader needs two intellectual abilities . . . the leader needs to have *a sense for the unknowable* and be able to *foresee the unforeseeable*” (p. 35). Other attributes that Greenleaf suggests are essential for a servant leader include persuasion, getting things done, ethics, conceptualizing healing and serving, power and authority, and community. The servant leader is the steward of resources, both the organizational resources and the resources of people (Couto, 2004).

The “leadership classic” by Bennis (2003) *On Becoming a Leader* closely parallels Greenleaf’s (1977) definition of a servant leader in many ways. Bennis (2003) adapts the older edition of his book to include four “essential competencies” that leaders must have. These include, “First, they are able to engage others by creating shared meaning. They have a vision” (p. xxi). Included in this first competency is empathy, rhetoric, and an ability to be “exquisitely attuned to their followers” (p. xxi). Secondly, he refers to the competency of a distinctive voice. This is particularly essential for those running for public office in a media-driven society. Thirdly, leaders must have the competency of integrity. Bennis writes, “Leadership is always about character” (p. xxii). Finally, he notes, “the key competency is adaptive capacity . . . Adaptive capacity is made up of many things, including resilience or what psychologists call ‘hardiness’” (p. xxiii). This competency is creative. “Adaptive capacity is a kind of creativity. And adaptive capacity also encompasses the ability to identify and seize opportunities” (p. xxiii). This includes recruiting mentors, wooing great teachers, finding young people to surround you as you grow older so that your ideas remain new and fresh, reinventing yourself, and always adapting and growing.

Russell and Stone (2002) examined servant leadership literature including popular writings, scholarly journals, and books looking for attributes that exist among servant leaders.

According to the literature surveyed by these authors they discovered nine functional attributes and 11 accompanying attributes that define servant leaders. They are careful to observe that the accompanying attributes are not secondary in nature. They appear rather to supplement and augment the functional attributes. Table 2.1 illustrates these servant leadership attributes.

Table 2.1

*Servant Leadership Attributes*

Functional attributes	Accompanying attributes
1. Vision	1. Communication
2. Honesty	2. Credibility
3. Integrity	3. Competence
4. Trust	4. Stewardship
5. Service	5. Visibility
6. Modeling	6. Influence
7. Pioneering	7. Persuasion
8. Appreciation of others	8. Listening
9. Empowerment	9. Encouragement
	10. Teaching
	11. Delegation

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*Note.* From “A review of servant leadership attributes: developing a practical model,” by R. Russell and A. Stone, 2002, *Leadership and Organization Development Journal*, 23(3), p.147. Used by license, Copyright 2002 by Emerald Group Publishing.

It is important to note that this list is not exhaustive. Many other leadership writers include other important themes and attributes to the servant leader. These include such essential hallmarks of leadership as: vision, honesty, integrity, trust, service, modeling, pioneering,

appreciation of others, encouragement, teaching, delegating, empowerment, persuasion, communication, credibility, and competence (Russell & Stone, 2002, p. 154). Even this list is not exhaustive as core beliefs, principles, values, and other variables influence the servant leader.

The ultimate goal of servant leadership is to train others to lead in the areas of modeling, delegating, empowering, and teamwork. Greenleaf (1977) notes, “The model of a single chief sitting atop the hierarchy is obsolete and consequently we are at a point of crisis for want of trust in our major institutions” (p. 84). The model of servant leader is a team model with equal power and equal responsibility; therefore equal trust is also at work. This servant leadership model is one of dedicated trustees willing to be vulnerable together embracing the complex issues of the day and serving with the interests of the community first and foremost.

As servant leaders build teams and create a model of training others to be leaders, they empower followers to become servant leaders themselves. This creates an environment in which there is not one leader who holds all power and who has the potential to succeed or destroy. Everyone has a share in the success or failure of the organization.

### **Spiritual Leadership**

Tied very closely to the concept of servant leadership is the idea of spiritual leadership. W. Patterson (personal communication, August 2, 2006) defines spiritual leadership with four basic practices. These include a more universal connection with the world, promoting gratitude, humility, and compassion, experiencing spiritual practices in community, and desiring to help others that enrich community life. Spiritual leadership is closely tied to community life and responsibility.

Complementing this understanding of spiritual leadership, Northouse (2004) observed that, “The strongest example of altruist ethics can be found in the work of Mother Teresa, who

gave her life to help poor people” (p. 304). Mother Teresa possessed both altruistic ethics, and spiritual leadership. She is also an excellent example of a spiritual servant leader (Northouse, 2004).

Further, Gehrke (2008) suggests that spiritual leadership is inclusive of behaviors, values, and a belief system that necessarily motivates spiritual survival. It can be defined as a sense of calling, a social membership or connection, an ability to find meaning in hardship, and a quest for finding purpose in life (p. 352). Gehrke asserted that the spiritual leader is one who effectively develops three dimensions of spirituality: consciousness, moral character, and faith.

Harter, writing for the *Encyclopedia of Leadership* (2004) characterizes spirituality as grounded in relationships. Spiritual leadership desires to improve present situations and bring them into alignment with the ideal regardless of how slight those changes may be. This relational grounding moves toward change that finds meaning within life’s hardships and purpose within life’s difficulties.

From another perspective, Reave (2005) reviewed over 150 studies showing a clear connection between spiritual values and effective leadership. She highlights values such as spiritual ideals, integrity, honesty, and humility. These have all had an effect on leadership success. Reave gleaned ten correlations between spiritual values and leadership success. These included personal integrity, trust, ethics, honest communication, humility, respect for the values of others, treating others fairly, listening respectfully, recognizing and appreciating the contributions of others, taking time for meditation, prayer, journaling, and communication with God (Reave, 2005).

Personal integrity reflected by ethical behavior is essential as the first attribute of spiritual leadership. Bass (1998), Bennis and Thomas (2002), Hendricks and Hendricks (2003), and

Pfeffer (2003), are among those who identify integrity as necessary for leadership success. Reave (2005) asserted that integrity is the “most crucial” spiritual value for successful leadership (p. 667). It is not what a person does but rather who a person is that makes all the difference in their leadership. From this study trustworthiness, also equated with integrity, was the number one positive trait necessary for spiritual leadership.

Trust is the second component Reave (2005) attributed to spiritual leadership. Trust is essential both for the success of the leader and for the perception of the follower. Reave’s research supports a direct correlation between trust in leadership and measures of altruism, civic virtue, conscientiousness, courtesy, and sportsmanship.

Ethics is the third component in this model of spiritual leadership. Ethics both inside and outside the organizations are critical to the leader (Reave, 2005). There is a sense of serving both God and the community that emphasizes respect for others and the environment in spiritual leadership. Reave (2005) cited the Ben and Jerry’s Ice Cream company as a poignant example of this form of spiritual leadership. Ben and Jerry’s employees give their jobs high ratings of meaning, camaraderie among coworkers, and trust in management. The reasons stated for such high ratings of job meaning are grounded in pride and support of the organization’s “social mission.” It is Ben and Jerry’s social mission that positions this organization as one that instills morality and meaning in its employees. Philanthropy and ethical leadership deepens the mission of this ice cream company to make it rise above other competitors and to offer both employee satisfaction and customer loyalty.

Communicating with honesty both to self and others is fourth among the ten components put forth by Reave (2005). Such communication provides integrity, internal and external consistency, and truth. Then when a crisis comes honesty is already the foundation of the

leadership in situations in which crisis management demands truth (Reave, 2005). A study of leadership by the GLOBE project (Dorfman, Hanges, & Brodbeck, 2004) indicates that outstanding leadership requires honesty.

Humility is the fifth value in a spiritual leader. Reave (2005) indicated that there is a direct relationship between humility and the ability to accept negative feedback. This important trait allows leaders to grow in their leadership abilities and to receive feedback from followers, thus enhancing the leader-follower relationship. On the other hand, Reave observes that if the leader rates too high in the category of self-esteem they are likely to be limited by ethical, diplomatic, and interpersonal skills. This can result in a leader who is irritable, dictatorial, or egocentric. Reave calls this the “dark side” of self-esteem (p. 672). Clearly, there must be a balance between humility and self-esteem for leadership to be effective in this spiritual leadership model.

The sixth value of spiritual leadership is the demonstration of leaders’ respect for the values of others, which leads to empowerment and sustainability. Leadership that respects the ideas of followers ultimately creates long-term empowerment and sustainability. This is much more powerful than dependence that is created if followers are simply told what to do (Reave, 2005). This respect of values leads to higher motivation, better performance, and the achievement of long-term success. Leaders and followers are more fulfilled if each can respect the values of the other in the workplace.

The seventh value is the value of treating others fairly. For employees, Reave (2005) reports that this is the number one concern, particularly when referring to compensation. Caring, concern, and fairness come as one component in the perception of employees. If the leadership and the organization do not treat employees with fairness, mutual respect and positive working

relationships are compromised. This, Reave asserts, is a key factor in a leader's success or failure.

The eighth value of spiritual leadership is listening responsively. One study cited by Reave was about healthcare where the leader is a physician or clinician. When this leader exemplifies listening and relationship-centered healthcare the traits of listening, sharing, decision-making, and respecting others improve patient incentive and their commitment to a plan of action, (Reave, 2005). This exemplifies the dynamic of the leader/follower relationship. In hospice care it is my observation that because we utilize an interdisciplinary team for every patient the art of listening, sharing, decision-making, and respecting our patients is a value we hold as essential for each encounter with patients and families.

The ninth value of spiritual leadership is recognizing and appreciating the contributions of others. Reave (2005) noted that when leaders acknowledge employee contributions, employees feel better about the organization. When employees feel more a part of a community they are more likely to stay with the organization. Reave suggests that employees are also likely to continue to contribute to the organization if they are recognized for contributions. The unfortunate reality is that a study by Kepner and Tregoe (1995) reports that only 40% of workers in North America receive recognition for excellent work. A similar number report never receiving recognition or praise for a job well done (Reave, 2005).

Taking time for meditation, prayer, journaling, and communication with God is the tenth value of spiritual leadership. This trait is called engaging in "reflective practice" (Reave, 2005, p. 680). This is a particularly important trait during difficult periods. These are times when it is critical for the leader to realize that there is much more to life than the immediate position they are in. As they are able to have a more global perspective, it enables them to have a non-anxious

presence during turbulent stressful times within an organization. They are mentally and physically more resilient, and better equipped to respond to stress (Reave, 2005).

Fry (2003) posited another, yet similar, definition of spiritual leadership, suggesting that spiritual leaders are holistic leaders who integrate the fundamentals of body, mind, heart, and spirit with a particular concern for a global society and a global community. In this context Fry defines spiritual leaders as those who hold the values, attitudes, and behaviors necessary to motivate both the self and others. They have a sense of calling and call others to membership. Key qualities within the definition include high ideals, standards of excellence, honesty, empathy, patience, courage, integrity, forgiveness, humility, compassion, kindness, perseverance, trust, and a willingness to “do what it takes” (Fry, 2003, p. 695). Many of these qualities echo those set forth by Reave (2005) and others who define spiritual leadership in a similar fashion.

Sokolow and Houston (2008) presented “A spiritual dimension of leadership” (p. 13) that is applied to educational leadership; however, its implications stretch much further than the educational arena. This model began as a “joint expedition of the soul that has led to a 20-year conversation about what it truly means to be a human being, and the implications of that awareness for our work as educational leaders” (p. 14). It is my assertion, that one could remove the word “educational” from this statement, and insert “effective” or “hospice” and still be within the bounds of truth. These authors go on to note that “These principles are not something you can check off your ‘to do’ list. They are habits of mind and soul that can act as guideposts for the perilous and wonderful journey we call the spiritual dimension of leadership” (p. 14).

Sokolow and Houston (2008) describe their model utilizing eight keys. Each key is a principle that is applied and integrated into the life of the leader. Their eight keys are the

principles identified by these authors as the “habits of mind and soul” needed for the spiritual leader. These include trust, intention, attention, gratitude, unique life lessons that the spiritual leader has learned, unique talents and gifts that the leader brings to his/her leadership, a holistic perspective of the vision set before oneself, and openness. Table 2.2 shows the similarities and differences between the three models: Reave (2005), Fry (2003), and Sokolow and Houston (2008).

Table 2.2

*Comparative Leadership Themes*

Reave (2005)	Fry (2003)	Sokolow & Houston (2008)
<b>Themes that are similar among the authors:</b>		
1. Listening	1. Trust/loyalty	1. Trust
2. Integrity	2. Integrity	2. Intention
3. Honesty	3. Honesty	3. Attention
4. Humility	4. Humility	4. Gratitude
<b>Themes that are different among the authors:</b>		
5. Respect for others	5. Courage	5. Unique life lessons
6. Fair treatment	6. Forgiveness/acceptance/gratitude	6. Unique talents, gifts
7. Caring and concern	7. Kindness	7. Holistic perspective
8. Work as calling	8. Empathy/compassion	8. Openness
9. Appreciating others	9. Patience/meeekness/endurance	
10. Reflective practice	10. Excellence	
	11. Fun	

### **Authentic Leadership**

Authentic Leadership can be described as a pattern of transparent and ethical leader behavior that encourages awareness of self and other and openness in sharing information that is needed to make decisions while accepting follower inputs. It is multi-leveled and includes the leader, follower and context. It is based on positive psychology and on a developmental model,

not on a deficit-reduction model. Optimism, balance, and hope are foundational in this model of leadership.

Authentic leadership originates from the concept of authenticity which is found in ancient Greek thought; in a more contemporary sense authenticity is defined as “owning one’s personal experiences, be they thoughts, emotions, needs, wants, preferences, or beliefs, processes captured by the injunction to know ‘oneself’” (W. Gardner, Avolio, Luthans, May, & Walumbwa, 2005, p. 344). Therefore one both embodies and acts according to how one thinks, feels, values, and believes.

The congruence and consistency of authentic leaders living out their values and belief structures and integrating the leader-follower model are essential within the hospice and palliative care interdisciplinary team. Monroe and Oliviere (2008) note “The emphasis is on generating a vision for the organization and the leader’s ability to appeal to higher ideals and values, thereby creating a feeling of justice, loyalty and trust in followers” (p. 209).

Authenticities within both the organizational culture and within the leadership foster “purpose, trust and accountability” (p. 212).

Avolio (2007) explains the core elements of an authentic leadership development model. He identifies five core elements for this model. These include: cognitive elements of self-awareness for both the leader and the follower; behavior that is ethical and transparent between the leader and the follower; a historical context for both leader and follower that allows them to know trigger points, self-awareness, and self-reflection; a proximal context highlighting an ethical organizational climate; and distal context including national or international events that may shape the organization’s development. Avolio’s conclusions are that the leader, the

follower, and the internal and external context are all a part of the leadership building for authentic leadership development.

First, Clapp-Smith, Vogelgesang, and Avey (2009) looked at positive psychological capital and authentic leadership in a study examining the leaders and followers of a small Midwestern chain of retail clothing stores. Their stated goal was “to advance leadership and organizational behavior research by extending the integrative theory of authentic leadership. Included in this theory are the roles of both positive psychological capital (PsyCap) and trust as contributors to firm performance” (p. 228). These authors relied on the definition of authentic leadership established by Luthans and Avolio (2003) and W. Gardner et al. (2005). This definition is as follows:

Authentic leadership . . . is a process by which leaders are deeply aware of how they think and behave, of the context in which they operate, and are perceived by others as being aware of their own and others’ values/moral perspectives, knowledge, and strengths. (Avolio, Gardner, Wallumba, Luthans, & May, 2004, pp. 802–3)

These authentic leaders are aware of a relational transparency, a need for balance, self-awareness, and a moral/ethical perspective that is not compromised (Walumbwa et al., 2008).

The second crucial part of the Clapp-Smith et al. (2009) study is positive psychological capital (PsyCap). PsyCap is defined as “the shared variance between self-efficacy, hope, optimism, and resiliency” (p. 230). “Self-efficacy is the positive belief or confidence in one’s ability to perform specific tasks” (Bandura, 1977, p. 230). Willpower is the drive that allows individuals to attain a goal. Hope means that an individual has enormous drive to make a goal happen. Hope allows leaders to find alternate routes to make a goal happen (Clapp-Smith et al., 2009, p. 230). This means that creativity is enhanced and the ability to form new pathways and in essence bounce back from challenges is made possible.

The third concept, “optimism or the positive explanatory style of individuals and groups, also contributes to performance” (Clapp-Smith et al., 2009, p. 230). Motivation is enhanced when the individuals lead with an optimistic point of view.

When individuals attribute successes to themselves, they are more likely to expend energy to create additional successes. Likewise, when optimists attribute failures to external circumstances (outside the self) they are less likely to believe the failure will be repeated and thus be more willing to repeat attempts to be successful. (p. 231)

For resiliency, Clapp-Smith et al. (2009) drew on the works of Luthans (2002), Masten (2001), and Masten, Best, and Garmezy (1990). Their definition is simple, yet precise.

“Resiliency is the ability of groups and individuals to bounce back from adverse or stressful situations” (Clapp-Smith et al., 2009, p. 231). To Clapp-Smith et al., resilience is reactive rather than proactive. It is a response to events, “specifically negative setbacks. When individuals or groups have a setback in accomplishing their tasks or goals, the extent to which they ‘bounce back’ quickly and effectively is the outworking of resiliency” (p. 231). This is a concise and helpful definition for the purposes of this study as I explore the setbacks and challenges of hospice leaders and followers.

Clapp-Smith et al. (2009) conducted a four-month study concluding that authentic leadership and positive psychological capital lead to trust between leaders and followers. On the business side of the equation this trust leads to higher profit margins as well as greater management and staff job satisfaction. Going back to the basic philosophical understanding of authentic leadership, “to thine own self be true,” this study indicates “that when the firm’s leadership embraces the idea of ‘to thine own self be true,’ significant relationships with trust and performance arise” (Clapp-Smith et al., 2009, p. 238).

W. Gardner et al. (2005) wrote a seminal article entitled, “‘Can you see the real me?’ A self-based model of authentic leader and follower development” (p. 343). They define the

relationship of authentic leaders and followers to have the following characteristics:

“a) transparency, openness, and trust, b) guidance toward worthy objectives, and c) an emphasis on follower development” (p. 345). In this article the emphasis is on self-awareness and self-regulation as they contribute to and enhance the discussion of authentic leadership. W. Gardner et al. observed that self-awareness is linked to self-reflection. As authentic leaders are introspective they gain clarity and self-awareness regarding their core values, identity, emotions, motives, and goals.

The framework of an authentic leader is posited with the central thesis that such persons are actively and continuously modeling for followers high levels of self-awareness, balancing process, transparency, and authentic behavior. Such positive role models serve to further develop authentic followers both in words and in actions (W. Gardner et al., 2005, p. 347). When leaders and followers have clarity of values, respect, understanding of motives, and goals that are in alignment with the organization, the climate is inclusive, ethical, caring, and strength-based.

Authenticity, transparency, values, ethics, caring, and trustworthiness are absolutely critical to today’s work environment. Warren Buffett, the Chairman of Berkshire Hathaway, sent a memo to his CEO’s in 2005 noting:

They could lose money, even lots of it, but they cannot afford to lose their reputation for honest and high ethical behavior, not a shred of it! It took Berkshire Hathaway 37 years to reach a third place ranking in terms of the most admired companies in the world, and that an inauthentic action on the part of leaders at Berkshire could result in a catastrophic loss of reputation in less than 37 minutes! (as cited in W. Gardner et al., 2005, p. 368)

W. Gardner et al. (2005) note an important hurdle for practicing authentic leadership: the authentic leader develops a great deal of trust with those who follow. They see it as imperative, then, that authentic leaders remain transparent and fair, so that all stakeholders receive equal care. W. Gardner et al. continue by observing that the leader’s intentions must be grounded in

altruism and ethical judgment so that all followers and the organizational performance are held in check.

Several important ways to prevent authentic leadership from becoming self-serving will ground this leadership model with ethics, servant, or spiritual leadership. These three leadership modalities each ground the authentic leader in a higher purpose, a greater vision, and a larger value than one's own personal gain. As Bennis (2003) observed, "At the highest stage of moral development persons are guided by near universal ethical principles of justice such as equal human rights and respect for human dignity" (p. 42). The authentic, spiritual, or servant leaders who ground themselves here are safely within the boundaries of a higher purpose and a greater vision.

How does the authentic leader deal with a situation of adversity or vulnerability? Ladkin and Taylor (2010) suggested that the quality of relating and being in "the here and now" is crucial to the authentic leader (p. 71). This quality suggests that the leader can authentically share with colleagues or followers what their present feelings may be as well as keeping in mind a "magic 'what-if'" (p. 71). This allows the leader to think outside the bounds of the moment's vulnerability and seek solutions to the adversity without developing a victim's mentality. It allows creativity to flourish rather than a time of paralysis or frozen thinking. The authentic leader is not a victim but an advocate for positive resolutions and creative thinking. This may not be comfortable for the leader but it is a creative way of being dynamic and growing.

Clapp-Smith et al. (2009) note that followers perceive the goals and directions of the organization when leaders are transparent, demonstrate this "balanced processing," have an internal moral compass and are able to use the positive psychology with its multi-layered construct. Followers catch the vision, the passion, and perceive the motivation that is exemplified

by the authentic leader. “Group members engaging in interactions with each other reinforce sentiments about leaders, which leads to perceptions that are shared and are interdependent with the individual perceptions of authentic leadership” (p. 230).

### **Emotional Intelligence**

The characteristics of emotional intelligence, defined by Goleman (1995), have significant implications for the nurse leader. At its origins, Goleman defined emotional intelligence as a set of characteristics that include being able to motivate oneself and persist during difficulties; to control impulses and to be able to delay gratification. He also included the ability to modulate one’s mood and to be able to think clearly even in distressing circumstances. Finally, Goleman names the characteristics of empathy and hope as keys to the emotional intelligent portrait (Goleman, 1995).

Other researchers have expanded their understandings of how emotional intelligence has grown in its value and definition for nursing leadership. Eason (2009) notes three qualities that define EI. They are the ability to control one’s impulses and also delay gratification. Secondly, the ability to regulate one’s mood, maintaining motivation in the midst of frustrating circumstances. Finally, the third quality of emotional intelligence is showing empathy.

A literature review of emotional intelligence of nurse leadership presented in research by Akerjordet and Severinsson (2008) broadens emotional intelligence to include eight characteristics of importance. They review articles published between 1997 and 2007 addressing emotional intelligence and nurse leadership. This literature review offers eight competencies that emerged along with four responsive leadership styles. Empathy was the hallmark of leaders who could transform followers and reach for common goals and the common good of the organization (Akerjordet & Severinsson, 2008).

The eight competencies identified in the the research by these scholars are: developing others, teamwork, collaboration, organizational awareness, building bonds, visionary leadership, respect, and open communication (Akerjordet & Severinsson, 2008; Kowalski & Yoder, 2004). With these competencies empathy is predicted as one of the most well documented core values that strengthens nurse leadership.

Due to the nature of hospice nursing and nursing leadership, for the purposes of this study emotional intelligence will be defined with the following characteristics. These include: empathy, the ability to develop others, teamwork and collaboration, organizational awareness, building bonds, visionary leadership, respect and open communication. This is a compilation of Goleman (1995) and other research reviewed for discerning a precise and applicable definition of emotional intelligence to the hospice and palliative care nurse.

