ABSTRACT

EQUIPPING THE CLINICAL TEAM FOR SPIRITUAL CARE

by

Donna Burske

The purpose of this project was to evaluate the effectiveness of a spiritual ambassador program in outpatient healthcare practices, a program designed to provide in the gap pastoral care and ministry when a chaplain is not present.

Physician practices by nature are in touch daily with those who are afraid, anxious, in a time of loss or uncertainty. Increasingly, patients and their family members seen are unchurched or "barely churched," and there is immense opportunity to add both faith and compassion-based faith to the outpatient care provided. Healing encompasses the entire person — mind, body and spirit, — and a trained spiritual ambassador can become a provider of blessing within this setting.

While the development of this program took some time, the implementation of it was easily accomplished without complication. Those who chose to participate have described finding meaning and purpose in their work that they did not previously have. Participants included healthcare team members from all roles and employment structures. The overwhelming discovery was that team members, doctors, and others are able to provide spiritual care without difficulty once they feel empowered and equipped to do so.

EQUIPPING THE HEALTHCARE TEAM FOR SPIRITUAL CARE

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by

Donna Burske

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To those two individuals, my dad and mom, who did not bring about my life, but gave me life and gave me Jesus. Their inner strength, commitment to the gospel, zest for life, unwavering faith, and uncommon commitment to ministry in the face of adversity, have upheld me. They were the muse for this research project.

To Justin, my son, caretaker of family memories, who carefully honors the life and ministry of the grandpa he never knew.

And with thanks to Greg Ellis, ministry mentor, leader, and friend. His guidance and support made this possible.

CHAPTER 1

NATURE OF THE PROJECT

Overview of the Chapter

As healthcare has found its balance again after two major Florida COVID-19 surges and the ongoing economic impacts that brought about, this project looked at efforts made to increase meaning and a spiritually grounded approach to clinical care in outpatient practices within AdventHealth Medical Group in six counties of Central Florida. This process was intended to equip and empower all interested healthcare workers, clinical and non-clinical, to extend spiritual care within the function of their daily work. This first chapter looks at the rationale behind the project as well as identifies key terms that have guided the implementation of spiritual care provided by team members in all areas of employment, clinical and non-clinical alike.

Personal Introduction

This project came about in a class in September of 2019. While listening to two professors expound on virtue and virtuous living, I was pondering a change in direction for my dissertation. I shared that with the person sitting beside me in class. Over our next break, she asked me to say more about that and my heart for spiritual care within outpatient healthcare ministry. Within a few minutes, she had grabbed a napkin and on it had written a potential statement of purpose that would hardly be modified since then. After years as a healthcare chaplain, it seemed more needed to be done to include the clinical team in the spiritual care of patients and their families. It seemed incumbent to find a way to equip the larger team to provide an ever-ready spiritual presence among those who are one-on-one with patients; those clinical team members who have an

interest in sharing a spiritual word of encouragement, prayer, or moment of faith just needed to be equipped and empowered. At that time, there was no hint of a coming pandemic.

My role as chaplain is to lead ministry and spiritual care for more than three hundred physician practices encompassing six counties in Central Florida. This large outpatient medical group includes more than 1,200 providers and 2,800 team members, and that number grows each week. It is impossible for a chaplain or several chaplains to be present whenever needed. My goal in this project is to train and equip team members at all levels of care to be frontline spiritual caregivers as part of their daily job. There was no question of gap: a few chaplains cannot effectively chaplain or pastor such a large, diverse group, spread out over six counties. Would it be possible to train one person in each practice to effectively provide spiritual ambassadorship kinds of care to patients and other team members? How would that be done? Those were the questions, and the need was severe. What I had no way of knowing at that time was that the challenge of our healthcare lifetime was just ahead.