### **Resilience**

The foundational work defining resilience began in the 1970s with “a group of pioneering psychologists and psychiatrists (who) began to draw the attention of scientists to the phenomenon of resilience in children at risk for psychopathology and problems in development due to genetic or experiential circumstances” (Masten, 2001, p. 227). After two decades of studying deficits and assumptions of what is “wrong” in these children’s lives, Masten (2001), Buggie (1995), and others began to examine the extraordinary strength or inner resiliency of children. Masten titles her findings “ordinary magic,” which she goes on to define as, “good outcomes in spite of serious threats to adaptation or development” (p. 228).

Tugade, Fredrickson, and Barrett (2004) study psychological resilience and positive emotional granularity. They are concerned with the factors that resilience has on the health of adults. The factors listed by these authors linking positive emotions and health are humor,

positive emotional disclosure, psychological health and the “undoing effect” that positive emotions can have on stress. “This is called the *‘undoing hypothesis’*” (p. 1167). These authors define psychological resilience as “flexibility in response to changing situational demands and the ability to bounce back from negative emotional experiences” (p. 1168). This is a very cogent and succinct definition that fits well with the understanding of resilience for the population of hospice interdisciplinary team leaders.

Patterson, Collins, and Abbott (2004) discussed how teachers face adversity in the environment in which they are teaching. The main question in their article is not how to recruit vital and resilient teachers but how to retain them. This study has an interesting parallel to the hospice environment in which I work. The social workers on our team are often looking for resources such as food, clothing, money to pay rent, heating bills, and funeral bills. Our interdisciplinary teams have partnered with “The Pine Box,” a corporation that buries people with very minimal expenses. I observe that it is a tragedy when, at the end of life, there are no funds to bury a loved one.

The purpose of the Patterson et al. (2004) research project was to discover, through a three-cycle interview process, resilient teachers and teacher leaders who have remained in urban school settings for over three years. A comparison of the results of this project with hospice interdisciplinary teams is noteworthy. Several common themes for resilient teachers were discovered. These resonate well with resilient hospice and palliative care interdisciplinary team members.

Drinka and Clark (2000) referred to the professional who “listens with the inner ear” as the patient is communicating (p. 81), leading to their observation that

professionals learn to recognize and appreciate that each has a different voice—a perspective or way of—“being in the clinical world”—that is equally valued and

valid. Perhaps most importantly, it is the voice of the patient that is the most critical and that must increasingly be seen as the core essence guiding professional practice. (p. 80)

Here the interdisciplinary team professionals are as responsive and responsible to each other and even more so to the patients to provide unique, creative, and compassionate care that is tailored to each situation. In the same way, Patterson et al. (2004) find resilient teachers to be focused on the individual student doing whatever it takes to make them successful and working together as a team, mentoring each other, supporting colleagues, and finding new ways to teach so that the primary goal of reaching their students is attained.

Norman, Luthans, and Luthans (2005) wrote about the “contagion effect” of hopeful leaders on the resiliency of employees and organizations. For Norman et al., hope and resilience are the key findings of this study. They defined hope as individuals having the determination and motivation as well as a viable plan to accomplish the task at hand. They defined resilience as the ability to consistently adapt even in the face of risk or adversity and recognized that at a recent American Psychological Association national conference resiliency was given special attention, suggesting that psychologists should have a new set of three R’s to focus on: reasoning, resilience, and responsibility. These three R’s can help leaders adapt and conform to the ever-changing world of challenges that is set before them.

Adaptation is a cohesive theme between the resilience of those in trauma and the resilience of leaders and organization discussed by Pulley (1997). Pulley defined resilience as being “associated with elasticity, buoyancy and adaptation. It is also associated with a strong life energy” (p. 2). She noted that “A lack of resilience manifests as paralysis, depression, defensiveness, and cynicism” (p. 2). Defining both what resilience is and what it is not helps to

clear the ambiguity of the definition and is particularly applicable for those in healthcare, hospice, and palliative care.

Pulley (1997) uses seven characteristics to define resilience in both individuals and organizations. These seven equate well to the hospice interdisciplinary team leader as well as to the hospice organization. The first and probably one of the most important characteristics of both the resilient individual and organization is being a continuous learner. Hospice and palliative medicine is always changing as are the needs, concerns, and conditions of the patients in this discipline. Continuous learning is essential for those who lead as well as for the organizations themselves (Gittel, 2009).

The second through fifth characteristics listed by Pulley are related to the individual. These include self-efficacy and self-reliance; reaching for a sense of meaning in your work and life; feeling secure in personal identity (recognizing the difference between “who I am” and “what I do”); and nurturing both personal and professional networks of support. These characteristics strengthen resilience and personal character for the leader and for the team members.

Characteristics six and seven relate to individual and organizational resilience. Pulley (1997) names the sixth characteristic “shapeshifting.” This means having the ability to find new ways of doing things. It means applying skills or improvising. The seventh characteristic is financial. How do individuals or organizations relate to money? Is identity or success defined by money alone? Or are there other internal values that allow either individuals or organizations to take risks or have the freedom to try something new because the financial bottom line is not the only motivating factor?

Pulley (1997) then applies these seven characteristics in a like way to organizations. One of the creative models she uses is the god Proteus from Homer's *Odyssey*. Pulley explained that "(Proteus) has the ability to change himself into different forms—animals, trees, even elements such as fire" (p. 2). In Greek mythology this ability to be shapeshifting is equated with wisdom. Proteus can be viewed as a model for the 21st century professional who can adapt according to the needs and circumstances (Pulley, 1997).

A study by Friberg, Barlaug, Martinussen, Rosenvinge, and Hjemdal (2005) examined resilience in relation to personality and observed: "For centuries, writers have been inspired by the extraordinary capacity some people show in combating adversity or misery. In psychology, however, the study of unexpected positive outcomes today is referred to as resilience" (p. 29). This study utilizes the Resilience Scale for Adults (RSA) and the Norwegian military version of the 5PF (measuring personality traits also known as "The Big Five."). These big five include: extroversion, agreeableness, conscientiousness, emotional stability, and openness.

Positively, Friberg et al. (2005) found that both the RSA scale and "Big Five" and social intelligence positively correlate with resilience. A negative correlation to this study that is equally important is the correlation between emotional stability and the resilience factor known as personal strength. If personal strength and emotional stability were low, anxiety and rumination were found to be problematic. This study indicates that strengths in emotional stability, extroversion, a positive perception of self (from the RSA), conscientiousness, RSA-perception of the future, and stress-tolerance were among the key components of resilient personalities. RSA-social competence was positively correlated with the Big-Five extroversion and agreeableness. All of these factors played positive roles in resilience. This supports Masten's (2001) theory that resilience is "ordinary magic."

## **Healthcare, Hospice Leaders, and Resilience**

In the hospice organization where I work we are being asked to work in flexible and adapting ways. Each week an email is sent asking the entire hospice staff to remain open to possibilities. For example, if you are an RN and are asked to complete a psychosocial assessment, our executive director encourages cooperation. Or, if you are a social worker and you are partnered with an RN to cover a difficult situation where a patient has “bled-out,” then you grab towels and gloves and go to the patient’s home. Our corporate “down-sizing” has required those of us who are left to be more like Proteus—changing into different forms as needed. It is all about being resilient, productive, adapting, and living out the mission of Mount Carmel Health Systems while the economy is under great stress.

Another example of how the Mount Carmel leadership team is resilient is evident in how they handle situations in which a complaint is filed. We work with the understanding of “service recovery.” Service recovery means first of all that there has been a significant error or a terrible mistake. For example, if a restless patient falls out of bed and dies many actions are put into place to comfort and support the surviving family. This is when service recovery begins. A nurse is immediately dispatched to the home. The on-call operator also offers a social worker or chaplain to come to the home. A supervisor is notified. This supervisor is often also an interdisciplinary team leader. The entire team begins by listening. Listening may be the most important point of this process. At times the physician is called in as well. He/she can also listen. Beyond listening the physician or team leader can explain what they believe was happening physically with the patient at the moment of death or at the moment of the fall. These are moments of taking on the pain of the family, hearing their deep sadness, disappointment, anger, and fear. We do not want to cut short their process of letting out their rage, their lack of trust or

their deep, deep grief. This process may take hours, days, weeks, or months. It often takes bereavement counseling months after the death. There may be residual trauma for those who witnessed their loved one fall out of bed and die. This too is addressed with counseling, listening, and encouraging the family (if there is family) to support one another through this difficult time. It is only after this has occurred that the family may be at a place that resilience is possible. The team members draw on many qualities to address this type of crisis situation.

Wright (2002) examining the qualities of 12 hospice nurses (10 registered nurses and two LPN's) who worked in the field from seven to 10 years at a hospice agency in the Pacific Northwest found 12 qualities that exemplify the role of the hospice nurse. These include the following:

(i) being humanly present, (ii) independent, (iii) compassionate, (iv) entrepreneurial, (v) having appropriate technological knowledge, (vi) being spiritual, (vii) confident, (viii) a team player, (ix) having a sense of calling, (x) being humble, (xi) being intuitive, and, finally, (xii) have a sense of humor. (p. 215)

If we compare these 12 qualities exemplifying the role of the hospice nurse and apply them to the role of the hospice leader and members of the hospice interdisciplinary team several parallels can be drawn.

One parallel is Greenleaf's (1977) embodiment of servant leadership in which he notes that the servant leader is servant first. For the registered nurse, licensed practical nurse, or aide who bathes the body of the recently deceased patient, the embodiment of "servant first" is clear. It is an example of a spiritual, servant leadership meeting. It is a quiet, humble, and sacred experience when the hospice team members walk with the family through the very first, intimate stage of mourning. There is not a more humble, servant-like moment than when the hospice worker is sitting with the grieving family member in these first few moments post-death. Integrity, honesty, humility, and a deep respect for humanity are the guiding principles of these

first, quiet moments as loved ones learn that their family member has breathed their last breath. No one should be hurried. No one should be distracted. Authenticity, the valuing of human life and the capacity to be physically, mentally, emotionally, socially, and spiritually present is required. The highest ethical and moral codes are to be at work. When these are missing it is not only glaringly obvious but the pain is extraordinarily difficult for the family member who is faced with a breach of confidence, a lack of care, or a moment of insensitivity. For this family, the emotional damage can be unimaginable.

Another comparison is possible using Fry's (2003) ethical leadership principle of fun, and integrating it with Wright's quality of "a sense of humor." This also illustrates the healing community of Greenleaf's (1977) servant leadership model. There are so many wonderful examples of celebrating birthdays, planning weddings, and organizing "dream trips" for patients who are aware that their days are limited, but for whom their desire for joy is not limited.

On a national holiday in 2010, a centenarian at a hospice in the Midwest held her 54th consecutive cookout for her family. The hospice team helped her with her shopping list, the purchase of supplies, the decorating, and the set-up. The interdisciplinary team report noted that the party was a great success. It was also noted in the team meeting that three days later this lovely patient died knowing that her party had been just the joy for which she hoped. Fun, humor, and making dreams come true within community is a part of living the quality life hospice teams are uniquely suited to provide patients and their families. This takes great compassion, being authentically present within both the hospice community and the community of the patient and family.

Hospice leaders integrate the essential depth of servant, authentic, and spiritual leadership models. Although there is not complete overlap the themes of each of these models are integral

to Wright's (2002) understanding of the effective hospice nurse. It is my observation that one could extrapolate to say that these traits are also present in the effective hospice leader and interdisciplinary team member.

Another critical aspect for the overall resilience of the hospice team is the organizational promotion of wellness and health among staff members. Employee assistance programs, education, risk appraisal and intervention, and fitness (Sperry, 1984) are several areas considered critical for employee retention, productivity, and morale. Sperry also examines lighting, air quality, noise, office design, and nutrition as factors contributing to employee wellness. He asserted that wellness programs affect the wholeness of the person, their job performance, and their home life.

Parks and Steelman (2008) conducted a meta-analysis study of organizational wellness programs. This study concluded that participation in the wellness programs was associated with higher job satisfaction. This may be because having a wellness program indicates to employees that the employer cares about them. Secondly, employees who value health and fitness are more likely to choose a company that emphasizes well-being and fitness. Third, when organizations offer fitness programs, they encourage their employees to reduce stress and to have an overall sense of well-being. This encourages wellness and resilience for individuals within the organization.

Verhaeghe, Vlerick, Gemmel, Van Maele, and De Backer (2006) studied nurses and the impact of recurrent changes in the work environment on their psychological well-being and sickness absence. This study revealed that nurses confronted with changes in the work environment over the past six months were more likely to experience distress. Changes threatened job satisfaction, raised distress, and raised absenteeism by both frequency and

duration. The nurse's ever-changing work environment has a negative impact on job stress. Further studies would be helpful to see how organizational wellness, employee assistance programs, or other organizationally driven programs could be helpful to this dilemma.

Carlson and Warne (2006) examined factors that encourage healthier nursing practice. These authors concluded that nurses are uniquely able to have a sense of "personal empowerment and a commitment to health promoting practices at organizational, professional and individual levels" (p. 511); however, many nurses are not able to do so because they believe that there are insurmountable barriers in their lives that prohibit them from having a commitment to health. These barriers include lack of education, economic status, and personal empowerment. Other contributing factors include shift work, high-risk decision-making, feelings of personal competence (or incompetence), and a need to close the practice-theory gap (Carlson & Warne, 2006). Working toward addressing these issues would lead to greater individual satisfaction and organizational well-being. These factors would also lead to fewer turnovers among staff and greater resilience among leaders and professionals in healthcare.

Professionals in hospice care also rely on organizational wellness. Models of leadership and resilience are critical to their abilities to greet ever-changing challenges. Servants, spiritual and authentic leadership, particularly as they are integrated in the hospice leadership model, begin to set the foundation for defining resilient leaders. From the honesty and care for people defined by Brown and Trevino (2006) in the ethics of leadership, to the compassion and sense of calling referred to by Wright (2002), hospice leaders require every ounce of compassion, care, humor, patience, altruism, and love that they can exude as they relate with co-workers, families in hospice, care, and the community.

My protocol for applying the three models of leadership that I have chosen along with resilience to the hospice setting is detailed in Table 2.3. This table visually depicts the definite correlations between the leadership models, the understanding of resilience defined in the literature review, and hospice leaders. It will be interesting to note how these themes are articulated through the interviews of participants in the study for this paper.

Table 2.3

*Attributes From Leadership Models, Resilience, and Hospice Leadership*

<b>SERVANT LEADERSHIP</b>	<b>SPIRITUAL LEADERSHIP</b>	<b>AUTHENTIC LEADERSHIP</b>	<b>RESILIENCE</b>	<b>EMOTIONAL INTELLIGENCE</b>	<b>HOSPICE LEADERS</b>
Listening	Listening/ honesty	Relational transparency	Transparency	Empathy	Being present
Ask the right questions	Integrity	Trust	Trust	Developing others	Independent/ confident
Servant first	Humility	Integrity	Continuous learner	Teamwork and collaboration	Compassionate
Empathetic	Empathy/ Compassion	High moral standards	High moral	Organizational order/ethics	Entrepreneurial awareness
Community	Appreciate others	Multidimensional construct	Ability of assessment	Building bonds	Technical knowledge
Healing love	Excellence	Higher order	Feeling secure in personal identity	Visionary leadership	Being spiritual
	Courage	Nurture self and others	Nurturing both personal and professional networks of support	Respect	Nurturing both personal and professional networks of support
	Forgiveness	Balanced	Good at processing	Open communication	A team player reality testing Resilience
	Patience/ Meeknes	Resilience, hope, optimism	Good ego boundaries		
	Fun	Self-efficacy	Self-efficacy		Self-efficacy
	Work as a calling	Self-regulation	Sense of humor		Sense of humor
		Self-monitoring	Reach for a sense of meaning in life and worl		Sense of calling
		Self-reflection	Safe haven of trust		Active listening
		Shape shifting	Change and adaptation		Shape shifting
		PsyCap	Being creative		Being creative
		Awareness of Self and others	Self-reliant		Self-reliant

*Note.* This is based on my own synthesis of Brown and Trevino (2006), Clapp-Smith et al. (2009), Fry (2003), W. Gardner et al. (2005), Goleman (1995), Greenleaf (1977), McCallin and Bamford (2007), Pulley (1997), Reave (2005), Vanderpol (2002), and Wright (2002),

My experience has been that hospice leaders reflect many of the characteristics found in Table 2.3. When they do not, they do not last in the work of hospice care.

### **Integrating Themes**

Table 2.3 illustrates the thematic compatibilities of resilience with emotional intelligence, authentic, spiritual, and servant leadership. It also denotes how hospice leaders integrate many of the characteristics that can be found in all six columns. Sparrowe (2005) built upon this concept discerning that one must be authentic to the self. He offered four features that are essential to the authentic self. These are self-awareness, an enduring nature of values, the role of self-regulation in facilitating transparency, and the relationship between the authentic and moral leader. These qualities are particularly cogent for the hospice leader.

Resilience and authentic leadership rise together. As one discovers purpose, understanding, and passion it is possible to also rise from the blows and/or the triumphs of life's day-to-day experiences. The key is that this authentic resilience must also be grounded in ethics or a moral code of conduct. This resilience that seeks the greater good and is leadership that reaches for a level of compassion, caring, and buoyancy for the team.

For hospice teams I learned that when functioning as supportive, authentic, and integrative teams, they are resilient. However, if they begin to splinter, back-bite, lose sight of the mission and purpose of hospice, or lose their personal balance, the teams start to disintegrate quickly. I was intrigued to hear how other hospice leaders perceive these observations as I interviewed them, and as they told their hospice narratives during my research.

As I move forward, I am applying the holistic definition of resilience that takes into account bouncing back through the acknowledgement that physical, mental, spiritual, emotional, and social integrity are critical to resilience. As Masten (2001) observed, resilience is “ordinary

magic,” attainable by all. Therefore, in application, my goal is to help hospice leaders and team members to be mindful of how to keep themselves resilient. It is my goal to intentionally address one’s physical, mental, emotional, spiritual, and social health (Harbaugh, 1985) so that resilience can be more readily accessible even in such a stressful work environment as the hospice setting.

I am also aware of the inherent vulnerabilities of leadership in hospice. It is possible to be the servant leader indicating that you give and give and give, yet never get “filled up again.” This is an observation that I made on numerous occasions. I heard this message particularly from registered nurses, social workers, and chaplains. They are also the “front line” of care for patients and their families. These professionals have cumulative grief that accrues with each patient that dies and with every family that mourns. Sometimes these losses are blessings such as the one hundred and three year old mentioned earlier in this paper. Sometimes losses are bitter, like the 21-year-old young man who died recently after a life-long battle with a rare genetic form of cancer.

Many tears are shed in our interdisciplinary teams. I have learned that these tears are tears of joy, sorrow, frustration, anger, fear, hope and hopelessness. Keeping these teams resilient, mission focused, and supportive of one another is the task of gifted, committed, grounded, servant, spiritual and authentically integrated leaders. I have watched new team members last less than one day and other team members spend their careers in hospice care. It is without a doubt work that calls forth an introspective servant who is ready to share with colleagues and families much more than eight hours a day.

Developing resilient teams begins with leaders who share the vision of hospice care with passion, authenticity, a willingness to serve, honesty and humility that acknowledges the precious and precarious nature of care at the end of life. These leaders are also gifted with a

sense of humor, clear moral grounding, and humility. If a patient “bleeds out” leaders need to be as willing to go with dark towels to that home for clean-up as are the nursing aides. One does what one has to do for the family, for the patient, and for the team. Clearly, that situation is not the “norm” but it is a possibility and it is confirmation that we are a team that works together, shares the same vision, and graciously cares for families first.

This vision of resilient team members who are willing to be servant leaders, fed spiritually by discovering over and over again ways to feed their minds, bodies and spirits so that they can be about this work of leading people from life into death is the definition of resilience that I heard in interviews with hospice leaders. The people who work in these positions do so because of passion and compassion. They do so because of a commitment to the hospice movement. They do so because somewhere in their life journey they learned or had the seeds of resilience planted in their souls. The goal of my inquiry was to hear their stories and to discover the threads of continuity within their resilience.

This review leads precisely to my research questions. I asked hospice interdisciplinary team leaders to share how they view themselves as leaders. I asked them about their own leadership understandings and definitions. They were asked to define resilience for themselves, their teams, and the organization with which they work. I also asked them to define ethical resilience and to note if this phrase works within themselves as leaders and within their organization as they perceive it.

In addition, I asked the participants what is missing for them. What could better serve them whether it is on the individual level, the team level, or the organizational level? How could their callings be better supported? How could ethical resilience be more formally sustained in their vocational lives? How could resilience and leadership be created and sustained more fully

in the lives of their team members? Do they see themselves as integral to creating and sustaining this leadership and resilient environment?

Finally, where are the gaps in the literature? Resilience is well defined in many venues, yet it is a very new discussion for end of life care. Financial stresses, the changing face of healthcare in the United States, the aging population in the United States, healthcare delivery, and many other issues such as end of life care and limited resources have not begun to be adequately addressed (Labaton, 2011). Academic research is beginning to embrace the implementations of creating and sustaining the organizational environment of healthcare and resilient leaders that can best serve the complex realities of the 21st century. Research by Drinka and Clark (2000), Monroe and Oliviere (2007), and Gittell (2009) represent the beginnings of building this body of literature. It is my hope to add to this body of literature with my study, focusing particularly on hospice interdisciplinary team leaders as they relate to the models of leadership set forth in this dissertation. This key position within end of life care sets the tone for many who work within hospice and palliative care. The hospice interdisciplinary team leader is pivotal to the team's communication, creativity, performance, and resilience.

## Methodology

Narrative inquiry is the research method chosen for this study. My life's work has been about meaning and the goals of narrative inquiry are a perfect fit for me. Polkinghorne (1988) stated that, "The study of human beings by the human sciences needs to focus on the realm of meaning in general, and on the narrative in particular" (p. 11). Riessman and Quinney (2005) state the goals of narrative inquiry most clearly when they ask the question: "What distinguishes narrative from other forms of discourse? The answer is *sequence* and *consequence*: events are selected, organized, connected and evaluated as meaningful for a particular audience" (p. 394). As I interview hospice interdisciplinary team leaders and hear their narratives, I learned how they find meaning, purpose, hope, and resilience in their life's work. The sequence and consequence of events reported, as well as the "how" and "why" events are storied, were a part of my analysis (Riessman, 1993).

With narrative inquiry as my research foundation, phenomenology was the lens of my research. The interview process that I used is based on a modified version of Seidman's (2006) *Interviewing as Qualitative Research*. These two methods complement one another as they both ultimately search for meaning through paths of human encounter. This chapter will briefly explore the history and application of narrative inquiry and briefly touch on the roots of phenomenology.