A few months later, as the team moved into the beginning of COVID-19 care, I asked our team members if there were those who might be interested in uncomplicated spiritual training that they could add to their clinical care. Positive responses came fast, and I began to realize that not only would this provide better care for our patients and their families but it would also come deeply from the hearts of those with whom I work. We thought COVID-19 would last three or four months, but in Central Florida, at four months we had not begun to see the worst of it. The clinical team felt threatened, afraid,

and helpless. As time went on, those feelings only grew. As the situation grew worse, I began to feel more and more urgency to implement this process.

I grew up the child of missionaries, primarily in Saigon, Vietnam. My missionary parents faced many challenges, but they didn't share those with their children, and I am not aware how they met some of their toughest situations. This I do know: My dad, the pastor and mission leader, must have found it difficult to lead ministry in a country with which his own country was at war. The long, ongoing nature of that war must have been exhausting and demoralizing. My dad died when I was nineteen years old. Throughout all the difficulty of COVID-19, I wished that I could talk to him about how he sustained himself in ministry through those complicated years. One thing I have come to believe as time has gone on is that training and equipping those around us to share in our ministry is a blessing and encouragement of extraordinary value.

As I began to work on an orientation plan and process for spiritual ambassadors, I put myself in the place of caregivers and the moments they stand beside those who are receiving a bad diagnosis, a terminal diagnosis, knowledge that their baby has died in utero, or the exhaustion of ongoing chronic disease and pain. What would be effective? With what could even the shyest individuals among us find comfort? How could I round the process out in a way that left them feeling empowered and enabled? Another question kept surfacing: Was I able to do this in a way that would be productive?

As a cancer survivor, I have two clarion memories. The first is the physician who sat with me in an exam room at the end of a long day. I'm sure he wanted to go home, but he willingly sat with me as I cried—really, bawled—having just heard the word malignant. I was three months into an unexpected divorce, a new single mother to two

teenagers, and now had cancer. I could not stop the tears, and he was in no hurry to leave. Whenever I see him to this day, my heart floods with overwhelming gratitude. He provided spiritual care by sitting beside me and letting me cry without any sign of anxiety on his part. That story undergirds the design of the spiritual ambassador training program.

The second clarion memory is after surgery and going through weeks of follow-up intervention. I was scheduled for four hours of imaging tests to see if the clinical process was working. Was the cancer gone or decreasing, or was the process not working? I had multiple scans that morning in a very cold imaging department. I was under-weight, truly emaciated, and the cold and the fear were overwhelming. My body rattled so badly that the tech kept asking me to stop. As I finished testing, someone came and asked me to stand by for a few minutes. They left me with a chair and two warm blankets and disappeared. A radiologist came a bit later, said he had talked to my doctor, and wanted me to know that all my scans had been read. She had given her permission to tell me they were clean, and, at least at that time, there was no more cancer in my body. I did not have to wait to see my doctor to know the results; that was a moment! And because of those two moments in my own journey, I am all-out as a chaplain in coming alongside those who are hurting. Less than a year after that "all-clear day," I was a student at Asbury Theological Seminary in Orlando, preparing for a massive career change from finance to ministry. Several years later, Master of Divinity in hand and clinical pastoral education behind me, I was ordained and ready to go. My heart for those who are suffering has not diminished to this day.

My educational experience at Asbury Theological Seminary prepared and equipped me well for ministry in a multi-faith setting. Not only did I leave with the

ability to study scripture more ably, I had a good understanding of ways to communicate that are non-threatening and lifegiving. Certain classes pertained directly to patient care and crisis care, and those principles remain with me. Four units of clinical pastoral education helped me understand myself better; however, perhaps even more, the experiences in those settings increased my passion for pastoral care.

In the past ten years, the work of Harold Koenig director of the Duke University Medical Center Institute of Spirituality and Healthcare has influenced me greatly. AdventHealth has been working with Koenig in the inpatient or hospital setting to aid his research on the role of spirituality in healthcare. I was able to participate in a study he was working on, and the result was that I became more aware of the potential for chaplains to improve the lives of their patients.