### Situating My Epistemological Stance

My views on epistemology and ontology are critical assumptions that affect my use of narrative inquiry. My epistemological stance posits that the relationship between the researcher and the participants is co-constructed, interactive, and co-interpreted. The dialogic discourse encourages dialogue between past and future conversations allowing for depth of utterance

across space and time (Hollingsworth & Dybdahl, 2007). The interactions of the discourse between those within the narrative (both the ones interviewed and the one interviewing) are important as I progressed within the narrative inquiry. This interaction built trust, found points of common ground, and also found moments of discord. As Conrad and Schober (1999) clarified, I am not seeking precise wording in each question, but rather “meaning” (p. 1). Both the participants and I embarked on this narrative conversation seeking depth, understanding and mutual respect. The participants and I were to be a part of the process of meaning making.

### **Historical Background and Description of Narrative Inquiry**

For a historical examination of narrative inquiry and phenomenology, both of these research methods find their roots in Husserl (1977). The concept of phenomenology described as opening up the world through the data of lived experience, and interviewing that is described as pure, comes from Husserl. He describes an observable, astonishing ability to discover the conscious self with its many complexities if one will only move within pure experience and data collection from pure interviewing. From this phenomenological understanding, meaning making is essential to the sciences, and also essential to narrative inquiry. More specifically, in my research, as patients are facing life’s end, the hospice leaders are working to make this a meaningful time at the end of life. This assertion aligns with Polkinghorne’s (1988) idea that “Narrative is a form of ‘meaning making.’” (p. 36). This meaning making comes as people tell their stories. Both the participants and the researcher were part of this process as stories were shared, relationships were changed and themes, common ground, discord, understanding, and many other nuances of narratives were uncovered.

Affirming the place of meaning making with phenomenological inquiry, Nagy et al. (2006) convey that phenomenology was a critique of positivism and its assumption that there is

an objective reality as a basis of human inquiry. Phenomenology views human experience or consciousness as a basis for understanding social functioning. The phenomenological researcher asks questions such as: How do persons experience the Holocaust (Frankl, 1959)? How do people experience meaning (May, 1983)? How do people experience death and dying (Rando, 1988)?

In referencing the use of narrative as means of inquiry, Mandelbaum (2003) noted: “We more aptly capture the character of human life when we characterize ourselves as proceeding according to the ‘narrative’ paradigm. That is, we understand, come to know, and formulate our lives and actions as stories” (p. 595). It was my goal to hear the stories of the hospice interdisciplinary leaders, to learn their histories, to listen to the details of their experiences and to hear how meaning has informed their life’s work as they create and sustain resilience within their hospice interdisciplinary teams. This was an exciting encounter of narratives unfolding within human relationships in a compelling setting.

Mandelbaum (2003) offers another way to examine narratives that was helpful as I sorted through the narratives of the hospice leaders. She discusses form and function, “grand narratives,” the “narrative turn,” and finally defines exactly what a narrative is as she raises these questions:

1. Do narratives have generic, abstract (or abstractable) structure? How do they achieve their structured character?
2. What is the relationship between a narrative and the “reality” it recapitulates?
3. For what purpose are narratives told? (p. 599)

Mandelbaum (2003) examines three ways that narrative skill can be used. These include the cognitive view, the literary view, and the communication view. She also referenced Labov and Waletzky’s (1967) form of examining the abstract, orientation, evaluation, complicating

event, resolution and coda; as well as Sacks' (1974, 1978, 1992) "ordinary conversation," unfolding one unit at a time (Mandelbaum, 2003, p. 611).

Mandelbaum (2003) offered many nuances to narrative skill showing the plethora of uses for narratives in research, and across the lines of disciplines. From law to medicine to psychology to social constructions, narratives have a powerful place for communicating perspectives. Mandelbaum made the case convincingly that narratives are interactive, co-constructive by the teller and the recipient(s), and offer a broad range of activities in multiple disciplines.

Working from the philosophical perspective of Buber (1958) that "all life is encounter" (p. 62), it is my personal belief and practice to encounter individuals one-on-one as the beginning of narrative inquiry. Passion, engaging stories, life-changing events, insightful epiphanies, and moments define and redefine relationships through these narrative experiences. As Clandinin and Connelly (2000) noted: "Narrative inquiry is a way of understanding of experience" (p. 20). The researcher and the participants were in dialogue with one another. The inquiry allows for a telling and retelling of stories and experiences that make up people's lives. These stories represent both the individual and the social experience. The researcher, by hearing and experiencing these stories, entered the midst of the narrative and was able to experience the stories with the participant.

While discovering and having access to these narratives, I used the lens of constructivism. Gray and Smith (2009) asserted that: "Constructivism is not a new idea; its roots can be located in the developmental theories of Piaget (1972), Dewey (1910/1997), Bruner (1986), and Vygotsky (1987)" (p. 156). Constructivism encourages individuals to make sense of their experiences by constructing and reconstructing their own realities. New information is

filtered through a person's existing experiences and mental structures. This allows them to integrate knowledge, fears, prejudices, misconceptions, beliefs, and preconceptions that they may already hold.

One of the main reasons for choosing constructivism as my paradigm was because I have congruence with active listening, open-ended questions, and building trust of the person-to-person context that will be utilized to elicit stories. To define the interpretive/constructivist paradigm, I rely on the definition of Schwandt (1994). He notes that the researcher should attempt to understand the world of the lived experience from the vantage point of those living it. This means that the mind of a constructivist is actively constructing knowledge. It also means being mindful of the social construction and the context of those who are constructing knowledge.

First of all, I used a non-directive stance for listening (Rogers, 1980) and the style of my interviews was conversational. A non-directive stance means that the interviewer takes an unobtrusive role with the participant. Furthermore, this means that I did not interject my opinions, definitions, insights, or knowledge as interviews were occurring. Although we were co-learners in these conversations, my goal was to hear the narratives of the participants on their terms not interjecting my experience with theirs.

I chose a conversational style of interviewing to allow an informal atmosphere for each interview. Although I had a list of questions (see Appendix B) and in each case completed every question, I kept the tone and the energy of each interview open for personal reflections, storytelling, and musings that strayed from the questions. This allowed participants to share much more than answers to the 13 structured questions that I asked.

Secondly, as a way of allowing the stories to be shared, I followed this constructivist model of interviewing shared by Hollingsworth and Dybdahl (2007). These authors utilize the structure set forth in Table 3.1. This model allows the interviewer to build rapport, sustain a professional cohesion, and learn the narratives of those whom I interviewed.

Table 3.1

*Structure of Constructivist Interviewing*

Motivating information sharing by emphasizing professional significance of participation of each participant

Sharing professional stories

Defining the researcher as a person with similar interests

Ensuring confidentiality

Negotiating meaning with spontaneous questions

Supplying linking statements to clarify meanings

Making supportive comments to continue the flow of thought

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*Note.* This summary is based on my reading of Hollingsworth and Dybdahl (2007, pp. 154-156).

Also included in this constructivist model is a structured global whole-text analysis approach. The analysis examines each narrative as a complete text as well as searching for particular words or themes that are globally common among the eight participants. This is consistent with a constructivist view that includes a multilayered reality allowing the possibility of themes or “universal statements” that could enrich the data (Van Manen, 1998, p. 107). Themes or universal statements, as noted by Van Manen, are cited in the fifth chapter, the analysis of the data. I looked for word analysis, seeking global interpretations of words, syntax, semantics, and grammar (Hollingsworth & Dybdahl, 2007).

Utilizing narrative inquiry as my foundation and carefully constructed questions as my entry point, I asked participants to tell their stories. Each participant had one 90-minute interview. It is noteworthy that some interviews lasted one hour, due to circumstances such as the participants being paged for a death during the interview. The circumstance of needing further clarification did not occur. These interviews are more fully discussed during the research design section of this chapter.

### **Methodological Framework**

As noted above, narrative inquiry is far more than just telling stories. Connelly and Clandinin (2006) offered the following succinct definition: “Narrative inquiry come(s) out of a view of human experience in which humans, individually and socially, lead storied lives” (p. 477). It is these stories that I captured through a variation of the phenomenological interview process of Seidman (2006). This process provided the methodological framework for this study.

The sample size of this study was determined as I gathered data reaching a point of theoretical saturation. Nagy et al. (2006) described this as a time when the researcher is finding the same results time after time from the individuals they are interviewing. My goal was not a large generalizable population, but rather discovering the gems of knowledge and the depth of understanding found in the intimacy of personal narratives. After reading many other dissertations utilizing narrative inquiry as the methodology, these suggest a sample size between eight and 12 participants. My sample size was eight participants.

### **Research Protocols and Design**

Ablett and Jones (2007) found that healthcare workers in cancer care, palliative care, and hospice “experience higher levels of psychiatric morbidity than the general working population” (p. 733). Conflict among team members, limited resources, and patient and family dynamics are

just a few of the stressors that greet interdisciplinary team members every day. The design of this study was to ask interdisciplinary team leaders in various ways about the levels of resilience that they create and sustain with their teams. It was my hypothesis that within the team and within the organizational structure there are intentional ways that team leaders create and sustain resilience in their teams.

My sample was hospice interdisciplinary team leaders from eight Ohio and Michigan hospices. I gathered my sample through purposeful sampling (Mertens, 1998). A consultation with Lori Yosick, the Executive Director of Mount Carmel Hospice and Palliative Care, led to 12 initial contacts for the sample. Of those 12 initial contacts, eight agreed to be interviewed. All of the hospice interdisciplinary team leaders interviewed were registered nurses in hospice care leadership positions. In every case these RN's were case managers for their teams making up an RN, a chaplain, a social worker, and aids who care for normally 10 to 15 families. They have served in their current position for a minimum of two years. There are two exceptions to this generality. One is a very small rural hospice and the other is a pediatric hospice. These each have much smaller patient censuses. Each hospice used is a member of the National Hospice and Palliative Care Organization.

The structure of this study was based on a variation of the phenomenological interviewing process of Seidman (2006). The interviews have the goal of understanding lived experience. The goal was to deeply and thoughtfully explore the interviews for meaning within the context in which these leaders serve.

Each participant agreed to one interview. This was explained initially so that any participant who does not wish to set aside a 90-minute time period could opt out of this process. Also at any point within the process, each participant was told that they could opt out at any

time. An independent counselor was offered if a participant feels that would be helpful to them; however, no one asked for or needed this offering before, during or after the interviews.

The interviews each lasted from 60 to 90 minutes. Every interview was filled with a variety of emotions. I took brief notes during the interviews and every interview was recorded. Before I left each hospice I wrote field notes about the site, observations about the organizations' appearance, hospitality and the overall sense of well-being that I felt in the building. I also wrote my own impressions of the interview and answered the question: Is this an organization for which I would want to work?

The interviews allowed the participants to tell their stories in intentional ways. Each interview focused on the leader, how they became a leader, and how leadership has been meaningful to them. Each focused on how the leader has grown, what the leader has experienced, and how resilience has informed their leadership with their interdisciplinary teams. I also asked specifically about ethical leadership and if resilience is something that this particular participant feels is a part of their leadership.

The reason I sought this investigation in leadership and change among hospice interdisciplinary team leaders, began with my own sense that the pressures of hospice leaders are not addressed by effective, resilient options for change, support, creativity and sustenance. Research by Graham and Ramirez (2002) supports this hypothesis that a paradigm shift in this inherently stressful work is imperative. The narratives of the eight participants in this study serve to tell this story of leadership and the call for change with honesty and hope.

The goal of this study is not a generalizable contribution. It is instead transferable data for similar situations in healthcare where interdisciplinary teams seek resilient leaders. The eight nurses in this study offer a narrative window into the stressful workplaces of healthcare workers.

They elucidate the coping, the shared leadership skills and the divergent gifts, abilities and leadership traits of hospice nurses in a variety of settings.

**Question construction.** Seidman (2006) begins with sound advice for narrative question construction. He notes “Listening is the most important skill in interviewing” (p. 78). It was first and foremost my goal to listen, to be careful not to interrupt and to allow the appropriate space and time for participants to comfortably tell their stories.

The goal of the questions I chose was to draw out the narrative of leaders. Thematic narrative tradition informed my research design and the questions I formulated. I utilized the metaphor offered by Janesick (2007) that the researcher is the choreographer of the dance. The research questions provided the framework for the dance. One 90-minute interview is a dance of analysis and interpretation (Janesick, 2007), a cooperative structure between the researcher and the participant.

I modified Seidman’s (2006) three-interview life history model to a single 90-minute interview model. My rationale for such a choice is two-fold. First of all, I believe that I would receive more people willing to commit to one 90-minute interview than would commit to three such interviews. I verified this on February 1, 2012, with a small informal, verbal sample of five Interdisciplinary Team Leaders at Mount Carmel Hospice, all of whom agreed that three interviews would be impossible given their time limitations. These team leaders were simply asked the question, “If given the opportunity, would you participate in a study that included three 90-minute interviews for dissertation research?” The second question they were asked was, “If given the opportunity, would you participant in a dissertation research study that included one 90-minute interview?” Finally, I believed that in honing the questions to the essence of the data

for which I was searching, the process was time well spent for the participants and the researcher. The wording of each question was intentional.

**Data collection and field notes.** I collected data in two ways. I had an audio recorder and a back-up audio recorder in case the first failed. My initial audio recorder was a new recorder that worked well. My back-up recorder did not work as efficiently. I lost one interview due to equipment failure and operator failure. As I was recording the last interview, it did not record. This would have been interview number nine. Once I typed the eight interviews, I realized that there was not a need to redo the ninth interview because I had reached saturation.

In addition, I took field notes during each interview. My field notes were helpful during the summaries of each interview. The tone, atmosphere and feeling of place were recorded in the field notes to be utilized in the participant summaries.

Originally my plan was to hire a professional transcriptionist to transcribe the audio-tapes; however, the audio recorder that I purchased had software that allowed me to put the interviews directly into my computer. I typed each interview and doing so allowed me to be much more familiar with each interview as I looked back at the data. I noted that fully formed words, pauses, and sounds that were not understandable be recorded on the transcript. All of these have meaning to the text (Ochs, 1979). In my field notes, I also recorded gestures or other movements that informed the transcriptions. Once the data from a recording was transcribed, it was emailed to the interviewee to be validated before the information is used for my analysis. This is called member checking (Creswell & Miller, 2000). This process allowed the participants the right to change their transcriptions prior to my using these transcriptions for research purposes. Emailing the transcriptions as encrypted messages saved their confidentiality and expedited the process. There were minor changes made to two of the interviews. Once I

incorporated those changes I had the two participants approve the revisions and began the process of coding and interpreting the results.

**Location of interviews.** I offered a variety of settings for the interviews. My intention was to make the location as comfortable and convenient as possible for participants. Every interview took place at the workplace of the participants. This allowed each person to stay on the clock and on-call while we interviewed. We made appointments by phone; I confirmed them by email and went to each workplace. I logged over 1,500 miles in miles driven to sites for interviewing participants for this study.

**Storage of data.** This data is stored in a locked filing cabinet in my home office. I used alpha-numeric coding, for example, A-1 for the first person I interviewed. This coding system was stored in a separate locked filing cabinet in my home office. Once this dissertation is completed, all recordings and transcriptions will be kept in my locked filing cabinet indefinitely. All participants are aware of these procedures. Each participant will have the last word on her data. As Josselson (2007) notes, “the participants must be accorded the human right to bestow or withdraw the use of their material” (p. 544). This option was given to each participant all along the way of the research inquiry.

**Data analysis.** The narrative purpose of my inquiry is to tell the story of how hospice leaders deepen and deal with resilience creatively in their leadership and staffing. By hearing life stories, by interviewing those who work in the trenches of hospices as their life calling, it was my goal to glean the themes, words, nuances of language and emotion, and discordant examples that exist within the lives of hospice leaders.

I analyzed the data I collected utilizing, but not limited to, thematic and structural analysis, as defined by Riessman (2008). I hand coded each interview once the corrected

transcription was approved and returned to me by each participant. I also used a peer de-briefer to code, thereby adding to the validity of the study. This enriched the conclusions and interpretations of the information discussed. The peer de-briefer and I coded for recurring vocabulary, coherence, and themes. The peer de-briefer is an Antioch PhD in Leadership and Change Cohort five member. We each reviewed and coded all manuscripts. We looked for discordant vocabulary, incoherence, and themes that contradict one another; however, to stay true to the narrative methodology, all coding and analysis was in the context of the complete narrative. Once both the peer de-briefer and I completed all coding, we shared our reflections before I began to write final observations. As Riessman (2008) noted, “There is debate among grounded theorists about the significance of ‘fracturing data,’ but narrative analysts do strive to preserve sequence and the wealth of detail contained in long sequences” (p. 74).

### **Coding**

Coding the data from each interview was a process. Bakeman (2000) underscores the importance of continually clarifying the coding process including behaviors, questions, and codes. As I interviewed participants, my field notes included observations regarding behaviors such as sighs, legs shaking, changes in posture and position, or changes in voice tone. These observations were coded as units of behavioral observation (B).

I used another set of codes for themes. Themes were coded as (T) theme observations. An example of a theme was the nature of spirituality referred to by several of the participants. Although the expression of spirituality was different with each, the theme of spirituality arose in several of the interviews.

Bakeman (2000) also suggests coding questions. I coded questions as (Q). One of the persistent questions throughout the interviews had to do with meaning making. Again,

participants chose different phrases and different ways of expression, but several participants brought up the question of meaning making within their narratives.

Mandelbaum (2003) uses the phrase, “dynamic and interactively constructed in communication” (p. 595) to describe her perspective on the narrative as skillful communication. In fact, each of the interviews in this dissertation consisted of dynamic, interactive communication between a participant and researcher who search to know the depth of resilience in a work that is challenging, rewarding, life-changing, and calls for resilience in every day functioning.

There were eight participants in my study. Whereas the results were not generalizable beyond this population, nevertheless this population has input both for further research and for those who are currently in the field of hospice leadership. This small population yielded rich and dense data that is replicable. The validity of the inquiry is as valid as the truth of the narratives shared and information duplicated. As Geertz (1995) stated: “It is necessary, then, to be satisfied with swirls, confluxions and inconstant connections, clouds collecting, clouds dispersing. . . . What we can construct are hindsight accounts of the connectedness of things” (p. 190).

Following this analysis of each narrative, I also sought to find what Mandelbaum (2003) calls a “grand narrative.” Individually, each narrative stands on its own, but my goal was to find the common themes, to listen for the grand purpose, to find the greater good that is embedded in these narratives. I have profound respect for those who have dedicated their lives to this work of hospice leadership, and I sense that their combined wisdom is for the greater good of authentic leaders in hospice and potentially beyond the institutions that serve dying patients and their families.

## **Ethical Considerations**

The primary ethical code to which I am required to subscribe is the code of my license as a Licensed Professional Clinical Counselor. The Ohio State Board of Licensed Professional Clinical Social Workers and Marriage and Family Counselors issues the counseling license that I hold. My license is renewed every two years. The highest mandate of this licensing board is to do no harm. Secondly, I am aware of the ethics of Antioch University and the PhD Program in Leadership and Change. The IRB was properly submitted and accepted prior to any interviews with participants, and, as was stated earlier, participants were volunteers who could opt out of this study at any time in the process. As Atkinson (2007) pointed out:

We are asking real people to tell us their personal stories and taking their story to a larger audience. We, therefore, have to ask ourselves and be able to answer satisfactorily several questions, starting with, What is ethically prudent of us to make this exchange both mutually beneficial to our interviewee and to our research agenda? (p. 239)

**Confidentiality.** Mertens (1998) noted, “*Confidentiality* means that the privacy of individuals will be protected in that the data they provide will be handled and reported in such a way that it cannot be associated with them personally” (p. 279). Along with this goal, it was important to ensure anonymity to the participants in this research project. “*Anonymity* means that no uniquely identifying information is attached to the data, thus, no one, not even the researcher, can trace the data back to the individual providing it,” (Mertens, 1998, p. 279). However, in my case, I know who said what because my sample size was limited. I thus observed the same confidentiality that I am obligated to observe as a clinical therapist under the laws of the State of Ohio.

**IRB and consent forms.** Also found in the appendix of this work are a copy of my IRB and the consent forms signed by each participant in this study. Although human subjects are

being used, there was nothing within this study that could be deemed significantly psychologically, physically, emotionally, mentally, socially, or spiritually harmful about this study. The participants were reflecting on the work that they do every day. Persons could withdraw from this study at any time. If they decided for any reason that they no longer wished to participate, they were able to withdraw with no questions asked.

**Trauma.** In all narrative inquiry, where people are telling their stories, the researcher must be sensitive to the potential for trauma. If a participant felt the need for counseling, or a debriefing after an interview, this would have been provided. I had a list of third-party professionally licensed counselors who were available (at no cost to the participant) to debrief the participants. I offered to arrange this appointment or give the referral names to the participants, whichever they chose to be the most comfortable. Josselson (2007) noted,

The challenge is for the interviewer to be able to maintain equilibrium, go on listening, and contain (i.e. calmly bear) the emotional experiences being recounted or expressed. In all my years of interviewing and supervising students, I have never seen anyone fall apart as a result of a research interview.  
(pp. 543–544)

Due to my own clinical background, I felt confident in my interviewing skills and in my ability to calmly bear emotional experiences of participants; however, I also took care to have the option of an independent counselor available to participants in the event that they felt the need for such support.

### **Critiquing the Researcher and Limitations of the Study**

The limitations of this study include the fact that my research will be restricted geographically and by gender. The hospice leaders that I intended to interview were within the Midwest and all were female. Science has, over the years, generally given precedence to quantitative research over qualitative research. Guba and Lincoln (2003) pointed out that,

“Historically, there has been a heavy emphasis on quantification in science. Mathematics is often termed the ‘queen of sciences,’ and those sciences, such as physics and chemistry that lend themselves especially well to quantification are generally known as “hard” (p. 105). However, the rise of qualitative research in this post-modern era is significant. Nagy et al. (2006) noted that qualitative research is holistic. It is knowledge building and truly “unique in content, focus and form” (p. 5).

I also used a single method (interviews) to gather my information as well as a single approach to conduct this study. Narrative research and qualitative studies offer in-depth research on small populations of people while quantitative research can offer much larger studies with more generalizable results; however, such results are not the goal of this study. The goal of this study is to tell a story that will highlight the excellence of leadership among hospice leaders, the passion of these leaders, and to motivate change that addressed the need to create and sustain resilience among hospice interdisciplinary team members. Riessman (2008) argued that narratives have several functions; among them narratives engage audiences, document realities, justify changes, and reveal truths about human stories.

My own experience in hospice leadership is one more reality that is both positive and negative in this study. I face a dialectical tension of being familiar with the hospice setting over the last nine years and in the not-for-profit community for thirty years. I draw on this experience as an advantage, knowing the internal changes and complexities of the hospice community over the last decade. I have experienced firsthand the rise in acuity levels and the decrease in resources; however, this can also be to the detriment of my research. I am an “insider.” My familiarity with hospice may have caused me to miss insights, be too close to the situation, or simply overlook something that a new set of eyes may find. One way that I worked to overcome

this potential negative was to have a peer reviewer who observed with a new perspective and did not see with my familiarity to the subject.