Recently, I was captivated by a student quote on a banner on the Asbury Theological Seminary Wilmore campus, saying, “We are to be visible reminders of the holy, which means that we are to be everyone’s pastor.” We live that daily in the healthcare setting.

Coming from the influence of my parents and personal experience, I find myself solidly in ministry within healthcare, and both COVID-19 and this project added a whole new layer of personal meaning and purpose. Would it be possible to train three hundred or more individuals to notice, walk with, and provide spiritual care in ways that were life giving and to do so actively and with purpose? I believed it was possible.

As I lead ministry and pastoral care within this setting, I am motivated to embrace the team in significant, hands-on spiritual care. Many find deeper meaning in their work by adding the meaning they find in their own spiritual journey to the work that they are

doing with others. Chaplains cannot be everywhere all the time. However, chaplains can equip and encourage the entire team to find ways to add spirituality to the care they are already providing. While doing this, the healthcare team would also have immediate access to the chaplain team to refer a patient for further help or to ask for guidance and encouragement in what they are doing.

As the country winds its way out of a worldwide pandemic that challenged healthcare as immensely as anything could, healthcare workers find themselves with increasing numbers of patients who are discouraged, depressed, financially despairing, anxious, fearful, and suicidal. Equipping the healthcare team to recognize and respond to these situations and working incarnationally with the Holy Spirit brings depth to healthcare and healing that is badly needed in our society today. It also adds a sense of fulfillment to our team members, as they express that it is helping them in those times that are deeply discouraging.

As I have come to know this large team of individuals, I have been overwhelmed by the depth of the need and the depth of their commitment to help. They do not give up. It is incumbent upon me to equip them with the tools, training, and perspective they need to be ambassadors of spirituality. Our corporate motto is “Extending the Healing Ministry of Christ,” and within that framework we are permitted and encouraged to be ambassadors of Jesus.

Statement of the Problem

According to Becker’s Hospital Review, nearly one in five healthcare workers quit their jobs during the COVID-19 pandemic, and that number continues to climb (Masson). In addition, healthcare workers of all disciplines are giving up. Some are

leaving specific jobs; others are leaving the practice of medicine entirely. These statistics include Central Florida. Could embedding spiritual care into their practice somehow also increase their sense of purpose and willingness to keep going? Could finding more than a diagnosis in each person bring back the love of the practice of medicine? This project was a hopeful experiment and experience to see what might happen.

Beginning in March, 2020, it was not believed that a pandemic would last for more than two years. Initially, it was expected that it would encompass a three or four month period of difficulty, discomfort, and displacement, much as an influenza outbreak would cause. As time went on, the frontline clinical team become more and more depleted, fearful, anxiety-ridden, and despairing. Several team members, among them doctors, ended their own lives, further increasing the anxiety and despair on the team. Nurses and doctors both chose to leave their profession; some nurses left their shift and never returned to work again. Non-clinical team members began looking for places to find work that felt less threatening. It became increasingly apparent that somewhere within the role of the chaplain, a resource had to find to extend dedicated spiritual ministry to everyone.

For the first time in its history, AdventHealth faced “Code Black” status during the pandemic. “Code Black” means all services are cancelled unless the need is determined to be emergent and there is a need to care for a patient with a specific, life threatening problem. During this time, an overwhelming load of COVID-19 patients and the risk of COVID-19 exposure to other patients within the environment created the Code Black designation. For those who work in healthcare, Code Black is most associated with the military battlefield as any time in caregiving. In Central Florida, seventy-five percent

of the patient beds were COVID-19 population, leaving very little room for emergencies and childbirth beds. While all these stressors were going on within the patient population, team members were also becoming infected with COVID-19, which created an ongoing significant staffing shortage.

In outpatient practices, things were much the same. Physicians were afraid to see patients, turning increasingly to telehealth appointments to avoid exposure and risking missing a vital diagnosis by doing so. Patients who were seen in person were asked to wait outside the building for a call to come in and be seen, greatly diminishing the number of patients a physician could see in a day and causing considerable anger in the patient population.

Perhaps most difficult in the outpatient setting were physicians with patients who were in a life-threatening situation and could find no hospital support. Physicians increasingly worried not only about the lives of patients, but also about the personal risks involved. More and more office employees were out with COVID-19, some for weeks at a time. It was difficult to keep the offices clean, get billing done, have schedulers available, and meet all the complaints of the patient population. Outpatient practices were also in crisis.

In this environment the scope of the project was born as an effort to increase spiritual presence and alleviate fear and anxiety within both the patient population and the caregiving population. The chaplain team was unable to meet the demands of patients and team members were discouraged at the immensity of the need in every direction. The only help available would come from within; no one else was equipped with time or training to do what was needed to meet patients' and team members' spiritual needs.

Whole person care is care that responds to more than physical needs; it also asks healthcare providers to look at the entirety of the person—mind, body, and spirit—and to see them as a creation of God, worthy of love and respect. How could those needs be met adequately? It was within that environment that this project began. At the time this project was being developed, never was there any thought that it would begin in the kind of environment that COVID-19 presented.

Purpose of the Project

The purpose of this project is to evaluate the effectiveness of a spiritual ambassador training program in an outpatient healthcare setting.

Research Questions

The following questions guided this post-intervention project.

Research Question #1

Are the newly trained spiritual ambassadors able to be of help in this role within their workplace?

Research Question #2

Did the newly trained spiritual ambassadors find the training deeply embedded in the teachings of Jesus?

Research Question #3

Did the spiritual ambassadors understand their role?

Rationale for the Project (1-2 pages)

Within medicine, whole person care is care that responds to more than the physical need, but also asks of us as healthcare providers to look at the entirety of the person – mind, body, and spirit, and to see them as a creation of God, worthy of love and respect.

Each individual who enters the workspace—each patient and each member of their family—are children of God. Each person, everyone, are joint heirs in bearing the image of God. AdventHealth Medical Group's guiding statement, "Extending the healing ministry of Christ," pertains to every encounter, whether silent, verbal, or visual. The healing ministry of Christ includes more than basic medical attention. It sees each individual as worthy of complete and full attention and that looks at the entire person—mind, body and spirit—through the eyes of *imago Dei*.

The study of spiritual care in healthcare can hardly be called new, yet it has encountered a renewed push in the last few years through voices like Harold Koenig, director of the Duke University Medical Center Institute of Spirituality and Healthcare. Koenig has published a list of reasons for attention to the spiritual needs of patients:

> Patients place a high value on their emotional and spiritual needs.
>
> Addressing emotional and spiritual needs is a top priority for quality improvement in the US, Australia, and Canada.
>
> Evidence exists to indicate a relationship between profitability and patient satisfaction in spiritual care.
>
> All patients possess emotional and spiritual needs, regardless of how unexpected or traumatic the reason for the admission.

In one study reviewed by the JAMA Network, an online site of the Journal of the American Medical Association, a majority of patients indicated that they would like their physicians to ask whether they have spiritual or religious beliefs that influence their medical decisions were they to become gravely ill (Ehman, Ott, Short). Another study found that 40% of patients felt that physicians should discuss pertinent religious issues

with them; however only 11% of physicians frequently or always did (Ehman, Ott, Short). It is sufficiently clear that, in addition to accountability to the bottom line in healthcare, there is an ethical accountability to provide solid spiritual interventions, and this accountability is greater in the case of a religiously affiliated healthcare provider. There is anecdotal evidence stemming from focus groups indicating that patients who select a religiously affiliated healthcare provider possess greater expectation for emotional and spiritual care and hold their healthcare team to a higher standard (Koenig 17).

Spirituality is often an overlooked yet still particularly important element of patient care. Addressing and supporting the spiritual journey of patients not only makes their healthcare experience more positive, in many cases it can even promote health, decrease depression, help patients cope with a difficult illness, and improve outcomes (Larson 370). In addition to the potential medical benefits, research indicates that patients want their healthcare providers to discuss spirituality with them (Larson 370).