I believe that my role in this study was appropriate and helpful. My commitment to the not-for-profit helping professions is deep and my knowledge of hospice care is extensive. I am an “insider” who cares deeply about the future of leadership, nursing, and the care of people. I am a resilient leader. This can only be substantiated by those who know me intimately. But they and I know this to be absolutely the truth. So it is standing on the survival of many moments calling for resilient leadership that I pursue the contributions of this study.

### **The Contribution of This Study**

The contributions that were made by this research include the following: an in-depth examination of resilient leaders in a limited number of hospice settings; how these hospice leaders address resilience with their staff to maintain resilience among those who serve the dying and their families; and potential insights for other leaders who are called to cast a resilient vision for followers in human service organizations. I have also added to the literature base a definition of ethical resilience, particularly as it is related to hospice and palliative care. It is my hope that ethical resilience is the gold standard for leadership in these organizations and in many other organizations. These contributions further the dialogue of resilient leaders both in hospice settings and in settings similar to hospice and palliative care inpatient settings.

Referring back to the understanding that nurses are leaders in place from the definitions of this document, it is important to emphasize that the leadership of nurses is essential in healthcare. Decision-making, individualized care, patient and family communication, education, and team building are just a few of the critical, daily functions nurses perform as leaders in place. Without resilience, nurses, hospitals, hospices, nursing homes and emergency rooms would not

function expediently. I also hope to spark further interest in this research because it is clear that hospice interdisciplinary team leaders are facing challenges, high stressors, and great challenges to the human heart and mind. It is my goal that this study will add to the body of knowledge in the fields of healthcare, education, and non-profit organizations. Each of these calls for leaders who are themselves ethically resilient, but also seek to create and sustain ethically resilient staff members.

Within applied practice, I believe that this study has the potential to address the areas of grief, trauma, depression, and leadership in a variety of arenas. I have already utilized the concepts of resilience one-on-one with individual clients. These clients have received a deeper understanding of themselves and their ability to “bounce back.” This model is also part of an initiative that I hope to implement for leadership in the next few years as we begin to deal with thousands of war veterans returning to the United States. It will take resilient leaders, resilient caregivers, and resourceful teams to address the multifaceted needs of the wounded warriors. According to the National Hospice and Palliative Care Organization, in 2008, 25% of Americans who died were Veterans (We Honor Veterans, n.d.-b). As Mount Carmel’s representative for the Veteran Administration, I have experienced that there is so much applied practice to be considered in the veterans’ reintegration arena alone. I work closely with the “We Honor Veterans” national organization (We Honor Veterans, n.d.-a) to implement care and compassion for local veterans in the Columbus, Ohio, area.

My most passionate arena of work, however, is as a leader for children who have come from violent experiences. Currently, I am the leader of a program called Evergreen, an organization of clinicians and volunteers who are teaching children to trust, laugh, and “be children” after having lost mom, dad, or both to violence or death. My most essential challenge

is to keep the staff of Evergreen resilient, engaged, educated, and inspired for the challenges we face. The body of knowledge that I have gained thus far has been so amazingly helpful. I know that after hearing from other hospice leaders, I learned much more, and grew even deeply in my passion for resilient leaders.

Listening to the narratives of hospice interdisciplinary leaders and discerning the level of how they create and sustain resilience within their leadership teams, I have deepened my understanding of leadership resilience, strengthened the body of knowledge for hospice interdisciplinary leaders, and added to further discussion for staff and volunteers who work with programs such as Evergreen. These unique programs fill a gap for children and adults who are hurting in ways that cannot be underestimated. One of the most frequent responses I hear from children after attending Evergreen is that they no longer feel “alone” in their pain. They know that there are other children who know what it is like to have a mom die by suicide or a dad be murdered. They are not alone. It takes ethically resilient leaders to prepare, receive, and be available to these children week after week, month after month, year after year, as they heal. Both a limitation and a strength that I bring to this work is my own experience in hospital and hospice care. This work can be a limitation because my familiarity with the subject may mean that I am blind to some nuances of the work. For instance, the peer de-briefer was somewhat astonished by the “on-call” expectations of health care. This is a norm that did not astonish me. I also bring the strength of knowing the system and the challenges from the inside. I understand fully what it is like to work “a double.” Sixteen hours is a long time on your feet and with your best judgment available to serve those you are asked to serve. When the person on the shift following you does not show up, working “doubles” is a common practice in hospital or hospice

care. It is not a safe or ethically resilient practice. But it is reality. It is a reality that needs to be addressed.

## **Narrative Results of the Study**

In this chapter I begin with a discussion of the participant selection process. I describe the process of choosing when and how personal interviews were conducted, indicating how long each interview was and the sample size as well as sample demographics. The data analysis is also reviewed. I break down and discuss each narrative individually, concluding with interpretive remarks at the end of each narrative. Finally, utilizing the Mandelbaum's (2003) model, I examine the grand narrative. The chapter also incorporates comments from the peer reviewer with whom I coded and reviewed each narrative looking for common themes, recurring vocabulary, coherence, and discordant themes. At the end of every interview I offer a brief assessment of the participant and their story.

The design of this study is based on Husserl's (1977) understanding of phenomenology and meaning making. It was my goal to establish trust with each participant as the interviews begin so that the depth of knowledge gained from these interviews uncovered a true sense of how each participant views themselves, their organizations, and resilient, ethical leadership. Critical to this is the establishment of common ground, understanding, and a shared story. In each interview these three experiences flowed naturally, a process that is explored further in the fifth chapter.

Among the discordant themes that arose was the question of role clarification. Initially, several of the participants thought I was a registered nurse, which I am not. I shared that my background is not in nursing but that my mother taught nursing for 30 years and my son is a nurse. My comfort in hospitals as a chaplain and my lifelong exposure to nurses thus functioned as my passport into the nursing world.

My goal in this research was to listen both to what was said and to what was not said. The themes, words, nuances of languages, emotion, and discordant examples among these hospice leaders' responses were rich data for understanding how resilient hospice leaders create and sustain resilience as well as when they do not. Mandelbaum's (2003) search for the "grand narrative," the "narrative turn," and defining narrative guided my quest for meaning and purpose in the narratives of the participants as well as the conclusions I drew (p. 599).

This is a narrative research study including eight participant interviews that were completed at eight hospices throughout Ohio and southern Michigan. These hospices were chosen for their not-for-profit status and are a purposeful sample (Mertens, 1998). Due to my own commitment of 30 years in the not-for-profit community I choose to stay within this scope of hospice practice. The Executive Director of Mount Carmel Hospice, Lori Yosick, LISW-S, was instrumental in helping me attain access to the hospices for this study. Table 4.1 outlines the demographics of the hospices in the survey. Table 4.2 gives demographics for the nurses for each hospice in the survey.

Table 4.1

*Demographics of Hospices in Study*

NAME OF HOSPICE/ <i>PARTICIPANT</i>	NUMBER OF PATIENTS	INPATIENT/OUTPATIENT	ADULTS/CHILDREN
Hospice by the River <i>Miriam</i>	700	Both	Adults
Holiday Hospice <i>Debbie</i>	200	Both	Adults
Midwest Hospice <i>Molly</i>	750–820	Both	Adults
Hospice of the Valley <i>Tricia</i>	220	Both	Adults/children
Pediatric Hospice <i>Shelly</i>	3–5	Up to 30 in patient palliative	Children
Hospice of America <i>Ellen</i>	200	Both	Adults
Hospice of the Hills <i>Karen</i>	15–17	No	Adults
Valley Hospice <i>Rebecca</i>	775	Both	Adults

Table 4.2

*Demographics of Participant Registered Nurses*

NAME OF PARTICIPANT	HOURS WORKED PER WEEK	FAMILY AT HOME
Miriam	40	Widowed, adult children no longer at home
Debbie	40	Divorced; children grown
Molly	40	Engaged; has recently cared for mother and sister on hospice
Tricia	40	Married with one child in college and one child at home
Shelly	20	Married with one child at home
Ellen	40	Divorced; caring for aging parents
Karen	40	Married; grown children; caring for aging mother in her home
Rebecca	40	Divorced; grown children

Once the interviews are described and a chart is presented summarizing the interviews, I then provide reflections on the interviews that represent both similarities and differences between the participants' observations. Table 4.3 summarizes participant definitions of key terms regarding resilience and leadership. Table 5.1 summarizes themes such as hospice leadership, resilience and ethical resilience, organizational resilience and burnout, and meaning. The summary of these tables and the grand narrative discovered through participant interview analysis leads into the discussion of fourth and fifth chapters.

Eight registered nurses from eight hospices were the participants in this study. The range of hospice censuses is from one to three patients in a pediatric hospice to seven to eight hundred in two of the adult hospices. All hospices utilized in this study are not-for-profit institutions. All

also have palliative care as a part of their structure. In each case the registered nurse interviewed was a Caucasian female ranging in age from 40 to 65. This was not an intentional specification, however, as the hospice directors chose those who would be interviewed this randomly became the population of participants. Seven of the eight participants have worked as RN's in hospice for three to five or more years. One of the nurses has been in her position for 18 months. I stopped interviewing when the themes of interviews started to overlap increasingly and became (Nagy al., 2006; Seidman, 2006, pp. 54–56). All names and sites were changed to protect confidentiality.

Before writing the summaries below I transcribed each interview from oral tape to manuscript. Once each participant had a full manuscript I went over each, looking for themes, concepts, words of interest, or discord. Each theme, concept, word of interest, or discord was noted for further exploration so that as I was summarizing the eight interviews I could also highlight these points within each interview summary and then draw conclusions.

Narrative by narrative, I coded recurring themes. Many of the themes were congruent. Some themes were discordant. As the peer reviewer and I sat together with each manuscript, we discussed what each of us had read. I viewed the narratives from the point of view of hospice care. She viewed the narratives from an educator's perspective. This gave an interesting dance of diversity to our observations.

### **Miriam, Hospice by the River**

Miriam was the most experienced nurse I interviewed, with a career dating to 1967. The hospice she works with currently has a census of approximately 750 patients. As with many of the other participants, Miriam's first experience with hospice was not as a nurse but as a family member. When Miriam was in her thirties her 39-year-old sister-in-law entered hospice. During

this time Miriam volunteered for the hospice that cared for this loved one until she died. After this experience, Miriam began to work part-time for this same hospice. Although names changed and organizational changes were made, Miriam has spent most of her nursing career as a hospice nurse. She retired in the spring of 2013.

Miriam defined leadership as the ability to guide members of the team. Although she served as a mentor to many newer staff members, she did not see herself as a leader. Miriam trained over 50 nurses in the program. In late 2012, Miriam was asked to be a part of the mentoring program at the Hospice by the River, yet due to the recent death of her husband, Miriam declined.

Families were both the most rewarding and the most challenging part of Miriam's position at hospice. Miriam lit up as she told a story of an 84-year-old patient who was about to celebrate her 85th birthday. The care plan for this patient included a quality of life goal of returning to New England to celebrate her 85th birthday with her daughter and to eat 85 pounds of lobster! Miriam encouraged her patient. The physician encouraged the patient. Everyone on the team backed this plan. As the birthday approached plans were made and this little lady traveled to her daughter's home. They ate lobster on her birthday. The next day the daughter called hospice to tell them that her mother did not wake up in the morning. She died. Everyone from the daughter to the team members was thrilled to hear that this woman had met her quality of life goals.

At the same time, however, Miriam expressed the challenges of dealing with families. Miriam quietly shared, "Learning to meet dysfunctional families on their terms is critical. People die the way they live. Helping them to find coping skills to help them get through and helping them get through things they cannot change. This is not for everybody." As Miriam reflected

back on her many years in the hospice world she intuitively concluded, “The acuity is higher. The standards are higher. We don’t just hold hands until someone dies!”

Miriam defined resilience as the ability to adapt to changes, remarking with a twinkle in her aging eye, “Change is a constant. You have to be able to sustain an energy level that it takes to do this work. You also have to have a life outside of hospice.”

Miriam, a woman of quiet spiritual depth, told this story about ethical resilience. She shared that she was training a new nurse several years back. This young nurse felt he was called by God to be a hospice nurse so that he could save those who had no faith before they died. She said, “He thought he needed to witness to them. I told him we need to honor the patient’s beliefs or non-beliefs whatever they may be. Consequently he did not stay.” Miriam’s ethical resilience lies deep within respecting people for who they are and for what they do or do not believe.

Creating and sustaining resilience means having a life totally separate from hospice. This was a simple definition for Miriam. She reported being involved in her church, her community and with a group of women. She meets with these women weekly and has for many years. They are her “accountability circle.” She proclaimed, “I would not have survived if I could not set these boundaries, especially when I was young and this was hard.”

Miriam noted that, over the years, camaraderie, staff support, a chaplain that leads coping skills seminars, and a variety of other methods have been used in her organization for resilience. There is a staff council that channels ideas for “de-stressing” the teams. They meet once a week to brainstorm. New ideas are always welcome. From these ideas have come diabetes classes, Zumba classes, yoga, Weight Watchers, and honoring everyone who works for the organization.

Holistic care for patients is integral to this hospice. Music therapy, massage, respiratory therapy, nursing, social work, volunteer, and chaplaincy are among the services offered to

patients. Some patients have their own spiritual support. Others choose to use the hospice chaplains. This diverse offering of services is fairly standard among the participants I interviewed. The only exception is the music therapist, which is a unique service at Hospice of the River.

Miriam shared that her organization is sensitive to resilience. The many offerings listed above are ways they address resilience. The staff council, the accessibility of the hospice director, and team sensitivity help to create organizational resilience. Miriam said, “I offer some ways I have learned to cope. If they are agreeable I pull in other resources like one of our chaplains, a social worker or our Employee Assistance Program.” All of these are good resources for burnout and for organizational resilience.

Miriam spoke with wise eyes and a slight smile, “I am given patients that other nurses are unable to cope with. I have a rather soft approach. I tell patients that I am a guest in their home.” It is easy to envision Miriam doing just that. She is soft-spoken, gentle, and tender. She is self-assured. I want her to take care of me at the end of life. She radiated kindness and compassion. When asked about the challenges and joys she expressed that she cherishes both. Hospice work was her calling.

Miriam’s spiritual depth was evident in her response to my question about her views on death. She replied, “I look upon it as another journey. I go in to help them make the best of every day they have. I tell them that they have the tougher job. I am there for an hour, but they are dealing with this 24 hours a day.”

Miriam referred back to her faith when she was asked about ethically resilient leaders, recalling, “I support families and patients with whatever spiritual or faith-based background they

have. We have many ethnicities and I respect everyone where they are. We are here to meet patient and family needs not ours.” This is how Miriam embodied ethically resilient leadership.

Miriam’s understanding of leadership and care was a gold standard for unconditional positive regard. She placed the needs, perspectives, and preferences of the patients and their families first. She placed herself in the frame of reference of the family she is serving. This is both ethical and servant in nature. She embodied ethical and servant leadership as she holds to the highest ethical standards set in hospice care.

When asked about meaning Miriam searches back to a five-year-old child whom she cared for in her early hospice days. Miriam shared with tears in her eyes, “We cared for her for eighteen months. She died in bed between mom and dad. She was nine. She had a brain tumor diagnosed at five years old.” Miriam went on to tell that the night this little one died she was not on-call; however, her partner had the foresight to call her. Both nurses went to the death call. She recalls, “It was good for both of us and for her family.” When this little girl could not longer move her arms and legs, we were her arms and legs for her. We loved her. We would take her to school when she was well enough to see her classmates. Miriam has a video that this little one’s parents made of a day at school. It is among her prized possessions. Miriam is retiring in early 2013 after a full career in hospice care.

Miriam was an amazing role model for resilience. She spent 45 years in hospice nursing. I was not only inspired by her stories but she has such a quiet, affirming spirit that I would love for her to care for me. She modeled amazing tolerance, quiet self-assurance, and a regard for human dignity. The healing love of a servant leader is present in Miriam’s persona.

As Miriam spoke of her husband’s death one year ago her eyes became watery but not filled with tears. It is clear that she sees his death as a part of God’s grand plan. She seeks

support from her circle of friends and is able to continue with strong faith and service. I hope to be so courageous one day. I also hope to be so resilient, bouncing back from life's traumas as they are presented to me.

### **Debbie, Holiday Hospice**

Debbie has been working at Holiday Hospice for nine years. She had bright, soulful eyes that danced as she talked. She easily made a connection with me as I interviewed her. Holiday Hospice has a census ranging from 200 to 250 patients per day. Prior to hospice nursing she spent time at a large, long-term care facility as a unit manager. While at this facility Debbie had contact with hospice staff as they would come in to care for hospice patients. She perceived that hospice nurses, aids, social workers, and chaplains were warm, responsive, and caring. As she became disillusioned with the company she was working with, Debbie had a defining experience that led her to move to a position with hospice.

Debbie indicated that while she was still at the extended care facility her cat died. She checked in with me to be sure I am an animal lover. Then she went on with her story. She said with tears in her eyes, "I came in the day my cat died. But I had to leave work. I got a card from one of the people at one of the hospices." This amazed Debbie. Unlike her co-workers at the extended care facility, the hospice staff genuinely cared. After she reconciled the concern of working with people who are "always dying" Debbie chose to apply to work as an RN at a large local hospice.

Debbie defined leaders as people who make decisions. She cited examples of these decisions, such as how the money is spent and how policies are created. She quickly noted that she is not in this kind of leadership position, digging deeper in this definition to note that leaders

lead by example. They communicate with positive attitudes, look for silver linings, and emphasize that change is definitely the name of the game in healthcare.

The most rewarding part of Debbie's vocation is the families. She saw this both as a challenge and a reward because sometimes patients and families think she "walks on water" but she also said quietly that other times, "I represent the system that failed them." Debbie saw that it is her challenge, in this last case to help patients and families redefine their goals and help them work toward a new set of goals. Rather than seeing healthcare as the system that failed them, Debbie hoped that she could help them see healthcare as the system that helped the patient be comfortable. This would also contribute to the family's comfort, knowledge, and understanding.

Debbie defined resilience as the ability to separate life and work, stating boldly, "I cannot care for you 24/7." She stressed several times that she works hard to have systems in place so that when she walks out the door at 4:30 she is able to leave her work behind, trusting that her patients are in good, capable hands. She would take up the work again tomorrow.

When asked about creating and sustaining resilience Debbie noted that this was both a challenge and a gift. Co-workers go out together and share the challenges together. They go to the Comedy Club just to laugh. They support one another. There must be life balance between home and hospice. Sleeping well, eating well, enjoying life, petting the cat, and having a glass of wine all make for a good way to re-fuel for the next day.

This work is very difficult if life outside of hospice is chaotic. Debbie said that it is almost impossible to come to work emotionally drained. The work itself is emotionally and mentally demanding. She commented that if you come to work tired or emotionally exhausted, "It is terribly difficult to do what I do."

Debbie defined ethical resilience as keeping patient information private, protecting patient rights, and not getting too involved with patients and families. She spoke of patients and families who invite hospice staff to cookouts or holiday celebrations. The impression is sometimes sent that if staff does not go to these functions they have let the family down. Debbie reflected that nevertheless, it is important to keep professional boundaries to maintain ethical resilience.

In Debbie's opinion organizational resilience at Holiday Hospice could be strengthened. Debbie reported that staff are encouraged to offer classes if they choose. Classes like knitting, dream interpretation, photography, and a board games group were offered. However the hospice leadership does little else to encourage self-care and nurture of life balance. She reflected that this is a hospice that has grown exponentially during her time there, which has made organizational resilience more difficult, more impersonal, and less likely to occur.

Nine years ago Debbie knew everyone on the staff. Now she has to check nametags to see with whom she is talking. Even the model of this hospice changed. When this organization was smaller, everyone began the work day at the office. Debbie noted that she now begins and ends her work day at home. There are many days when she does not touch base at the organization at all. This disconnect between staff and organization is growing, making it more difficult for the organization to plan or engage staff in events to foster resilience or even to know one another by name.

Debbie suggested that if she knew a staff person who seemed to show signs of burnout she would approach them. She indicated that the most prevalent sign of burnout she sees in her organization is that suddenly someone will resign, commenting, "Many people just hold their feelings in and leave."

Finally, Debbie expressed one important caveat that she left out earlier in the interview. She wanted me to know that humor is critical to her work. She uses humor with the patients and their families as well as with staff. Debbie illustrated this with the boldness of an onstage actress, “When I walk through the door of a patient’s home, I am on! I’m there to take care of them, but I want to make them smile.” As I remarked above, Debbie has a vibrant personality and a beautiful smile that is contagious. Even in the darkest moments she could bring some sunshine into the room as she cared for the families to whom she is assigned. This is the meaning that she brings to her life’s work. Debbie is resigning her position at the end of 2012. She plans to live on a boat off the East Coast with her partner and sail for the next several years.

My primary reflections about Debbie were that she is bright, vibrant, and very much alive. She was able to compartmentalize her hospice work and her life work. Hospice does not go home with Debbie. Home does not come to work with Debbie. She entertained her patients with jokes and smiles loving them through her shift each day. I see Debbie reflecting the hospice leadership model of being present, independent, and confident. She had an excellent sense of humor. She did not indicate a spiritual grounding, however, she holds “genuine care” as an important value. Debbie was confident in her knowledge as a nurse and able to address questions as she is in patient homes. She was present, entrepreneurial, and confident.

One story that Debbie told illustrates her confidence and sense of humor. All of the pain medications given to hospice patients have a variety of side effects. One common and frustrating side effect is constipation. Every day Debbie asked her patients if they “pooped” today. She made a joke of it. One day a patient named George made himself a t-shirt that reads, “Debbie I pooped today!” The shirt had a big smiley face on the front of it. Debbie and George laughed and laughed about that shirt. Such levity brings creativity and light into what could otherwise be a

dark and dreary journey. I appreciated Debbie's way of compassionately caring with levity and laughter.

### **Molly, Midwest Hospice**

Molly began her career in nursing in the emergency room. She quickly discovered that emergency room nursing was not for her. Molly's goal as she began her job search was to find any position that was not in an emergency room. The first opening she found was in hospice care. Midwest Hospice has a census of between 700 and 800 patients per day. Molly has been a nurse in hospice for about 18 months. She recently transitioned to a new position in information technology, however, and will no longer be visiting patients in facilities or their homes. Nevertheless, for 18 months Molly has had the experience of working as an RN case manager, heading the team of a social worker, chaplain, and aids to care for up to fourteen patients in their homes. As of November first Molly's position changed.

Molly defined leadership as constantly challenging one's self. She called for out-of-the-box thinking, pushing the limits, and learning new skills, offering the example of the new position in information technology to which she was transitioning. She exclaimed, "This is way out of my comfort zone. It is a challenge. I like it. It is leadership—taking on something new and big."

In her hospice work Molly found that being with patients and families was most rewarding and challenging. She reported, "Being able to use my skills to see that what you are doing is helping. I'm so thankful that I can help them." The challenges for Molly were also with patients and families. She worked to keep herself in check. She wanted to be thorough not to rush and to give every patient the care and attention they need. This is becoming more difficult as the census of Midwest Hospice grows and the responsibility of every RN increases. The

Medicare spending cuts and the intense profit and not-for-profit competition weighed heavily on this hospice.