This research makes it apparent that the effort to enable and equip the entire healthcare team to provide in-the-moment spiritual care for their patients is not only worthwhile, but something that many patients expect or desire.

Medical pioneers of the Seventh-day Adventist Church began a new paradigm of healthcare in Battle Creek, Michigan, in 1866, based on an understanding and appreciation of the healing ministry of Jesus. During that time, many medical facilities were providing treatment and sanitarium care that was profoundly harmful. Beginning in 1905, Florida Sanitorium—located in the Orlando, Florida area, and brought about by the dream of a Seventh-day Adventist minister and his physician wife, educated in Battle

Creek—provided procedures with a purposeful effort to do no further harm. In addition, patients and their families were taught disease prevention and ways they could help themselves through good nutrition, exercise, and appropriate hygiene. Within that education, they were encouraged to incorporate faith and worship into the effort of achieving optimum health. Every individual was seen as a child of God and worthy of respect and optimum life (AdventHealth, You Tube).

There, by a small lake, deep within the orange groves, the AdventHealth system was born with whole-person perspective, that healing is more than the body—it incorporates the mind and spirit. Spirituality has been embedded within all care from its very beginnings YouTube.com).

For over one hundred years, AdventHealth has carried on that perspective as their mission. “Extending the Healing Ministry of Christ,” the corporate motto, encourages everyone to consider each individual a child of God, their entire person worthy of our care.

AdventHealth has invested heavily in the presence of pastoral care. Within its inpatient settings, chaplains are provided unfettered access to any patient, in any location, something that is rarely practiced in medical settings. To support and encourage pastoral care within healthcare throughout the region and beyond, a clinical pastoral education program was begun in the late 1980s to educate and support spiritual ministry reaching far beyond its own doors, encompassing those of all faiths and ministry settings. That clinical pastoral education program is one of the largest in the United States today.

Even with that rich history of inpatient ministry, however, it has only been within the last two years that a ministry presence has been provided in the outpatient setting. This project is embedded in the roots of the future holds in outpatient spiritual care.

Definition of Key Terms

First, a spiritual ambassador is a team member in any capacity who would like to receive training to add spirituality to the work that they are doing with patients, patients' families, and colleagues.

Second, an outpatient is a patient not seen in the hospital. They could be a patient in a physician office, an outpatient surgical center, or an urgent care center.

Delimitations

This study focused on healthcare workers in outpatient practices within AdventHealth Medical Group in Central Florida. The study includes men and women of all employable age groups, beginning at age eighteen, extending to post-retirement age. Physicians and other providers, social workers, corporate leaders, and individuals at all levels of employment completed the training. Individuals were of all faith backgrounds, including both Eastern and Western faith traditions, as well as all ethnic backgrounds represented within our organization. No one employed by AdventHealth Medical Group was denied the opportunity to participate in this study.

Review of Relevant Literature

This project relies heavily on several foundations of ministry. First, all people are children of God and worthy of love and respect and the best medical care possible. Second, everyone is made in the image of God, further deepening the respect and care

given in the medical setting, regardless of gender, age, ethnicity, socio-economic level, or any other distinction.

The literature used encompasses pastoral ministry, mission (the *missio Dei*), the biblical study of the image of God (the *imago Dei*), examples of delegation of ministry effort beyond designated clergy found in the Bible, and the study of religion in the field of medicine.

This literature includes work by Duke University and others in the field of healthcare and spirituality, drawing heavily from journals and written sources that have come from the pacesetting work Duke University has done.

Among those relied upon for spirituality and biblical foundations were Michael Moynagh, Brian D. Russell, John Drane, Stephen Seamands, Richard Rohr, and Timothy Keller, accessing their wisdom on extending spirituality beyond church, the Old and New Testament perspectives on mission, the place of incarnational ministry and presence in healthcare, and the work of the Trinity in supporting missional calling and care.