Molly was quick to define resilience. She said: “Resilience is the ability to bounce back from a stressful situation. I do it very well.” She elaborated by saying that she did not get overly involved with patients and families. She did her very best but knew that in the end if a patient decides not to take their medication that is their decision, reflecting, “I am really good at boundaries. This is my job and this is what I do.”

When asked about ethical resilience, Molly paused. She was thoughtful and intentional in her answer, referring to the question that many family members ask: “Did I kill my loved one with all that morphine?” Molly answers, “I am confident in the disease process. I explain it carefully. I support the vision of hospice and see no ethical dilemma in hospice.” Molly was able to reconcile these issues with relative ease.

The question, “Did I kill my loved one with all that morphine?” is a piercing question that I, as a bereavement counselor, am asked on a regular basis. I will explore this question further in my fifth chapter (“Discussion and Analysis . . .”). It is imperative to the hospice model that both those who work in hospice settings and those who may choose hospice for themselves or their loved ones understand the answer to this question.

Creating and sustaining resilience within herself and team members Molly affirmed, “We are all human. We try to set boundaries. But when a text message comes from home during work I take it. When I’m home my talk about work is short and sweet.” Hospice work calls for balance.

With team members Molly asserted, “You get to know your team members . . . if you see that a team member needs extra help I offer it.” She is quick to try to lighten the load of another

peer. It is clear that collegiality and partnership work in this team. Listening, supporting, and sharing ideas all help to minimize burnout and stress.

According to Molly, Midwest Hospice offers strong organizational resilience. She pointed out several containers throughout the building intended as repositories for anonymous notes containing feedback from employees. The hospice director addresses each note and, in turn, the staff is confident that these issues will be addressed.

Molly reported that she loves to learn. As a leader in the organization this quest for knowledge addresses both the challenges and joys she encountered. With the knowledge that every patient will die, Molly expressed that she is very grateful to be invited in to these families' lives at this most intimate time. Molly saw herself as an ethically resilient leader as she is open to change, being flexible, and constantly learning.

When asked about meaning Molly emphatically said that her job “absolutely has meaning. It changes the way I view my life and the lives of the people around me. I totally have respect for the families that I take care of.” Molly thoughtfully considered the many social, economic, racial, ethnic, religious, mental, physical, emotional, and gender challenges that the families she serves face each day, expressing the tremendous respect and honor she feels toward these amazing families. As mentioned above, at the time of the interview Molly revealed that she would be leaving patient care immediately for an office position in information technology.

My assessment of Molly was that she is an introvert, quiet and reflective. She may have found her niche as she was now utilizing her nursing knowledge with information technology. Molly's ability to “compartmentalize” helped her to remain resilient. Her words are, “I can't change what happens after I leave. I have done everything I can . . . It is always their choice . . .

not mine.” From this point of view Molly can be seen as a servant leader. She remained resilient by utilizing the strengths of feeling secure in her own identity and her assessment abilities.

Molly’s statement regarding the need to do what she could and leave the rest in the hands of the family resonated with me. This demarcation of roles allows the professional to remain compassionate and present without taking on every problem faced by every family in the program. Such boundary-marking allows leaders to appreciate the circumstances of those for whom we care but also allows for the opportunity to nurture ourselves.

Molly was also clinically insightful when she discussed the morphine dilemma. Many families want to blame someone or something when their loved one dies. It is easy to blame the hospice team or the morphine because those elements are present and tangible in the family life. The disease process, which is the real culprit, is much more difficult to grasp. It is not as tangible. There are no immediate CT scans or MRI’s to blame. Near the end of life these tests are futile. Families begin to ask questions like, “How do I know that the cancer in my loved one’s brain is growing? I cannot see it?” But they can see the morphine. They can see the other medications. They can see their loved one deteriorating right before their eyes. So is it the tumors? Or is it the care they are receiving?

Hospice has a continual component of education that is critical. Every team member must educate and re-educate every family member as the patient declines, takes a turn for the worse or even has a good day. The body and the disease process are complex partners in the terminal stages of life and dying. Molly helped to illustrate the complexity of this dance toward dying as she highlighted the morphine dilemma.

**Tricia, Hospice of the Valley**

Tricia became interested in hospice nursing in the mid-1980s; however, she knew that she needed other nursing experience first. Prior to her hospice career, she worked in oncology, bone marrow transplant, and other nursing experiences. After her second child, Tricia took a leave from nursing. During this time she had two very personal experiences with hospice. A number of years ago Tricia's mother died under the care of a hospice. She described this experience as "horrible." Then a few years later Tricia's father died again under hospice care. This time Tricia described her experience with hospice care as "mediocre." At that point Tricia made a personal resolution. She said, "I sort of determined that I would not give the care that I had seen given to my parents. I love it." Tricia has been with Hospice of the Valley since 2005.

Leadership was multileveled for Tricia. She enjoyed the interdisciplinary nature of hospice team leadership. She referred to the medical director on her team as the leader. Collaboration, meeting and working together, and discussing the best ways to manage the patient's concerns all help leaders to do what needs to be done. Tricia saw herself as one who leads by example. She realized that there are times that she gets "off track," but when that happens you step back and change course.

Tricia's hospice role was within a hospital. Unlike other participants, she saw patients who are hospitalized and who may or may not be hospice appropriate. Tricia's rewards and challenges were thus a bit unique. She expressed that the rewards are the variety of patients and families she encountered. Although she saw many people who were appropriate for hospice, either the patients themselves or their family members often were not emotionally prepared for such news. The decision to enter hospice care is a very delicate and gentle conversation that happens over hours, days, or sometimes up until the patient dies.

Tricia confessed that her biggest challenge is working with physicians who are hospitalists. She said, “I want my patients going home with a good discharge plan and with everything they need.” This is sometimes not the case if the physician doing the discharge is a hospitalist. Tricia reported that medications are not reconciled, prescriptions are not filled, and chart notes are often not completed. This was her biggest challenge.

Tricia defined resilience as looking at whatever barriers are before her and pushing past them to do what needs to be done. She added, “I do the best I can and accept that.” Adding the word “ethical” to this definition, Tricia noted, “Ethical resilience is finding the strength to do what is right. This means not necessarily what I think is best but helping families find what they think is best.”

As a current example, Tricia referred to a patient who was in intensive care. She was on many medications keeping her alive. Both the palliative care physician and the team that included Tricia know that this woman will not survive once these medications are withdrawn. Neither the patient nor the family was prepared for the finality of such a decision. Tricia was quick to note that the patient was comfortable. Giving the patient and her family more time to come to terms with what was ahead did not compromise this patient’s care. Tricia observed, “To me it seemed much more sensible to move her to palliative care but they are not ready to do that. This is not who she is either. She has a choice. It is still very early so we wait.” This is ethical resilience in action.

When asked about creating and sustaining resilience for herself or her team, Tricia answered with a broad smile and a tilt of her head, “I’m only fair at this. I’ve learned to feel when I am on my edge. Knowing my stressors and managing them is important.” Tricia affirmed that she steps back, relies on her faith, prayer, meditating, and sitting still. With others Tricia was

a team player. She helped when she could. She noticed when co-workers were anxious or stressed. She offered to trade visits so that if a co-worker has a difficult visit, she would take that visit and give one of hers to them. This eased both of their workloads.

Tricia saw all that she and her team do as holistic care for the patients and their families. She gave the example of a person with lung disease. Of course the physician checks lung function. Then she explained, “We look at how lung function affects every aspect of life. Where do you draw your strength? What are your physical, emotional, spiritual supports? All of these are important.”

The organization for which Tricia worked is flexible. She noted that when she came to a place that home visits were just “too tough” for her, a position in one of the hospitals became available to her. This was an example of both organizational resilience and what happens when someone faced burnout. It is important to note that Tricia took the initiative herself to find a new place to revitalize and stay resilient. This was the key to linking her experience of organizational resilience and burnout. She loved visiting patients in homes for a time, but now greatly appreciates being in a hospital setting every day.

Like many of the nurses in this process, Tricia was a person of spiritual depth. When asked about caring for those who are dying she replied, “Death is not a bad thing. We all are going to die. My goal is to help the patient die comfortably and close to what they want and I can help the family manage that.”

Tricia defined an ethically resilient leader as one who has foresight. A leader who communicates, knows the difficulties of this work, and encourages people is ethically resilient. A leader that realizes the individual challenges of each profession within this work is an ethically resilient leader.

Finally, Tricia smiled enthusiastically when I asked about meaning, stating, “This is incredibly meaningful work otherwise I wouldn’t do it. I find my gratification at the bedside working with families. I think hospice is very, very important. This is difficult work.” Tricia recently transitioned from hospice home visits to the hospital hospice and palliative care work after eight years in the field.

My observations of Tricia began with the acknowledgement that Tricia knows her limits. She readily admitted that she is “only fair” at taking care of herself and managing her stressors. I too have this tendency. We both remarked that it is easier to see and help with the needs of others than it is to care for ourselves; however, at the same time we both know that nurturing the self is critical to bouncing back in stressful circumstances.

I admire Tricia’s depth of faith and persistent drive to push her spiritual self. In spite of a full family of responsibilities and a full workload, Tricia makes time to develop her spiritual self. She meditates, prays, and sits in stillness. I deeply appreciate this dedication to spirituality and the discipline that is a part of this journey.

In my work as a bereavement counselor I have many clients who ask why their loved one died. They are angry and feel robbed of someone they truly loved. I have worked in this field now for nine years and listening to these participants hospice allows us to see that death is an integral part of life. We are born. We live. We die. This work has enabled me to see the deaths in my own family as part of life’s fabric. I have not been robbed by death. Death has simply touched my life as it touches every life that is born. Hospice work allows the hospice workers to see life with many different perspectives. Every day is precious, every life is sacred, and death is one more passage in the journey.

**Shelly–Pediatric Hospice of St. Mary Beth**

Shelly began as an RN case manager approximately seven years ago at this pediatric hospice. Prior to a pediatric hospice Shelly worked with babies in newborn intensive care. She openly beamed as she says, “I love to work with babies.” Pediatric Hospice of St. Mary Beth has a highly fluctuating census. It can range from one to three or up to seven patients on any given day. This program started with two nurses, one social worker, and a program manager. Now they include a palliative care program as well and the staff has expanded to include several other staff members and a medical director. Shelly works half time.

Shelly’s interest in pediatric hospice began many years ago when she had a defining personal experience that raised her interest in pediatric hospice care. Shelly shared openly with tenderness the story of her own baby girl who lived for four days. Shelly had a daughter who was in a pediatric hospice some years ago. The hospice cared for Shelly’s infant until she died. With love and devotion she noted, “We made a lifetime of memories in four days; all of my pregnancy and four days. We are super grateful for that time with her.” The pediatric hospice that served Shelly and her family taught her to be a mom and not a nurse. They encouraged her to enjoy her baby. This is the vision that she now carries to the families with which she works. Shelly reflected that this experience taught her family to cherish each day with her daughter and to be resilient.

Shelly defined leadership as “out-of-the-box” thinking, which includes supporting others, finding strengths, and finding ways to help people be cohesive in the tasks they do together. She also noted that who you are and the example that you set is equivalent to leadership.

Inquiring about the most rewarding and challenging issues of her job Shelly commented that the families bring the greatest rewards to her work. Shelly reflected that in getting to know

families and walking with them through the loss of a child, “There are some families that I will never forget.”

The most challenging part of this position is the “on-call” hours. Furthermore, Sherry is now the mother of a teenage boy, which has given her insights into how difficult it is for her to care for teens that have cancer. “I have my own fifteen-year-old son and that is difficult to get around.”

Shelly defined resilience as the ability to recover or to bounce back, offering as an example the difference between Silly Putty and a foam ball. The Silly Putty cannot return to its original shape, but the foam ball under pressure returns to its original shape when the pressure is released.

Shelly connected her moral beliefs to ethical resilience, discussing the example of a common dilemma in pediatric hospice over whether or not to feed a dying child. Shelly noted that this is where ethical resilience becomes essential, commenting, “A mother sees feeding her child as nurturing and loving that child. To many moms, not to feed then means not to love.” Shelly reflected on this for some time, pointing out that, to the contrary, in many cases feeding a dying child can compromise their well-being. It can make the child feel bloated or sick. They can vomit or have other signs of discomfort as the body shuts down and no longer needs food to exist. Ethical resilience in these cases means allowing families and care teams to dialogue and work through all of the possibilities. In discerning what is ethical Shelly had a profound insight that derived from the practices of the medical director at her pediatric hospice. She and other members of her team utilized the following two questions frequently: Are we doing this *to* our patient? Or are we doing this *for* our patient? If we are doing it to our little one it is time to stop. “All that we do,” Shelly stated with love and gentleness, “must be for their benefit.”

Shelly stated that creating and sustaining resilience is critical in her field. This is one of the reasons she worked part-time. All of the people on the staff at this particular facility with one exception were part-time. The one full-time position usually turns over every 12 to 18 months. Turnover in this hospice was very high; in fact Shelly was leaving her position to take a position in the hospital on December 1, 2012.

Shelly shared that team members at Pediatric Hospice of St. Mary Beth were very supportive of one another. She questioned whether or not full-time positions are a good model here. This organization does many supportive team-building activities including painting, a Labyrinth Walk, and dinner together with employee families every six months or so. The nurses also go on one bereavement visit with the families. This helped to put in perspective the reality that the families do begin to heal. It is important to see families begin to heal. This is especially critical if you are the primary nurse for a child and saw that child several times a week for many months, were one of the staff members who donated blood platelets for this child over and over again, or if you were one of the nurses who walked with this little one's family side by side through all of the ups and downs of the disease process for months or maybe years. Finally, if you were the primary nurse with one of the families you may just need to have a good cry.

Shelly shared, "You cannot measure the changes a kiddo may make in your life." She noted that whether a child lives a few hours or a few years you are changed forever. She also said that even though every child in their program will die she has never had a parent or family say, "We wish we never had that time." Instead the families always come back and say, "Thank you for helping us live with the time that we had."

Shelly concluded that meaning for her is defined by the reality that she has made a difference in her nursing career. Last year alone the memorial service remembered 25 children.

Over the last seven years that Shelly has been here you can multiply out the number of families touched by her service and know that the difference she makes is achieved through compassion, resilience, and lifelong commitment.

I was deeply moved by my interview with Shelly. As she spoke of the children she cared for she often smiled a bright smile and tears glistened over her eyes. The joy and sorrow of pediatric hospice are so deeply entwined that this work calls for a servant and spiritual leadership that only a few people are called to give. The ethical resilience of these hospice leaders comes with incredible knowledge, a community that fully supports and understands the mission, and rarely waivers. Excellence is mandatory in this work and high moral standards are a given. Shelly represented all of this and more. I felt honored to be in her presence. This hospice will truly miss her.

### **Ellen, Hospice of America**

Ellen has worked at Hospice of America since 2005. Hospice of America has a census of between 200 and 250 patients per day. Prior to this Ellen worked in psychiatric nursing in a management position. She has a Master's degree in management. Due to the need for both management skills and an interest in psychiatric nursing, Ellen chose to begin her career in hospice care. She began as a care manager working with a team that consisted of a social worker, a chaplain, aids, and a physician. She became an administrator who manages personnel files, completes evaluations, oversees the master schedule and helps to facilitate the overall administration of the teams. "I'm very lucky," noted Ellen "I have mature nurses, a cohesive team, and good social workers."

Ellen said that her job is to do a lot of teaching. She envisioned herself as leader who seeks feedback from her team. She tries to use herself as a resource. She prefers to give

immediate evaluations, both positive and negative. She spent many years in the field and knows what should be happening there and was thus able to give evaluative responses with knowledge and wisdom from her own expertise. Ellen has a “no nonsense” appeal to her and is articulate and bright, smiling frequently.

The most rewarding part of Ellen’s job was working with patients and families. She liked to solve problems quickly. On the other hand, what she liked the least are the things that cannot be changed. Ellen noted that there are areas of concern that no one pays attention to so they do not get addressed. “I want to pick problems apart and find out why they keep recurring,” observed Ellen. Here Ellen responded much like an investigator wanting to solve the problems so that patients and families have a better experience.

Resilience for Ellen was defined by enjoying what you do. It also included having a life outside of work. She noted, “I want to know I make a difference.” She also noted that she exercises, is involved in hobbies outside of work, and is autonomous. In terms of self-resilience Ellen liked to keep things interesting. She loved to teach, have personal interaction with people, and try new things.

Examining team and organizational resilience, Ellen noted that these were tougher to define. She used humor with the team. She also stressed communication. For example, if someone is having an issue you can usually tell because the quality of their reporting starts to go down. They need a break. They need time off. That is when Ellen gives them a scheduled day off or goes out and has a drink with them after work.

Organizational resilience is much harder. Comradeship is difficult because, she says, “we are such a large group. Not everyone knows everyone.” Ellen observed that in her hospice, “We used to have retreats. We used to have educational events where everyone came. But we are

too big for this now.” Ellen concluded, “All we hear about now is that it is our job to keep the numbers . . . keep the numbers up.” As Medicare reduces reimbursement and as competition is fierce, our number one goal is to keep the numbers up.

Ellen elaborated upon resilience in a situation where every patient’s trajectory is to die by saying, “You come to the understanding that this is part of the life journey.” She suggested that the role of the hospice nurse is to teach, to prepare families, to let them know what is coming, noting, “I provide the knowledge that people need.”

Ellen defined ethically resilient leadership by her religious background, which provided the framework within which she works. By working with honesty, improving diversity, serving the poor and stressed families, addicted folks, people of a variety of ethnic and religious backgrounds, the goal of hospice nurses is to provide the best care possible. Ellen said, “I believe people have the right to choose. I do not want to impose my views on someone.” This richness to Ellen’s openness to serve allowed her to serve in an inner city, poor, racially diverse neighborhood that has multiple challenges with addiction, violence, and marginalization. In addition to caring for the physical needs of the families assigned to Ellen and her team members, they also care for the emotional, mental, social, and spiritual needs. Finding money to pay the electric bill, keeping the heat on through the winter, removing loaded guns or locking them safely away from a suicidal patient are daily challenges faced by Ellen and her team members. All of these challenges fall under the category of being ethically resilient leaders. As a final note, Ellen explained that she was redefining her position and was either retiring or going to half time at the end of 2012.

Ellen impressed me as a leader who was seasoned, thoughtful, and asks the right questions. She was able to assess situations by pulling them apart and finding creative solutions.

She was self-reliant, independent, and confident. The religious background that centers Ellen holds her in check as she ethically makes decisions and sought resilience. I enjoyed her sense of humor, her willingness to accept people of diverse backgrounds, and her sensitivity to the underserved populations within her service area. She seemed to have no fear. She was willing to walk in where there is a loaded gun, drug addiction, or other challenging circumstances. She allowed her creativity and experience to inform decisions in these circumstances and was not intimidated by such events. I find myself to be a bit more restrained than Ellen. I quake when the loaded gun is on the table and I appreciate the police backup when drug sales are happening as I get out of my car. I do not find myself quite as courageous as Ellen reported herself to be.

### **Karen, Hospice of the Hills**

Karen has been in nursing since the 1980s and began her career as an oncology nurse. She reported that with this background, she was aware that some people who received chemotherapy improved, recalling distinctly one woman who had a tumor the size of a basketball. She had surgery and chemo until she died. Karen reflected, “Was she sick? Yeah. Was she in pain? Yeah. Could she have used hospice? Yeah. But hospice was in its infancy back then. There wasn’t a hospice in our town back then.” Now Karen works as an RN case manager and is one of several nurses in a hospice that can have a census up to 20.

Karen defined leadership as showing other people how to get where you want them to go and shared her view that some people are leaders and others are followers. Karen defined herself as a leader as follows, “We don’t always do what we want to do, but we do what we have to do. In my job I see that as my role to follow the rules.”

The most rewarding aspect of Karen’s vocation was the flexibility and the families. She quieted as she said, “You get invited into people’s lives when they are dying and there is turmoil

and they share everything with you . . . They trust us beyond their doctors sometimes because their doctors won't come to their house.”

The most challenging part of Karen's vocation is being on-call. Due to the size of this organization everyone takes on-call assignments both during the week and on the weekends. She explained that this means that you may be on-call and up all night with a death, yet then are expected to come in at eight in the morning and begin your day. With a twinkle in her eye and much honesty Karen remarked, “I'm getting too old for this! Once I hit 50, these all-nighters started getting tougher!” This makes it difficult to find balance between life and work.

Karen began defining resilience with a confession, remarking that, “Sometimes I am not very resilient. If you are resilient you take what you get thrown at you and you just buck up and do it whether you want to or not.” She went on to tell a touching story illustrating just how resilient she truly was.

Karen had some difficult news to bring one of her patients. This man had lived by himself for his entire adulthood. He cherished his privacy and individuality. He was under 50 years old and a hermit. But on that particular day the news he would hear was worse news than hearing that he was dying. Karen said, “He knows he's dying. He doesn't care about that.” The hard news this man must hear was that he can no longer stay in his home alone. He knew this day was coming. The line in the sand that was agreed upon was the day he could no longer make it to the bathroom he would need to go to an extended care facility. Last night he called the night nurse to come and clean up his soiled floor. Today with a loaded gun on his kitchen table Karen must tell him that he is no longer able to live in his home. He must go to an extended care facility. This is hard news. This patient is in dire straits. He is a hoarder. He is filthy. He is in denial. He has obsessive-compulsive disorder. He has every right to dignity and his own way of

living. She concluded, “Resilience is just doing what you have to do when you have to do it . . . even when you don’t know what you are getting into.”

Karen was pressed when asked to answer a question about ethical resilience. The example she offered referred to physician-assisted suicide. She noted, “I could not do abortions. I could not assist a patient to do something . . . I draw some lines. People ask you to go out on a limb for them. You just cannot do that.”

On the other hand, Karen responded decisively to my question about her perspective on creating and sustaining resilience. She repeated several times the word “downtime,” stressing the need for vacations, days off, time away, and time to rest. Karen turns off her work phone as she leaves the office. She became quite animated when referring to co-workers who cannot draw this boundary. She said, “I need time away. And I get frustrated at others when they can’t get away. Go. Take time out!”

Karen appreciated the hospice holistic care model. In this organization she indicated that the holistic perspective comes from a Christian foundation. Karen perceived the ideal as a holistic team that cuts the pie into five equal pieces—nursing, social work, chaplaincy, counseling, and nursing aid; however, in reality she sees a pie with one big piece (nursing) and four little tiny pieces.

According to Karen, organizational resilience was positive at Hospice of the Hills. She reported that the board of directors was excellent at acknowledging what team members do well. They are great with flexibility for families of staff members. She revealed, “When you are little and you have a handful of excellent people, wow, that is great.” She continued by noting that everyone in the staff has either little children or aging parents. Those stressors mean that

peer-to-peer support is critical particularly in a small staff. This staff covers for one another for vacations, sick children or parents, funerals, and other unavoidable life occurrences.

The challenges and joys for Karen were always growing and changing. She seeks educational experiences, opportunities to see what other hospices are doing, and was certified as a hospice nurse to reach for greater quality and professionalism. She was excited to “find out where our agencies strengths and weaknesses are when I go to a conference like Orlando . . . You come back and say, ‘Look guys, this is the new standard and we’ve got to do it in this way.’” She also could relate closely another nurse who attended the conference. This nurse had been on-call the night before and was called to a death at three in the morning. Then she got in her car and drove to the conference. From this Karen learned, “You know we don’t have it any differently.”

I admire Karen’s tenacity. The struggles of a small rural hospice are many. She strives for excellence and commented, “A few excellent staff are better than many mediocre people.” Yet the stress of constant on-call, a small staff, a secretary who brings her four-year-old to work every morning until his preschool starts, and the chaos that ensues as this hospice experienced growing pains would be challenging for me as a professional. Although this hospice has been in existence for 20 years, its demographics are such that it does not grow like an urban hospice would grow. This one struggled for every step forward. I am not sure that I would have had the patience to stick with an organization with such limited resources for very long. I am impressed by the staff members who do.

Karen was definitely a servant leader. She was energized by her faith. She was committed to her community. She loved her work. Clearly she was in the right place. She was able to listen to the needs of the folks of her county and respond with appropriateness. Karen was a team

player with integrity who was able to nurture herself and others by applying active listening to her daily visits and to her family responsibilities.

### **Rebecca, Valley Hospice**

Rebecca began her career in nursing as a critical care nurse. She then took an 18-year time-out to raise children. She returned to nursing by furthering her education with a master's degree in nursing. When her daughter went away to college, Rebecca took a two-day-a-week position at a nursing home. Rebecca's goal was to sharpen her nursing skills and to stay in that position for one year. Slyly, she grinned and said, "I lasted nine months."

After seeing hospice at work in the nursing home, on a whim Rebecca went to the website of the hospice for which she currently works and pressed the button that read, "Apply Now." She reflected, "It was very impulsive. I filled out the application. I interviewed. The director suggested a position for me and I have been a full-time case manager for five years." Valley Hospice currently has a census of 720 to 800 patients per day.

As leader of one of the many teams at Valley Hospice, Rebecca defined leadership as the ability to guide, manage, and support the people that work with you. She was quick to point out that she does not view herself as a leader within her organization stating, "It is important to respect people. It is also important the leaders don't expect followers to do anything that they themselves won't do." Rebecca followed the practice of leading by example.

The most rewarding part of Rebecca's vocation was the hospice families. She replied, "I like it when families send cards saying how great the care was and that they couldn't have done it without us." She appreciated the autonomy and responsibility of caring for families and hearing feedback that she makes a difference in their lives.

Rebecca found the challenge of her vocation to be the pressure of numbers. She recalled a time when her caseload included ten families, noting, “We used to see our families twice a week. Once would be a full assessment and the other would be more of a courtesy follow-up, show up and be present. That doesn’t always happen anymore.” She reported that most RN case managers now have 12 to 15 families. With some dismay she dropped her head and said, “Right now I have 16 families, but that is an exception.”

Rebecca defined resilience as the ability to set good boundaries and to cope. She also suggested, “The alternative is that this job will suck you in and spit you out.” Rebecca added that the support of the team and being able to adapt are critical to resilience in hospice work.

Professional boundaries are essential for Rebecca’s understanding of ethical resilience. She gave the example of a staff member who invited a patient to his wedding, commenting, “That was a problem. Then when the patient dies, the grief is our grief and it should never be our grief.” When professional boundaries are maintained, the grief remains with the patient’s family. The staff members remain as caretakers for the families.

Rebecca was slow to admit that she made a real effort not to get close to families and patients. This was her coping mechanism so that she could create and sustain resilience for herself. She then admitted, “Some people you just love. Some people you just don’t. You always have to remind yourself, ‘I am an RN, I’m a professional and I am providing a service.’” She concluded by saying that it is critical to have a life outside of hospice.

Rebecca’s life outside of hospice included traveling, going out with friends, reading, and walking for exercise. She has two sisters with whom she is in contact frequently. Her children live out of town so she takes frequent visits to see them. These activities add life and work balance for Rebecca.

Rebecca often helped newer team members as they learned to create and sustain resilience for themselves. She indicated that this usually included boundaries and balance. She tried to engage the newer staff in dialogue that helps them to understand the necessity of boundaries and life outside of their hospice vocation. In Rebecca's experience this is a way to resolve experiences of burnout or "running for the hills."

Organizational resilience is a goal that Rebecca saw her organization striving for, but not always reaching. She related that suggestions have been made to have weekly team leader meetings but they simply did not happen. Such an idea might start off strong but people just get too pressed and stop coming. One bi-annual event that Rebecca particularly appreciates is an all staff member event at which attendees can write notes, cards, thoughts, prayers, or whatever one would like. This is typically a well-attended event that brings the staff closer and promotes healing among those who participate.

Rebecca acknowledged that in a position where every patient is on a trajectory to die, this work takes a lot of support. This type of support comes from the teams at Valley Hospice. Rebecca remarked, "Team leaders go over and above to make sure that we are okay. The leadership of this hospice is sensitive, encouraging, and allows us to manage our own schedules." Rebecca concluded, "If we hit a tough place, a team leader will step in and make a visit for us."

Rebecca has found meaning in her work. She experienced the impact of Medicare cuts, stiff competition from other hospices, and the pinch of doing more with less. In spite of these drawbacks she reflected, "This is a wonderful organization. I work on a terrific team. I love what I do. It is important."

My assessment of Rebecca was that she was able to remain professional and caring about her families. She knew how to keep boundaries and was able to fulfill her own needs outside of her work. She enjoyed her work, but also enjoyed being away from work. She found a healthy balance of life and work.

Prior to reflecting on the narratives, a summary of each participant's definition of key terms will be summarized in Table 4.3. This will be helpful as I then define the grand narrative that runs through the participants' responses as well as the dissonant themes that emerged. The grand narratives and the dissonant themes will be discussed in the section entitled "Reflections on the Narratives."

Table 4.3.

*Participants' Definitions of Key Terms Regarding Leadership and Resilience*

<b>Participant</b>	<b>Leadership</b>	<b>Resilience</b>	<b>Burnout</b>	<b>Ethical Resilience</b>	<b>Organizational Resilience</b>	<b>Life/work Balance</b>	<b>Meaning</b>
<b>Miriam</b>	Guiding team members, mentoring, seeks excellence	Adapting change life outside of hospice	Coping skills Suggests other resources	Respecting people	Staff council New ideas always welcome	Deep spirituality Support group	Touching many lives over many years.
<b>Debbie</b>	Make decisions Lead by example, communicate positive attitude emphasize change	Separating life & work Boundaries	Listen	Keeping patient information private	Could be strengthened Classes offered periodically	Keep strict boundaries between life & work self-care examples: Comedy club, knitting	Humor brightens the difficult realities of this work

<b>Molly</b>	Out-of-the-box thinking. Pushing self to learn new skills	Ability to bounce back Defining boundaries	Shares ideas, listens & offers suggestion	Teaching honesty sharing knowledge of disease processes w. families	Open communication	Balance and boundaries are critical	Respecting and honoring life
<b>Tricia</b>	Multileveled collaborative leading by example	Looking at barriers then pushing past them	Being a team player	Foresight, good communication Understands difficulties of this work	Flexibility & willingness to work with staff who need changes	Boundaries Faith Meditation Sitting still	Incredibly meaningful work Gratifying
<b>Shelly</b>	Out-of-the-box thinking; Leadership by example	Ability to bounce back	Burnout a given when working w. babies, children w. brain tumors teens w. leukemia & children w. hematologic diseases.	Parents want to feed their children, but not always best plan of action: huge ethical dilemma.	Organization does great deal: Labyrinth Walks, team-building, dinner out with staff & family members, painting, variety of other healing activities	Life and work balance occur for most staff by not working full-time.	There has not been one family who has reflected back and wished they did not have their child.
<b>Ellen</b>	A resource to her team Goal to provide the best care we can	Enjoying what you do Having a life outside of hospice Bouncing back	Addressing issues Offering a day off Taking a time out for refreshment	Ethical resilience deeply rooted in faith honesty, diversity, serving the poor	Difficult in large group; not as well provided as in times when organization was a smaller	Exercise, family religious background, hobbies, all protect boundaries	Caring for poor & addicted at the end of life
<b>Karen</b>	Reaching for excellence	Take what is thrown at you and do it	Burnout directly tied to on-call service.	Do not assist patient to die Do not perform abortions	Organization emphasizes the positives in its employees. It is flexible and family centered.	Time off Time off Time away Time off	You are invited into people's lives at the most vulnerable moment in life as they are dying.
<b>Rebecca</b>	Ability to guide, manage, support; leading by example	Being able to set good boundaries. Adaptability	Professional boundaries; keeping a life outside of hospice	Professional boundaries also define ethical resilience	Organization strives for but does not always reach goal of being resilient. Ideas start off strong then people drop out. Bi-annual All Staff ceremony is nice.	Traveling Visiting children Going out with friends Walking Reading keep life balanced	I love what I do.

## **Reflections on the Narratives**

Seidman (2006) asserted that the researcher should “live with” the data (p. 128). I chose to do this by conducting the interviews, taping them, transcribing each interview, and finally writing the analysis of each interview. In doing so I have lived with and fully immersed myself in the people and their responses to the questions outlined for this study. I will discuss the many insights that emerged from this cohort of participants in two categories. The first category consists of insights gained from participants as they shared similar thoughts and experiences. The second category includes contrasting insights as participants articulated outlying thoughts, experiences, or expressions of their vocational process. In all cases candor, honesty and deep respect are shown with every participant. They each are profoundly committed to caring for the dying and their families. This cannot be stressed with enough appreciation and admiration. Also noted among these insights are observations made by the peer de-briefer, which will be indicated as such.

## **Insights of Similarity and Differences**

Several themes emerged from the narrative interviews that are substantiated by a number of the participants. Although phrasing or wording may be slightly altered, the themes remain the same. A narrative followed by a comparative chart will summarize these consistent themes, which center on the definitions of leadership, resilience, burnout, and ethical and organizational resilience. They also focus on the meaning of hospice work, life and work balance, and leaving hospice as a vocation.

## **Emerging Themes Regarding Key Terms**

The following discussion focuses on themes derived from the narrative analysis within which I looked for common and divergent themes and asked for definitions of leadership and

resilience. As each participant told her narrative, I listened for universal statements and lived stories.

The working model of leadership espoused most clearly by all eight participants included leading by example, being able to accept change, and mentoring. Although each of these nurses is an RN Case Manager in charge of 10 to 16 patients overseeing the chaplain, the aid, and the social worker that work with them, only about half of them initially saw themselves as leaders. Those with tighter definitions of leadership in their organizations named those who held titles such as chief executive officer or hospice director as leaders. Table 4.3 indicates that four of the eight participants identified leadership as leading by example. Two participants used the phrase “out-of-the-box” thinking to represent a good leader. The tone of seven of the eight responses is guiding, mentoring, collaborating, and positively communicating. The eighth respondent was more direct. She desired a more influential role in the lives of the patients and family members. This response seemed congruent with the eighth respondent’s personality.

Hospice leaders, as portrayed by these eight participants, work with autonomy and great sensitivity. The example of Miriam as a servant leader thinking first of the patient and family, considering the insights, belief systems, honoring the needs and choices of each particular culture and people, demonstrates the unique balancing of this healthcare paradigm. Miriam has a tremendous tolerance for those whom she serves and she models this tolerance with the staff that she mentors.

Shelly and Tricia embody the spiritual leader guided by grounding in their own spiritual journeys and focused on meaning-making that is centered in faith. Ellen also expresses her leadership through the depth of her Roman Catholic upbringing and her solid understanding of social justice. The peer de-briefer noted the high number of participants who indicated their

participation in Bible Studies, congregational life or parish participation. She seemed somewhat surprised by the high number of nurses involved in congregational life or some expression of spirituality.

Molly, Debbie, Rebecca, and Karen all identify as leaders who work within boundaries, manage as they reach for excellence, and particularly focus on the tasks and goals at hand. They are effective leaders utilizing humor, competence, and challenging themselves to be better leaders and nurses. The peer de-briefer noted that each of these participants also expressed their own sense of religiosity. Karen served as a parish nurse in her congregation. Debbie, Molly, and Rebecca had less institutional connections with spirituality but still expressed a deep sense of faith.

Debbie, Molly, and Rebecca could be characterized as authentic leaders in that they have relational transparency, trust, integrity, and high moral standards. They were also able to work with multidimensional constructs, believed in a higher order, and are able to nurture self and others. They worked with resilience, hope, and optimism. Authentic leaders are self-regulating, self-monitoring, self-reflecting, and have self-efficacy. They are able to shape-shift and have good awareness of self and others. A more in-depth discussion of this will follow in the fifth chapter.

Fun, humor, and flexibility were common notes of this leadership style. Debbie used the example of being “on stage” when she enters the homes of her patients. She wanted to brighten their days and bring a smile to even the darkest of times. This was a common theme. It is an integration of fun and humor into what could be a difficult circumstance. Bennis (2003) labeled this integration as an “adaptive capacity or hardiness; the ability to reinvent oneself” (p. xxiii). Debbie and the other nurses did this day after day as they journey with patients who die by

inches, slowly losing more and more of their capacities to live life to its fullest, while they are still living, breathing, have dignity, and were valued.

### **Conclusions to the Interviews**

Although each of the eight interviews revealed a unique and compassionate leader of her interdisciplinary team, several global conclusions were drawn. First of all, all eight RN's made a conscious choice to become a hospice nurse. Each valued the ethics and paradigm of hospice care. Each saw in this nursing a way to help patients have dignity, comfort, and the right to make their own choices at the end of life. Each RN had been touched by hospice in her own personal life and knew intimately the power and the pain of this experience. Through their work, they sought to give back to those for whom they now care.

There were also differences in the group. Miriam and Shelly both felt comfortable working with dying children. Although this was not one of the research questions, several of the participants (Debbie, Molly, Karen, and Rebecca) volunteered that they were not comfortable working with dying children. Tricia and Ellen both had limited experience with administering chemotherapy to children with various kinds of cancer. Although this was not their first choice for a vocation, Tricia and Ellen could work with children or adults.

Molly was also in the position of making a significant role change. After serving as a hospice nurse for two years she was transitioning to work with information technology at her hospice. This is a unique role among those whom I interviewed. Molly was training to work with the technology resourcing to hopefully make the technology more "user friendly" in the field for the nurses and other members of the interdisciplinary teams. The vision at this hospice is that with better technology the team can be better supported and more efficient, resilient, and supported. Molly was too new in her position to give her opinion on this experiment.

Overall, there was a wealth of knowledge to be gleaned from these eight participants. Each shared much about their own narratives as hospice nurses and their understandings of resilient leadership. Each nurse showed courage in her own position in life and in work. As H. Gardner (1995) wrote, each of these nurses is “the embodiment of personal courage” (p. 275).

## **Discussion and Analysis of the Narrative Results**

This chapter will discuss the findings of my research as well as interpret the findings in light of the research questions and proposals set forth in the literature review in the second chapter of this dissertation. I began by reviewing the research questions detailed and elaborated upon in the first and introductory chapter and third chapter on methodology. In each section of this chapter I then compare and contrast the findings of the interviews with the literature review. Finally, a summary, evaluation and interpretation of the data will show how findings answer the research questions.

I review the research questions posed in the first chapter and answer each. Leadership will be viewed through the understandings of servant, spiritual, and authentic leadership models as the participants of this study addressed them. Resilience and ethical resilience are defined as the participants of this study defined and clarified them. Finally, a discussion of further research possibilities leads to the concluding discussion in the sixth and final chapter.

### **Answering the Research Questions**

The first question of this research is how do interdisciplinary team leaders create and sustain resilience within their teams? Teams were defined as the chaplain, social worker, counselor, and registered nurse who are assigned to hospice patients and their families. These teams provide end of life care, supporting patients and their families in homes, nursing facilities, and hospice houses until life's end.

How do these leaders define "resilience?" Is this resilience grounded in ethics? These questions continue with how do the participants cope with the difficulties interdisciplinary teams have with burnout and stress? How do they apply their knowledge and their understanding of both the challenges and the joys of this work? How are organizational structures, continuing

education opportunities, and health and wellness programs utilized and made available to interdisciplinary team leaders and members? How is resilience created in the face of a caring situation where every patient's trajectory is to die? These core research questions are answered through the eight interviews and are summarized below.

Visiting additional hospices and interviewing participants, continued until saturation of data was met (Nagy et al., 2006). This became apparent when themes raised by participants became redundant and no new findings were uncovered. I was certain to include the demographics of hospices that represent pediatric, rural and urban areas in the Midwest. Unfortunately, I did not have control over the particular people in the interviews (all female registered nurses) because they were chosen by the Executive Directors of the sites.

### **Core Research Questions**

**Defining resilience.** As I sought to answer the core research questions of this dissertation, it was important to begin with a working definition of resilience. I asked each of the participants in this study to describe resilience in terms of the factors listed in Table 4.2, essentially an understanding of being able to adapt to life's changes, set healthy boundaries, bounce back, and take what is thrown at you. Resilience through the research of Masten (2001) began with the terms "ordinary magic" (p. 228). Tugade et al. (2004) confirmed this accessible trait of psychological resilience and positive granularity, while Drinka and Clark (2000) applied resilience to healthcare professionals in terms of the ability to intuitively listening with an inner ear with creativity and compassion. Goleman (1995) asserted that emotional intelligence is important for leaders functioning within systems such as the interdisciplinary teams of hospice leaders. McCallin and Bamford (2007) confirm the influence of excellence and job satisfaction leading to resilience and team effectiveness in today's healthcare environment.

In the feedback from participants in this study, Debbie noted the importance of “Supporting one another; sleeping well, eating well; filling your bucket so you can empty it again,” while Rebecca remarked, “I set boundaries. When I am at work, I am at work. When I am home, I am home.” Tricia added, “I bake, I cook and I know my limits. I pray, meditate and sit still.” Miriam defined resilience as “The ability to adapt to changes. It is also the ability to sustain the energy level that it takes to do this work.” These descriptions echo Norman et al. (2005), who emphasized the importance of individual determination and motivation, hope, and adapting to ever-changing responsibilities.

In an effort to further deepen the definitions of resilience gleaned from the literature review, in Table 2.3 I define resilience as being a model with trust, transparency, high moral ethics, a continuous learner, the ability of assessment, being creative, self-reliant, having a sense of humor, and good ego boundaries. Resilience also includes nurturing both professional and personal networks of support, meaning in life and work, and a safe haven of trust.

In healthcare resilience is offered as a systems approach that is individual, micro-organizational, and macro-organizational (Jeffcoat, Ibrahim, & Cameron, 2009). This study defines the individual, the interdisciplinary team (as the micro-organizational) and the macro-organizational as the whole organization. The goal of a resilience approach is multi-layered. It focuses on how we can build resilience into complex healthcare systems so that patient safety is enhanced. This resilience is critical to excellence care and to how people in teams perform, think, communicate, and interact with technology (Jeffcoat et al., 2009). Molly’s new position working within the information technology department of hospice is an excellent example of creating a resilient model by trying a new structure to cope with the stressors of ever-changing technological advances in hospice care.

The healthcare resilience examined by Medland et al. (2004) illustrated the importance of wellness among the interdisciplinary team members from the vantage point of staff retention. This group of authors used the case of Northwestern Medical Hospital (NMH) and the statistic that on the oncology unit the turnover rate for nurses is 40%. The remaining turnover rate for nurses at NMH is 14.2%. This difference in retention points to the need to re-evaluate wellness and consider how to nurture those who care for cancer patients.

This is evidenced within the participant study as well. Although two participants are retiring, several others are choosing to resign from their hospice positions and move in to other nursing opportunities. Shelly is moving to a less intense field within pediatric nursing. Debbie is leaving nursing. Molly is transitioning to information technology within hospice. Rebecca and Karen remain within their current positions.

Based on my research and the results of this study, resilience can be defined as an integrated experience of bouncing back, stretching, and re-shaping ones' self, tending to one's emotional, spiritual, physical and mental needs and being malleable in stressful and crisis situations. Ethically resilient leaders in hospice interdisciplinary teams have the malleability of Silly Putty and the pliability of Nerf Balls. They move and turn, twist and return to the shape needed to head to the next patients' home with a smile, a word of encouragement, and a willingness to shed a tear or two as death draws closer.

**How do leaders create and sustain resilience in the interdisciplinary teams they serve?** Literature and the data point to the question: how do leaders create and sustain resilience in interdisciplinary teams? Resilience being defined as it is above, the model posed by Medland et al. (2004) points to creative possibilities and an approach that nurtures body, mind, and spirit for those who lead, teach, and serve in hospice, palliative, and oncology care. The data from both

this study and the literature reveal a holistic approach to wellness, self-care, life-balance, spirituality, and a deep understanding of who you are and why you do what you do can help to open the path to resilience in hospice and palliative care leadership and change.

The grand narrative heard time and time again from the participants in this study reveals that creating and sustaining resilience within the interdisciplinary teams comes from an array of physical, emotional, social, mental, and spiritual processes. In addition to the aspects mentioned above, a photography class, a Zumba class, a glass of wine after work, a caring, listening ear, holding one another as you grieve the death of a young mother together—all are ways that hospice interdisciplinary team leaders help their teams create and sustain resilience.

The components of endurance, emotional intelligence, and resilience are all a part of creating and sustaining resilience in an interdisciplinary team. After interviewing five hospice nurses, Gaydos (2004) concludes that “insight, independence, initiative, relationships, humor, creativity and morality” (p. 22) are the keys. The processes for creating and sustaining resilience typically occur within the teams themselves. In the teams in which I participate, we read the names of those who have died at the end of every team meeting. We talk about family members for whom we have special concern. As bereavement coordinator, I take note of those who need to be contacted sooner rather than later.

A hospice aide who worked for our organization for nearly 30 years made this team-time memorable a few months ago. At the end of sharing information on recent deaths and family concerns, one of our chaplains prays. On that particular day, it was my day to pray. Just as I said, “Amen,” Shirley’s phone began to ring. Normally, this would be irritating. But the ring on Shirley’s phone is the tune to “When the saints come marching in.” That day our team had more

resilient hearts. We corporately smiled. The saints had indeed gone marching in. We were gifted to be the team to assist in that march.

Resilience can be neglected. Jeffcoat et al.'s study (2009) noted a direct tie between patient safety and healthcare workers who are overworked, working at a fast pace, and stressed out. These authors asserted that applying resilience training in healthcare settings will lower human errors and thus increase patient safety. In fact, their study proves this hypothesis and my study corroborates their findings.

Creating and sustaining resilience within the interdisciplinary hospice team is, as Jeffcoat et al. (2009) pointed out, a patient safety issue. It is also, as Swetz et al. (2009) point out, an issue of ensuring longevity and fulfillment for those who work in the field. The participants in this study concur that on a regular basis they as leaders and their team members in the field need to be acutely aware of self-care, life-balance, and the need to keep resilience at the forefront of their minds.

In summary, the participants in this study created and sustained resilience in the interdisciplinary teams they serve, in the following ways. First of all, listening to colleagues with empathy when they need a compassionate colleague is critical. Secondly, having time away and setting boundaries between work and home allows the hospice professionals to nurture resilience in teams. Thirdly, enjoying one's work and having a sense of humor goes a long way toward fostering resilient professionals. Finally, offering an array of physical, mental, emotional, and social opportunities to nourish one's life and vocational calling allows ethical resilience to grow in hospice interdisciplinary teams.