Literature evaluated for the influence and need for spirituality specific to healthcare came heavily from Harold Koenig of Duke University, Jeff Levin, Daniel Sulmasy, Wendy Cadge, and the Association of Professional Chaplains.

Research Methodology

The research for this project comes from a Survey Monkey survey of those who participated, as well as five one-on-one conversations with those who had completed the training process. The survey was anonymous. There was no assessment tool. The orientation was developed with a study of the spiritual meaning of life and embedded

within the teachings of Jesus, kindness, and compassion, as well as corporate standards of service.

Type of Research

The post-intervention research included one online survey providing both quantitative and qualitative evaluation. The online survey was comprised of five statements, rated in value from one to four, and one question with a selection of areas of work to choose from. In addition, it asked for a write-in response about what was most helpful and what was least helpful in the training.

Participants

Participants included men and women over the age of eighteen, of all socio-economic, education, and workforce levels of employment, a multi-ethnic, multi-faith group, all of whom have completed the spiritual ambassador orientation.

Instrumentation

The instruments included a survey created to bring understanding of what was effective and what was not the best use of time in the orientation process. The survey was evaluative of the training. In addition, an evaluative interview process was done in semi-structured interviews. I audio recorded conversations from the interviews and then transcribed those into documents.

Data Collection

This is a post-intervention project, evaluative in nature, using both qualitative and quantitative methods of data gathering. A Survey Monkey survey was provided to those who had been trained for at least one month, with a requested one-week turnaround time. The survey directed the results of the research. In addition, the one-on-one interviews

were conducted with five individual who had completed the training at least one month prior. Conversations from those interviews were audio recorded and then transcribed into documents.

Data Analysis

For this project, the efficacy of a lay-person spiritual ambassador program in the outpatient healthcare setting was considered an opportunity to increase a spiritual presence in the lives of patients, their families, and the team. In an environment where chaplains and vocational ministry individuals are not able to be consistently present, it provided an opportunity for team members who felt a calling to participate in the spiritual life of the practice to be trained and ready to do so.

The data from the survey indicates that those spiritual ambassadors who were trained in this program found it rewarding and meaningful. The data overwhelmingly shows that their greatest barrier is a lack of time. The efficiency with which the practices operate allows them little time to add spiritual attention to what they already do.

Both in an online survey and interviews, this project asked questions of those who were oriented and trained. Those questions included a look to the incorporation of the project as well as the future of the project. The directed interviews were conducted to ascertain a deeper level of understanding of the process as experienced by the team. The directed interviews showed the intentions and feelings of the team; and further developed their experience of the training. The team indicated that the training had positively impacted them both in the workplace and in their personal lives and they found it of immense value.

Generalizability

This project is adaptable to most healthcare settings in all geographic regions with effort made to contextualize it to a company's vision, values, and overall approach to healthcare. Whether inpatient or outpatient, emergent care or not, spiritual needs are present in most patients. Increasingly individuals are unchurched or barely churched and it is incumbent upon the healthcare team to assess spiritual needs, particularly as it may be indicative of patient care outcomes. At times the needs can be met simply by the provider or team member who is present; other times the help of professional clergy may be needed. However, equipping the team to hear and understand the spiritual needs of the patient is the beginning of excellence in patient care that encompasses the whole person—mind, body, and spirit.

Project Overview

The purpose of this dissertation project was to evaluate the effectiveness of a spiritual ambassador training program for outpatient physician practices encompassed within the AdventHealth Medical Group in six counties of Central Florida, to equip and empower all healthcare workers, clinical and non-clinical, to extend spiritual care within the function of their daily work. Chapter 2 of this post-intervention study demonstrates the biblical and theological foundations for in-the-moment spiritual care, provided by frontline clinical caregivers. Chapter 3 presents the research design, methods of research, and data analysis methodology. Chapter 4 outlines the results of the research and analysis of the collected data. Chapter 5 offers the interpretation of the research findings along with observations and suggestions for improving the training process.