**How do leaders cope with interdisciplinary team members who experience burnout or stress?** The question regarding burnout and stress is worded this way: How do leaders cope with interdisciplinary team members who experience burnout or stress? Miriam answered that she encourages those who are feeling burned out to share their feelings with her. She then shares with them some ways that she has coped over her many years of nursing. Miriam uses a servant leadership model of listening, asking the right questions, serving first, and healing love to address burnout with others in her organization.

Shelly acknowledges that burnout is simply part of working with pediatric hospice. When babies are terminally ill and children have brain tumors, burnout comes with the job. She also notes that many of her colleagues do not stay in pediatric oncology or pediatric hospice for long periods of time. This could be a separate dissertation study. She also noted that exercise, spirituality and conversation with colleagues at work were helpful.

Karen tied burnout directly to the stress of the necessity to be on-call. Ellen discussed addressing issues that may be causing undue hardship and offering time off if that would bring refreshment to the person on the team experiencing burnout. Tricia readily admitted that she knows that exercise and good self-care help with burnout, but she is not very good at these. Debbie concluded that burnout is something that she listens for and tries to be sensitive to. If someone she knows is feeling burned out, she will ask them to go out so they can talk privately. Molly indicated that their team leaders try to share the patient loads so that if one person is feeling overloaded another nurse will take a couple of their patients to lighten the load for the week. She believes that this helps everyone feel better and prevents burnout. Finally, Rebecca reports that she is a good listener. She noted that going home with your problems is not a good

idea. Family members do not understand this work. Colleagues do understand. Rebecca tries to listen and find creative solutions with her team members to prevent burnout in the workplace. Swetz et al. (2009) studied burnout in 40 hospice and palliative care physicians. They found that physicians who paid attention to physical health, professional relationships, and adopting a transcendental perspective— defined as “understanding that which makes us human, aspects of personhood, and how one deals with spirituality and nature” (p. 76)—were able to prevent the signs and symptoms of burnout. These transcendental experiences are consistent with Holland and Neimeyer’s (2005) study suggesting that professionals engaged in end-of-life care described “daily spiritual experiences” as a means of reducing the risk of burnout (p. 178). A fourth important theme for these physicians is talking with others. Relationships with colleagues, above family and friends, was very important and minimized burnout (Swetz, et al., 2009). My study corroborated the findings of these authors. It was Ellen who noted that a glass of wine with colleagues was an excellent way to minimize burnout. Miriam was mindful of pulling colleagues aside and listening when they needed support or encouragement. Tricia and Shelly both concurred that supporting colleagues was helpful.

To summarize, burnout and stress are common among colleagues in interdisciplinary teams. Talking with one another, listening to colleagues, relationships with friends and co-workers, and being team players are among the ways to address the challenges of hospice and palliative work. Coping skills, emotional intelligence, spirituality, and time off for refreshment are other ways to address burnout. In the end, some professionals simply decide that this work is not for them.

**How do hospice leaders apply their knowledge and understanding to the challenges and joys of this work?** Ablett and Jones (2007) noted that ten palliative care nurses in a hospice in northwest England were interviewed to collect data on well-being and resilience in their work. These nurses' responses echo well the responses of the eight participants in this study. They have a zest for living. They enjoy today. They cherish life. They want to choose "a good death" for those they serve. These nurses do not fear death, but rather see it as one more part of the life journey.

The challenges of this work rise to the surface quickly. Participants in this study knew immediately that they need to face their own mortality before they could be hospice interdisciplinary team leaders. The challenge of knowing who you are and that you will die is essential in this work.

Humor is also clearly an important component of this work. Humor is consistently listed as a core leadership trait. Debbie spoke of "putting on a show" for her patients. Ablett and Jones (2007) noted, "Humour is clearly important to this setting and has many functions," (p. 735). I use humor daily with my clients. We laugh about grief's absent-mindedness or about how many tissue boxes I go through in a day. I tell all of my clients that I buy stock in "Puffs." This lessens their embarrassment about tears and enables them to normalize tears as okay in my presence. I am a safe person for their grief.

In conclusion, from the results of this research will assist hospice leaders in applying their understandings of living and dying to their work. The interviews presented here reveal that hospice nurses view the challenges and the joys of their work through their own understandings, often based on a spiritual understanding of life and death, so that death is simply one more passage that everyone must make. These professionals use humor. They use their own

experiences with hospice. Several of the nurses shared their personal experience with hospice, disclosing that their own loved ones had died under the care of a hospice or that they were the caretaker for a loved one in hospice. These experiences were life changing for them. They see life and death as a continuum that is gratifying and meaningful. They feel honored to be a part of the end of the journey with so many lives at the end of life.

**How are organizational structures, continuing education opportunities and health and wellness programs utilized and made available to interdisciplinary team leaders and members?** Holland and Neimeyer (2005) report that continuous exposure to stress, brought on by dealing with end of life care, can be devastating and have an impact on a clinician's ability to perform at peak levels. Ablett and Jones (2007) also concur with this understanding in their study on palliative care staff and hospice nurses. These studies assert that interventions by organizations and thoughtful ways of addressing the unique needs of these clinical staff are critical to performance, success in preventing absenteeism, intention to leave and poor communication (Ablett & Jones, 2007).

Karen, who works at the smallest, adult hospice of any participants I interviewed, spoke highly of her organization. Although the organization does not have a multitude of resources, they are willing to meet her and the other team members halfway. She gave the example of a conference she wanted to attend in Florida. Karen explained to the executive director why and how she believed this conference would enhance her skills and benefit the hospice. Karen agreed to pay her own travel and lodging expenses if the organization would pay for the conference. The executive director agreed that this is a good idea. Karen came back with many new insights to share with her colleagues. The executive director experienced this as a win/win proposal and

embraced her vision for vocational growth. As a result, both Karen and the organization benefitted.

Debbie, on the other hand, noted that her organization does little to nothing to support her and her colleagues, a sentiment was also expressed by Ellen, Tricia, and Molly. These four participants are allowed time off for continuing education, but there is no financial help or incentive to seek programming. Nevertheless, programming is necessary for their licensures. The leadership of these organizations focuses less on staff development, communication, and nurturing, instead, prioritizing results tied to patient-nurse ratios, budgets, and bottom lines.

Miriam, Rebecca, and Shelly are all part of organizations that provide or encourage both wellness and continuing education events. Leadership in these organizations sets a tone of cooperation, teamwork, collaboration, trust, and honesty. Shelly reported that her team went together to a Labyrinth for a retreat and prayer. Miriam spoke of an entire week of special services directed toward educating and appreciating the hospice staff during the annual Hospice Awareness Week. Rebecca noted that her site has “Football Fridays” where everyone dresses in their favorite jerseys. Even the families share their football rivalries. It makes for a fun fall activity and promotes humor, wellness, and joy. During “Football Fridays” the organization provides cookies, punch, and other special treats every Friday. Again, the leadership at all of these organizations promotes wellness, trust, honesty, a supportive environment, cooperative and collaborative openings for learning, wellness, and mutual growth.

From this research, it seems that inspiring, motivating, promoting wellness, encouraging resilience, reducing the risks of burnout, and instilling commitment so that staff members are robust and not seeking other positions, are the essential tasks of leaders in hospice and palliative

care today. These lead to the final question of this research dissertation, the question that is the most obvious and the most painful of this work.

**How is resilience created in the face of a caring situation where every patient's trajectory is to die?** Ellen became philosophical when asked this question, reflecting, "You come to the understanding that this is part of the life journey. We help the patients incrementally toward the goal of dying. It gets tough when you do not have time to do what the family needs." Debbie replied, "This takes support. Sometimes we receive it and sometimes we don't. When we don't, they don't get the best out of us on those days." Rebecca noted, "I go into this knowing that this is not my loved one. I will know the patient for a very short time. I am grateful for the fact that I will get to know them. I am providing them with a service." Shelly answered, "You cannot put a measure on the changes a kiddo may make in your life. Though their life was short, some kids can have an impact on someone even though another person may live to be eighty." Tricia undergirded her answer with her spiritual understanding of life and death. She answered, "For me, death is not a bad thing. We are all going to die. My goal is to help the patient die comfortably and as close to what they want as I can. I also want to help the family manage that. If I do that, I have been successful and it is rewarding." Miriam echoed a similar opinion to Tricia. She replied,

I look upon death as another journey. I do not go in with a 'doom and gloom' attitude. I go in with a positive mood. I go in to help patients make the best of every day they have. I tell them that they have the tougher job.

Molly explained that she shares her own experience with her patients. For example, she often shares the fact that she took a leave of absence when her own mother was dying. In this manner she lets them know that she knows what they and their family members are experiencing. Molly reflected, "I have been in the caregiver's shoes. I know the journey. I tell my families that." Karen also shared that she took care of her uncle. She knows the journey. She shares her

story and her pain with the patients and families. She is caring for her mother now. She too knows the journey.

These views are supported by Swetz et al. (2009) who note similar responses from physicians working in end of life care. Thirteen themes arose out of this study indicating ways of coping with the finality of this work, including exercise, personal boundaries, passion for one's work, realistic expectations, humor, remembering patients, talking with peers, and spiritual well-being.

Jones (2005) also noted that a self-care plan for hospice workers allows the interdisciplinary team members to maintain better balance as they care for dying patients and their families. Jones used a model of input and output of energy to describe how hospice workers can identify both the stressors of their vocations and how they can work to maintain balance between life and work. The metaphor of "filling up one's bucket" was used by several of those interviewed in this study.

Jones (2005) suggested that an individualized self-care plan is one way of addressing the stress of hospice workers, discussing options such as maintaining a spiritual connection, setting good relational boundaries and finding soothing ways to cope with emotions like a warm bath, walking, or running. She also suggested hobbies like gardening, sailing, fishing, traveling, golf, bridge, horseback riding, and making time for play. These are all ways Jones encourages the care-giving hospice worker to nurture himself or herself.

Holland and Neimeyer (2005) presented a study suggesting that end-of-life care settings are positively impacted when practitioners in such settings have a spiritual or religious belief system that undergirds their daily experiences. The positive implication of lessening burnout

occurred on three levels of testing: physical fatigue, cognitive weariness, and emotional exhaustion.

Finally, because of the reality that in hospice care, every patient's trajectory is to die, it is important to emphasize the urgency of creating and sustaining resilience for the leaders and professionals who work in this team setting. Daily practices of spirituality, good relational boundaries, soothing ways to cope, ethically sound decision making grounded in values that honor dignity, and humane care and death without pain or trauma are the foundations of such resilient interdisciplinary teams. This work is difficult, and is best done when grounded in authentically resilient, ethical leadership.

### **The Grand Narrative Comparing Literature and Research Data**

In the third chapter, my goal was to identify the grand narrative that was woven among the participants and throughout the research. The core of this information, detailed in Table 5.1, defines and corroborates resilience as it pertains to these hospice nurses and the questions of this study.

This study has provided a view into the authentic ethically resilient leader. She may find herself within the bounds of a servant, spiritual or authentic value system. She is grounded in deep commitment to her vocation and her values. She is a continuous learner, curious, competent, and compassionate. She is fearless.

Resilience is second nature to this leader. She defines resilience as the Silly Putty that can be pulled in many directions or the Nerf ball that can be shaped and re-shaped but comes back bouncing. She is flexible, capable, competent, and open to change. She loves people, particularly the people on the margins of life and death. She has a deep passion for life and knows that beyond life, there is still meaning. She is tolerant, open to beliefs that are different from and may

Table 5.1.

*Traits of Leadership, Resilience, and Emotional Intelligence in Literature and This Study*

<b>Traits of Leadership, Resilience and E.I.</b>	<b>Literature</b>	<b>Data</b>
Empathy, listening, compassion	Servant leadership, Greenleaf (1977); Spiritual leadership, Reave (2005), Fry (2003); Emotional Intelligence, Goleman (1995); Resilience, Wright (2002), Pulley (1997)	Debbie responded that <b>listening</b> was a key for her. <b>Empathy</b> was modeled by Miriam, Tricia, and Shelly. <b>Open communication</b> for Molly included good <b>listening skills</b> .
Maintaining a spiritual connection, higher calling, higher order	Servant leadership, Spiritual leadership, Authentic leadership, W. Gardner, et al. (2005), Resilience	Miriam nurtures a <b>deep spirituality</b> . Tricia, Shelly, and Ellen all spoke of <b>faith impacting work</b> .
Wellness and life/work balance	Emotional Intelligence, Resilience, Authentic leadership, Spiritual leadership	All eight participants responded in various ways indicating the necessity of a <b>work/life balance</b> .
Shape-shifting, changing and adapting	Authentic leadership, Resilience, Emotional intelligence	Debbie emphasized the need to always be <b>open to change</b> . Karen spoke of going to conferences to <b>find new ideas</b> . Molly spoke of <b>sharing new ideas</b> .
Trust, valuing decision-making, integrity and respect	Spiritual leadership, Authentic leadership, Resilience, Emotional intelligence	Debbie spoke of <b>trusting</b> those who come on at the next shift to care for her patients well. Tricia, Karen and Ellen <b>trust the process</b> of communicating with families at the end of life.
Sense of humor, fun	Spiritual leadership, Resilience	Debbie's story about her patient <b>George</b> .
Developing others, teamwork and collaboration	Authentic leadership, emotional intelligence, resilience	Miriam spoke of being a mentor and <b>guiding others</b> for many years. Debbie, Tricia, Shelly and Rebecca all spoke of <b>leading by example</b> .
Ethical decision making	Authentic leadership, Resilience	Shelly spoke of the <b>depth of searching</b> that goes with decisions regarding end of life decisions with babies and children. Ellen spoke of her <b>passion</b> for the poor and underserved.

challenge her own. She understands that life is not fair and not just; however, every person deserves to have a life and a death with as little pain and suffering as possible. They also deserve dignity, compassion, respect and honor. Hospice nurses offer these kind and benevolent opportunities every day of their vocational journey. It is a gift. It is a calling. It is an ethically resilient life embodied.

It is instructive to compare leadership responses to the leadership models of Table 2.3. Six of the eight participants clearly identified spirituality or faith as an integral part of who they are and how they both lead and remain resilient. The very core of these participants is saturated and understood through the lenses of their belief systems. In examining Table 2.3 it becomes apparent that these six leaders may identify with any or all of the categories of servant, spiritual, or authentic leadership. The answers they give reflect parts of each of these leadership models.

### **The Ethically Resilient Hospice Leader**

Boundaries and bouncing back are words that are repeatedly affirmed by the participants in their responses to these questions. Respect, honesty, good communication, privacy, and deeply honoring people reflect the participants' answers regarding resilience and ethics. In addition, in the absence of a specific question on balance, every participant spoke of the importance of life/work balance. This critical theme arose in every conversation and thus I made it one of the seven categories in Table 4.1. The life/work balance of each participant is an essential part of how they bounce back. It renews each nurse so that she is able to return to her position and give all that is necessary in this demanding vocation.

It is also important to recognize that some resilience traits are framed with different words and phrases in the participant definitions. Although no one used the exact words "trust" or "transparency," these concepts were of importance and were shared along with words like

“honesty, “openness,” “not being fraudulent,” etc. No participant spoke of “feeling secure in personal identity,” however, all eight alluded to an attitude of confidence as they referred to relating with patients and families, trouble-shooting problems, nursing protocols, and the hospice philosophy of care. The eight participants spoke of respect, honesty, integrity, and open communication, thus conveying principles of resilience that are noted in Tables 4.3 and 5.1.

Recalling the study by Tugade et al. (2004), psychological resilience and positive emotional granularity are concerned with the effects that resilience has on the health of adults. These authors identify humor, positive emotional disclosure, psychological health, and the “undoing effect” that positive emotions can have on stress. Psychological resilience results when persons are able to show flexible responses to changing demands. The ability to bounce back from negative emotional experiences is key to this understanding of resilience.

Karen enters her patients’ homes ready to encounter whatever circumstances arise. She shared the narrative of a particular day with the elderly gentleman who cherishes his privacy and home. On this day, Karen must deliver the news to him that he is no longer able to be safe in his home alone. The loaded gun that is on the kitchen table between Karen and her dear patient is only one reminder that this will be a tough and tender conversation. Ethical resilience that includes humor, positive emotional disclosure, and flexible responses to changing demands were critical to the conversation and movement that were necessary in this situation.

This patient knew well in advance of this conversation that when the time came that he could no longer make it to the bathroom by himself, he must move. That time had come. The paramedics and the hospice nurse were called out in the middle of the night to help this kind man with a fall and a difficult bathroom situation. The time had come in his disease process that he could no longer live alone. Karen delivered the news with love, respect, honesty, and firmness. It

was a vulnerable, painful experience for both Karen and the patient. It took resilience as defined by Tugade et al. (2004). Karen's day was not ending with this encounter. Her day was only beginning.

Returning back to honing the definition of resilience and the hospice leader, Pulley (1997) identified the seven characteristics for the individual and the organization that were discussed in the second chapter. The first of these is being a continuous learner. Molly, Shelly, and Tricia all used the phrase "out-of-the-box thinking" when referring to their approach to leading change in the hospice and palliative care settings. Each of the eight participants stressed how important embracing change is in their practice and leadership.

Pulley (1997) lists self-efficacy and self-reliance as characteristics two and three. Nowhere are these more necessary than in the homes of patients when nurses or other team members are solving problems and addressing issues. Ellen, Shelly, Tricia, and Karen reach for a sense of meaning in their work and life. Debbie acknowledged feeling secure in her personal identity. All of the participants are proficient in what Pulley calls "shapeshifting." This means finding new ways of doing things. It means applying skills or improvising. For the participants this can be as simple as finding a new way to make a bandage when they do not have the correct supplies available or improvising a way to get a patient to drink Ensure (by adding ice cream) because normally it tastes so bad! I personally promised a 101-year-old man that I would buy him a Heineken if he would drink his Ensure while I went to Kroger to buy the beer. It was amazing how quickly that Ensure disappeared! The seventh characteristic is about money. How do individuals or organizations relate to finances? All of the participants expressed the current healthcare reality of "doing more with less." Each one echoed this phrase in one way, shape or form.

Earlier I referred to Akerjordet and Severnison's (2008) eight competencies of Emotional Intelligence. These are also used to define resilience and include developing others, teamwork, collaboration, organizational awareness, building bonds, visionary leadership, respect, and open communication. These eight competencies are embodied well in the eight participants of this study. Interdisciplinary teams in the hospice model are designed to promote respect among the various disciplines within the team. The sense of teamwork and collaboration is built into the model. Open communication, organizational awareness, building bonds, and visionary leadership vary from hospice to hospice based on the leaders and the teams in place. All of these variables have a significant impact on the resilience of the individuals and the organization in the hospice model.

Resilience in the hospice field is creative. It is multifaceted. It can be grounded in things as simple as the "time-off" and "boundaries" spoken of by Karen and Rebecca. It is also fostered in organizational activities such as Zumba classes or photography sessions. Regardless of its origins, according to these eight participants, resilience is necessary to maintain healthy longevity in the hospice leadership world. Taking time off, having boundaries, doing things with family and friends, having hobbies, being engaged in church activities or Bible studies, traveling, cooking, balancing life and work, meditating, exercising, knitting, having a glass of wine, reading—whatever the participants named as their ways to balance life, these are essential to the resilience and the renewal needed to go back in to work the next day and address the needs of the dying with excellence and compassion.

I have chosen to use the terms "excellence" and "compassion" because these two themes undergird each of the participant interviews. I became aware of this trend in my field notes as Tricia reported that the reason she went into hospice nursing was so that she could "do a better

job” than the hospices did when both of her parents needed hospice services. She was seeking to be more excellent and more compassionate than those who cared for her mother and father at the end of their lives. This same theme arose again with Shelly when she reported that she entered hospice nursing to emulate the excellence, compassion and care with which she and her husband were gifted, as their infant daughter died under the care of a hospice nurse. The theme also arose when Debbie spoke of the compassion and excellent care she saw when she watched hospice workers as she was a unit coordinator in a long-term care facility. This care and compassion was even extended to Debbie when her cat died, an event that motivated her toward hospice nursing as a career. There were many more examples of excellence and compassion among the participants. Field notes and interview quotes support that these traits are significant to the satisfaction and resilience of the hospice nurses in this study.

So precisely what does the resilient hospice leader look like? How does one create and sustain resilience in interdisciplinary team members? To begin answering this directly, let’s look at what breaks down resilience. Here are the findings of the interviews from this study and previous research.

Emotional exhaustion, burnout, high depersonalization, and low personal accomplishment are the four characteristics reported by oncologists, palliative care physicians, radiologists and surgical oncologists in a study by Graham and Ramirez (2002). Burnout, absenteeism, psychological morbidity, quality of care, and distancing from patients were among the results found in a study of hospice nurses surveyed by Ablett and Jones (2007). Medland et al. (2004) noted that stress, reduced productivity, exhaustion, and poor patient care were among the results found when hospice nurses ignored their own grief and were pushed too hard.

The nurses in the study indicated that they love their work; however, those who have had children in hospice find themselves depleted. Also, those who are currently caring for aged parents find themselves exhausted physically and emotionally.

Shelly, was the one pediatric hospice nurse interviewed, who was leaving her position. She stated that watching children die is too difficult at her life stage. She has a son living at home. To care for dying children all day and then to go home to care for her own child is just too difficult. Because her current job is emotionally too painful for her, Shelly is transferring to a less intense position within the hospital system.

Other nurses in this study reflected upon the stress of being “on-call.” Those who work a 40-hour week and then face being “on-call” for the weekend found this to be distressing. “On call” led to very quick burnout. Karen reported that she could be up with a dying patient from midnight to four in the morning. Then she would be expected to be in the office at eight in the morning to fulfill her responsibilities for the day. She laughed as she said, “I’m just getting too old for these all-nighters.”

Another theme of the grand narrative was the fact that the life/work balance was often out of balance for the participants in this study. Only one of the eight participants exercised regularly. All recognized that they needed to do so. All had ideals that they held themselves. All were frustrated that they did not meet the expectations that they have set for themselves.

This strong division between home and work is a common theme in hospice work. One participant said, “I also do not share the details of my day when I return home to my family or friends.” Jones (2005) concurred that setting and maintaining clear boundaries with relationships outside of work is essential to health hospice work (p. 127). An example of this occurred in my life recently. The following conversation may help to elucidate the dilemma for those who do not

live in the world of such vocations on a routine basis. This is the summary of a conversation I had in December 2012 with a physician who works with a pediatric hospice. We were at dinner together and realized we shared client family.

Oddly enough I sat at a dinner next to the Medical Director of this pediatric hospice. As we began to share our vocational callings we realized that she and I share a family in our work life. She cared for the little one before death and I am caring for the family after death. She made this comment, “Our jobs are conversation stoppers. Once you tell someone what you do they don’t want to hear anymore. You are better off telling them about the weather not about your day with the children.” She is so right. Family members, although they are supportive, cannot manage the details of a day. It is not fair to friends to traumatize them with what we do. Confidentiality requires that little is said about anyone that we serve. My answer to people is, “If you watch the evening news the families of those murdered, run over by cars, killed in accidents . . . those folks will find their way to me in the next few weeks. They need a safe place to heal.”

Family and friends are not the first line of support for those who work in hospice settings. Medland et al. (2004) observe:

As the pace of nursing care accelerates, staffing levels reflect the diminishing RN workforce, and the United States’ nursing shortage looms on the horizon, helping oncology nurses to cope effectively with their challenging work environment emerges as an organizational imperative. (p. 47)

This imperative that oncology nurses and hospice workers discover outlets, ways of taking care of their personal needs for support, encouragement, and self-healing, is revealed in studies by Abendroth and Flannery (2006), Ablett and Jones (2006), and Van Westrhenen and Fritz (2012). All of these studies note examples in line with Abendroth and Flannery’s statement that,

“Compassion fatigue is a preventable and treatable phenomenon. Hospice organizations with policies, interventions, and evaluation methodologies that address compassion fatigue risk may result in substantial employee benefit cost savings, uninterrupted professional nursing care, and increased patient family satisfaction” (p. 355).

My study’s participants confirm this resoundingly.

### **Meaning**

Palmer (2000) writes, “A leader is someone with the power to project either shadow or light onto some part of the world and onto the lives of the people who dwell there” (p. 78). The participants in this study are bearers of light. They use humor, honesty, dignity, trust, excellence, and touch the lives of people at the most vulnerable apex of life’s narrative. As Miriam says, “I go in to help them make the best of every day they have. I tell them that they have the tougher job. I am there for an hour but they are dealing with this 24 hours a day.”

These nurses acknowledge that they touch many lives throughout their hospice careers and they themselves are changed. They love what they do. They meet life at its most vulnerable moments and work diligently for comfort, dignity, and compassion.

Meaning for each hospice leader is a personal journey. For many leaders it begins with the question posed in the Medland et al. (2004) study: “Did you choose oncology or did oncology choose you” (p. 51)? A sense of calling rises out of this question, as does a greater sense of purpose.

Several of the participants in this study had experience as caregivers of loved ones in hospice before they became hospice nurses. Shelly cared for her dying infant daughter. Tricia cared for both parents in two separate hospice experiences. Molly lost two immediate family

members. Her sister died in the hospice where she works. While doing my PhD studies, my mother also passed away.

Those of us who work in this field recognize that death knows no limits. Death is guest in every heart and home. There are vaccinations against the flu and smallpox, but death is an equal opportunity reality in every life. Therefore as one works with those who have loved and lost, it is much more of an imperative to cherish each day. The guarantee of tomorrow is promised to no one. In the words of Tillich (1952), the hospice leader is called to have “courage (that) is the self-affirmation of being in spite of the face of non-being” (p. 155). It is the understanding of finding meaning in affirming life, living each day to its very fullest with integrity, serving those whom we have been called to serve.

In my own work with dying children, I have felt called to be the one to carry the tiny caskets. As a servant of God and as the pastor to the families who bury their little ones, I always offered to carry the baby caskets. It is a humbling task. What rests inside those caskets is a beautiful baby and the hopes, dreams, imagination, and unbearable pain of a family.

The day we buried Nicholas was one of those unbearable days. His mother and I were both six months pregnant. Nicholas died after nine heart surgeries. His heart was never able to support a growing toddler. He was 18 months old at his death. The ground was nearly frozen and the winter winds whipped through the cemetery as only the chill of death can do. We passed the “No Exit” sign as the procession pulled to the back of the cemetery where children and infants were buried. There, Nicholas would spend eternity.

The only hope that Nicholas’ mom had for a healthy baby this time was if someone read to her. She was illiterate. The OB/GYN had briskly given her pamphlets on late-stage perinatal diabetes. She could not read them. But the second time around, she asked for help. Now in her

sixth month of pregnancy with diabetes at its onset, she had her sister read to her. She watched her diet. She kept her weight under control. She kept her blood sugar in check. Her baby, Robert, was born healthy.

The day of Robert's baptism was quite a celebration. Nicholas would forever be in his parents' hearts. Memories and pain are forever etched in their lives. Resilience and hope are also part of their life narratives.

## **Summary and Implications**

This concluding chapter includes several sections. I will begin by summarizing the implications based on the literature review. This is followed by implications based on the participant interviews and findings of my research. Thirdly, I will note practical implications for the fields of health and hospice care. Recommendations will be made for further research. Theoretical and methodological recommendations will also be made. Finally, personal reflections conclude this chapter.

### **Implications From This Research**

The eight nurses interviewed in this dissertation reflect ethically resilient practitioners who define themselves within the understandings of servant, spiritual, and authentic leadership. This is illustrated by referring back to the summary of leadership models, resilience, and hospice leadership presented in Table 2.3. It is also echoed in the responses of the eight participants in this study.

Table 2.3 refers to servant (Greenleaf, 1997) spiritual (Fry, 2003; W. Gardner et al., 2005; Reave, 2005), and authentic leadership (Brown & Trevino, 2006; Clapp-Smith et al., 2009). It also defines resilience (Pulley, 1997) and summarizes the traits of hospice leaders (Vanderpol, 2002) found in the literature.

According to Greenleaf (1997), the servant leader shares the gifts of listening, asks the right questions, is a servant first, and offers healing love. He/she is also empathetic and concerned for the whole community. Gandhi and Mother Theresa are contemporary examples of servant leaders who devoted their lives to community well-being, always putting others before themselves. The world has recognized both for their legacy of serving humankind.

All eight of the study participants practice excellent listening skills and know how to ask the right questions. Ellen's concern for the poor and the underserved reflected the servant leader practitioner as characterized by Greenleaf (1977). Shelly and Miriam demonstrated openness and acceptance as they served children who were dying.

The spiritual leader, defined by Fry (2003), Reave (2005), and W. Gardner et al. (2005) also listens and is honest. This leader upholds integrity, courage, empathy, compassion, forgiveness, and sees their work as a calling. The spiritual leader is courageous, compassionate, appreciates others, and strives for excellence.

An authentic leader, as defined by the research (Avolio, 2007; Clapp-Smith et al., 2009; W. Gardner et al., 2005) includes high ideals, values of justice, loyalty, trust, an ethical organizational climate, and positive psychological capital. These leaders are hopeful, optimistic, and resilient (Clapp-Smith et al., 2009). They include individuals with the willpower to attain goals. I think back to Karen who was willing to be with a dying patient all night and then drive to a conference the following day. From the depths of meaning to the mundane of the conference, she expressed the willpower and leadership to incorporate both of these experiences in a 24-hour period.

A hospice leader should be able to be confident, compassionate, entrepreneurial, successfully access technical knowledge, nurture both professional and personal networks, be a team player, be resilient, have self-efficacy, have a sense of humor, have a sense of calling to the profession, be a good active listener, be able to shape-shift, be creative, and be self-reliant (Vanderpol, 2002). These traits are echoed in the eight participants of this study in many ways. The grand narrative shared by all eight participants indicates that humor, creativity, spirituality, compassion, confidence, resilience, good listening skills, proficiency in the field of hospice

nursing, and leadership skills are valued and used by all who were interviewed. Debbie's narrative of her patient George, who made a t-shirt for her visit saying, "I pooped today!" expressed the compassion and humor of such leaders.

### **How to Create and Sustain Resilience in Interdisciplinary Teams**

The primary research question studied in this dissertation is "How do interdisciplinary team leaders create and sustain resilience with their team members?" Interdisciplinary team leaders, at least those interviewed, do work to create and sustain resilience within their teams. This answer, however, can be viewed on a sliding scale of good, better, and best. Some individual leaders and some organizations are more aware of the necessity and more willing to provide resources to promote well-being, resilience, and an atmosphere of cohesive, team environments that encourages teams to support one another, listen, trust, care, and be compassionate not only with patients and families, but also with team members.

The overarching themes of life/work balance, meaning, organizational resilience, ethical resilience, burnout, leadership, and resilience that arose from the interviews of the eight participants were summarized in Table 5.1 of the previous chapter. These are also themes that arose time and again throughout the literature review.

Scholars have varieties of ways of addressing these themes and practical recommendations for health care and hospice will follow. Suffice it to say that these seven themes represent a kaleidoscope of answers and opinions, and many common threads surfaced among the participants.

All who were interviewed acknowledge that self-care and wellness are important to hospice nursing well-being and resilience. This corroborated the research of Holland and Neimeyer (2005), and Jones (2005) and While these are forefront in the discussion, self-care and

wellness are not forefront in practice. Several of those interviewed in this study noted that they know self-care and wellness are important; they simply do not practice what they know to be fundamental.

An implication for future study and for future practice is to make self-care and wellness a priority in hospice and palliative care settings. This means organizational leaders acknowledging the priority of this feedback and research. It also means financially and organizationally funding self-care and wellness as mandates in the systems of care.

The literature review states decisively the necessity for hospice leaders to understand their roles and responsibilities as leaders. Couto (2004), Greenleaf (1977), and Russell and Stone (2002), set forth the understanding of servant leaders as servant first, embodying personal courage and listening, teaching, encouraging, and competence. Although at the beginning of each interview the participants shared a disclaimer that they did not view themselves as leaders, every participant in her own right is a strong and influential leader. Once placed in the context of interdisciplinary teams, they agreed that a leadership role is a “fit” for them. Each defined this role in the context of her personality, experience, and self-understanding.

All participants held spirituality as a part of their personal framework. Spiritual leadership as defined by Fry (2003), Reave (2005), and Sokolow and Houston (2008), was present in the participants’ reflections, particularly as they reflected upon the deaths of their own loved ones or the deaths of patients. Seeing work as a calling, having reflective practice, respecting others, showing care and concern, honesty, kindness, and trust are a few of the ways spiritual leadership was demonstrated both in literature and in the study participants.

Several participants utilized the phrase “out of the box thinking.” This out of the box thinking reflected the shape-shifting of authentic leadership (Pulley, 1997). Constantly adapting,

leading by example and communicating positive attitudes were also common themes. It is notable that these leaders fit well into the servant, spiritual, and authentic leadership constructs set forth in the literature review.

Ethical resilience was easily defined among the participants in this study. Cellarius (2008) defined the “ethics of hope.” This is close to ethical resilience, however for purposes here, ethical resilience is the ability to attain good outcomes in the midst of difficult circumstances with a context reaching for the greater good. This was a difficult concept to find in the literature, but in hospice and palliative care it is a daily practice. The participants use terms such as respect, honesty, diversity, foresight, and setting professional boundaries as means to living out ethical resilience. This concept encompasses administering medications, giving or withholding nourishment, understanding and explaining disease processes, and many other difficult decisions that affect human life, well-being, and dignity.

### **Practical Recommendations for Health Care/Hospice**

The recommendations that come from this research, the literature review, the interviews of participants, the methodology of narrative study, and the years of experience I have within the non-profit healthcare settings, are several. First of all, probably the most important recommendation is a mandate to listen. The narratives of lives, whether they are the professional hospice interdisciplinary team leaders or the patients and their families, are filled with wisdom, compassion, and knowledge that go far beyond the scope of this dissertation. I was in awe with each interview, every narrative, and in every building as I walked through sacred spaces where the living and the dying are cared for.

Secondly, ethical resilience is at the forefront of excellent healthcare. From the vantage point of Van Westrhenen and Fritz (2012), who examined hospice care and creativity in

Gauteng, South Africa, resilience and creativity will produce optimal care for hospice patients suffering from HIV or AIDS. If one is examining healthcare and safety outcomes through the lens of Jeffcoat et al. (2009), resilience and ethical resilience will lead to the most effective, safe service of intensive care patients with clinical handover reducing risk of clinical errors. The mandate of ethical conversations, ethical conferences, and ethically resilient leaders at every level of healthcare implementation will produce excellence, safety, and an environment of just and equitable care.

Third, hospice leadership is fun. Fostering the joy, the humor, the lighter side of this work is energizing and enlivens leaders. Nurturing well-being can begin by acknowledging the creativity, the passion, and the calling of this work. In her research, Piper (2005) calls on health care leaders to have the ACE factor, which stands for analytical ability, creativity, and emotional ability. She presses further to assert that emotion intelligence is crucial in healthcare leaders. With this emotional intelligence, I also believe that the hospice leader must find depth, joy, love, passion and the ability to motivate people to be compassionate, to care deeply about what they are doing and to know at their very cores that this is life changing work.

### **Recommendations for Further Research**

The most important recommendation I have for further research is to broaden this study in two ways. First of all, I would like to study resilience in broader populations within the hospice teams. I would like to include a more diverse population in a study. This was not possible in this study due to the way the eight participants were chosen through the purposeful selection. Their executive directors chose each of the eight. I had no say in the age, gender, religious choice, etc.

Secondly, further studies pertaining particularly to pediatric hospice leaders are needed. It is clear that this is a very new field. Preparing hospice leaders to work with dying infants and children is an enormous challenge. Although I do not do this work, I am sure this takes a special kind of person. When I met Shelly, I felt I was in the presence of a very special nurse. I realize that she is one of many who do this job every day, unsung heroes caring for tiny, terminal patients with love, devotion, and dignity.

Thirdly, there is global work to be done. The understanding I gained from reading about the hospice workers in Gauteng, South Africa, as well as other articles about hospices in India, the United Kingdom, and the Netherlands taught me that global issues of well-being, resilience, and understanding hospice care globally can deepen our understanding of hospice and palliative care in the United States and elsewhere. The global community has much to learn about excellent, resilient hospice care as we share together how to care for patients at the end of life.

### **Theoretical and Methodological Recommendations**

Mandelbaum (2003) asks the question, “For what purpose are the narratives told?” (p. 559). This question opens the nuances of the theoretical and methodological choices made for this dissertation. The theoretical assumptions behind this work are that life can be captured, analyzed, and processed through narrative. Human experiences are represented and respected as people tell their stories. Given time, space, trust and the opportunity, researchers and the academic community can discern truth from such narrative explorations.

Seidman (2006) particularly focuses on life interviews. His format suggests the merits of conducting three ninety-minute interviews. This format would be excellent to utilize with hospice patients or caregivers. The in-depth interview process would allow rich data to be collected on the resilience and well-being that is established as one is dying or caring for a dying

loved one. Due to the nature of this time in life, hospice patients and caregivers may be willing to share such time with researchers. The narratives collected would offer tremendous insights for patients, family members, and hospice and palliative care professionals.

### **Personal Reflections**

For I was hungry and you gave me food; I was thirsty and you gave me drink; I was a stranger and you took me in; I was naked and you clothed Me; I was sick and you visited me. (Matthew 25: 35–36, New King James Version)

After 33 years in not-for-profit leadership, my developed model of resilience is that ethically making decisions that are best for the least among us and living by the words of Jesus from Matthew 25: 35–36, will take a person far in this life. At the depth of my being I believe that if I serve my brother or sister, no matter their color, class, creed or sexual identity, I am serving Christ. I believe that what is done for one is done for all and that when one person rises, all can rise. Mother Theresa so eloquently says it this way, “We are touching Christ’s body when we touch the poor. In them and through them, we feed the hungry Christ,” (Gonzalez-Balado, 1983, p. 34).

Zolli (2012) echoes this model of resilience in the vision of Hancock Bank after Hurricane Katrina, recounting that clearly the executives at Hancock Bank had rehearsed how they would respond if such a disaster occurred on the Louisiana coastline. At a time when the residents of the parishes surrounding that disaster could not find their checkbooks, Social Security cards, driver’s licenses or any other forms of identification, what they needed most was cash. Hancock Bank representatives were ready to serve their community. This resilient institution handed out more than \$42 million to the residents of the storm-ravaged area. The money was given out in \$200 loans with IOU’s on post-it notes to anyone who came to a card table in front of one of the bank’s branches and needed money. Complete strangers received this cash; 99.5 % of the loans were paid back. The executives of Hancock Bank had strong shared

social values, trusted their community, and empowered their employees to think “outside the box” to make a tremendous difference in the face of such an overwhelming disaster.

This story speaks volumes for the resilience that is needed in healthcare and particularly hospice today. The disaster on the horizon for healthcare is financial. It is also the quickly aging baby-boomer generation. In the eight years that I have been with Mount Carmel Hospice, our census has risen from 75 patients per day to over 225 per day. We can now experience the number of deaths in one day that three years ago we experienced in one month. In the month of December, on one day we experienced 19 deaths and 44 admissions. This was a highly unusual day, but a day that leaves every discipline of the interdisciplinary team exhausted physically, emotionally, spiritually, and mentally. Ethically resilient leaders are critical in such an environment.

Zolli (2012) wrote, “The journey toward resilience is the great moral quest of our age” (p. 275). This is so true when it comes to hospice leadership. Ablett and Jones (2006) suggested that hospice leaders who have opportunities for reflective practice should be followed more closely for their sensitivities in resilience and hardiness. This is a question for future study in the field of hospice nursing and resilience.

Combining Zolli’s quest for ethics, and Ablett and Jones’ quest for resilience, leads me to the apex of ethical resilience. This is definitely fertile ground for future leadership study. Ethical resilience is rarely found in leadership studies. Ethical resilience in hospice leadership is also rarely found in literature. These are open subjects for further research. When I posed the question of “ethical resilience” to the participants in this study, each had to pause to define “ethics” and “resilience” before putting the two words together. On a day of 19 deaths and 44 admissions,

ethical resilience is a pressing necessity. What fills up those who are working on the front lines of life and death and the transition between the two?

It is my goal to create a holistic approach to addressing the non-profit leader's journey toward burnout and hence, a lack of resilience as a leader in place. This study has deepened my insights on my personal leadership style, time management skills, self-care, the ability to step away from the intensity of the work I do, and of the expectations I have of myself.

I have met many people, particularly leaders who are women, who experience the same pressures and challenges that I do. I expect 150% from myself. One of the first lessons for many of my female student interns is, "Be gentle with yourself." Funny—those are words I echo into my own psyche as well.

The creatively resilient leader is one who is mentally, physically, emotionally, socially, and spiritually in balance. As Zolli (2012) writes, "It turns out Goldilocks had it right all along." (p. 259). Resilience is having a balance in life. It is being balanced between being connected, but not enmeshed. It is about a delicate balance, a fluid stance of strategies and actions. It also includes standing on a set of values and purpose (Zolli, 2012). Therein lies the quest for the ethically resilient leader. One who can flex when the need calls for adaptability, but also one who stands firm with an ethically grounded base.

Ways that I intend to concretely address the leadership issues rising from this research include publishing this dissertation as well as publishing further research on the topic of ethical resilience in hospice leadership. Beyond publishing, I am speaking on the national and local levels regarding the urgency of implementing processes and evaluations in hospice settings that will take the pulse of interdisciplinary teams as they ride the ever-changing tides of this medical climate in the United States. There is so much to be learned from those who have been in the

field since its inception and so much to be learned from those who are successfully moving forward in the turbulent healthcare climate of the 21st century.

My goal in focusing on leadership in hospice care has been to address leadership from models of leadership and perspectives of understanding leadership inherently as a discipline to be learned, practiced, and shared. Many of the leaders I have met in hospice care are there due to tenure or having been at the right place at the right time. Visionary leadership, good communication skills, developing others, building bonds, servant leadership, authenticity, and a host of other leadership strategies are needed to nurture the next generation of hospice leaders. I plan to intentionally model and share leadership capacities so that current leaders can grow in their leadership abilities and new leaders can be informed and intentional in their leadership identities.

The exploration of ethical resilience in healthcare is just beginning. Engaging ethics panels in hospitals, defining the critical issues of ethics, resilience, hospice care, and resources available is the task ahead. I plan to begin through the organizations of which I am already a part: the National Hospice and Palliative Care Organization, the Ohio Hospice and Palliative Care Organization, and the Ohio Counselors Association. Through these bodies, my goal is to open dialogues, bring passion to the issues of ethical resilience, and highlight further discussions for the healthcare professions and non-profit sector on how to remain resilient in the marathon of caring when people and resources are finite but needs are infinite.

## **Appendix**

## Appendix A: Consent Form

### Informed Consent for Participants in Dissertation Resilience Project

I \_\_\_\_\_, agree to participate in the Dissertation Resilience Project for Renee Ahern, MDiv, MS, PCC-S as she continues her doctoral work at Antioch University in Leadership and Change, Yellow Springs, Ohio.

This project will include three interviews with every participant. This will be made clear at the outset of recruiting participants. Each interview will be approximately 60 to 90 minutes in length. The interviews will be recorded on an audio cassette recorder and transcripts of the recording will be typed for the reading of the researcher only. These interviews and all information shared will remain confidential.

As a participant in this project, your name, position, and the institution that you serve, as well as the answers you disclose, will remain confidential. Each person and institution will be assigned an alpha-numeric code. I will only use that which you give me permission to use in my report after you have read a transcription of our interview. All tapes of interviews, transcriptions, consent forms, and any follow-up will be kept indefinitely and we have agreed on what will be printed in my dissertation.

The risks you are taking will be minimal. You are free to call Mount Carmel Hospice for grief support or an individual counseling session at any time. We service patients and families twenty-four hours a day and seven days a week. Our phone number is: (614) 234-0200.

If you experience emotional distress during our interview, please tell me immediately and I will discontinue the interview. If you would like to be referred to a therapist to process the distress, I will be happy to provide you with referral information or the name of another therapist here at Mount Carmel who will be happy to assist you.

Any participant in the study can withdraw at any time.

Participating in this study will not yield any financial remuneration.

Your emotional and personal safety are of utmost importance to me.

If you have any questions about this study, please contact:

Carolyn Kenny, PhD.  
Professor of Human Development and Indigenous Studies  
Ph.D. in Leadership and Change  
150 E South College  
Yellow Springs, Ohio 45387  
805-565-7535            email: ckenny@phd.antioch.edu

Two copies of this consent are provided. Please sign both. This indicates that you have read, understand and agree to participate in this research project. Please return one copy to me and keep one copy for yourself. Thank you.

\_\_\_\_\_  
Name of Participant (please print)

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Researcher  
Renee Ahern, researcher  
Bereavement Coordinator,  
Mount Carmel Hospice

\_\_\_\_\_  
Date

## **Appendix B: Interview Questions**

### Interview Questions

The following questions will guide a 90-minute interview with each participant in the study.

Because each interview will take its own narrative turns, every question may not be used.

1. Please begin by sharing with me how you began your career in hospice care and what your journey was like to becoming a hospice interdisciplinary team leader.
2. How do you define leadership? How do you apply this definition on a daily basis?
3. What is most challenging about your current position?
4. How do you define resilience?
5. How would you define ethical resilience?
6. How/or do you create and sustain resilience in yourself?
7. How/or do you create and sustain resilience in team members?
8. How/or does the organization for which you work help to create and sustain resilience in you and your team members?
9. How do you cope with difficulties interdisciplinary teams have with burnout and stress?
10. How do you apply your knowledge and understanding to both challenges and joys of your job as Interdisciplinary Team Leader?
11. How is resilience created in a workplace where every patient's trajectory is to die?
12. What does it all mean?
13. Can you talk out loud about how an ethically resilient leader might work within a leadership position?

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