CHAPTER 2

LITERATURE REVIEW FOR THE PROJECT

Overview of the Chapter

This project evaluated an orientation process to equip front-line outpatient healthcare workers and clinical team members to provide in-the-moment spiritual care for patients. This project encompassed the six-county area of Central Florida within AdventHealth Medical Group, with nearly four hundred physician practices of all disciplines and including more than four thousand employees—professional clinicians and team members. While healthcare literature continues to encourage the participation of physicians and their teams in providing in-the-moment spiritual care, many times healthcare providers do not feel empowered or equipped to do so. This research demonstrated an easily accessible process to provide an understanding of why and how medical personnel can all participate in the spiritual care of patients.

As a part of the overall research, the disciplines explored are within the study of spirituality, medicine, leadership, Biblical history, and Biblical and medical literature.

Biblical Foundations

Moses and Lay Leadership

Moses was a man chosen by God. He was chosen to bring his people out of pagan Egyptian culture and genocide, and into a new life with God. Exodus 3 opens with Moses as a shepherd taking his sheep into the wilderness where God finds him and calls him. Throughout the chapter God promises to make a way but Moses protests. This calling was of God, but Moses was reticent.

Walter Brueggemann sets forward a resounding example of the life Moses was called to in saying, “the task of prophetic ministry is to nurture, nourish, and evoke a consciousness and perception alternative to the consciousness and perception of the dominant culture around us (Brueggemann 3). Moses was called to lead and guide a group of people steeped in Egyptian culture. His work was both visionary and task oriented. Moses’ calling was both personal and in community, as Guinness says, “…the call of Jesus is personal but not purely individual; Jesus summons his followers not only to an individual calling but also to a corporate calling” Guinness, 93). Moses found himself in a large community.

Within Moses’ story, scripture offers an example of spiritual ambassadors in an unlikely place—the desert. Jethro, a Midianite priest and father-in-law of Moses, discovered that his son-in-law was working far beyond human capacity, trying to do everything by himself. He strongly encouraged Moses to delegate, to hand off to “trustworthy individuals who fear God” (Fretheim 199). Moses was not delegating, nor was he able to do everything there is to be done because it was not humanly possible. It was without question that people who needed his time were having to wait because of his workload.

Fretheim points out, “Moses is to represent the community before God, bringing their concerns into the divine presence and discerning the will of God for their daily life. Moreover, he is to teach the community to walk in the ways God would have them walk” (199). There was much in the day-to-day life that he was able to delegate to trustworthy individuals. By delegating much of the in-the-moment needs, Jethro wisely pointed out that this would bring peace to the people who must wait to see Moses. This deeply

grounds the training and equipping of spiritual ambassadors in the healthcare environment. They are to be people of God, grounded in faith, and easily and immediately accessible in the moment and place of need.

Jethro drives his point home by saying God so commands this, even though the reader of Exodus does not find anything suggesting an overt word from God in this matter. Rather, one accepts Jethro as a priest and a man of God who walks and knows his own journey of ministry and accountability.

The Bible tells us no more of Jethro: he returns home, and yet his legacy in this story lives on in the well-ordered way of the people of Israel. Giving attention to the needs of the people in an orderly and accessible way would live on as spiritual leaders and listeners were put forward within the community to encourage the faith and wellbeing of the community. Fretheim writes, "God the Creator has been powerfully at work . . . in the interests of the well-being of all." God uses each person's strengths, wisdom, insight, and willing faithfulness to build up the community in ways that are life giving.

Delegation continues to be a leadership topic today: As Harvard Business Review puts it,' One of the most difficult transitions for leaders to make is the shift from doing to leading. 'There's a psychological shift to focus your attention on areas that are vital to the company and become less involved in the daily tasks. That shift can bring about fear. 'What will happen if I let go and delegate that responsibility? Will I be able to make the transition to my new role and focus? 'Will I be seen as less vital if I delegate certain tasks?' 'No one can do it as good as me'" (Craven).

This is no less true of the ministry leader. Moses found delegation necessary, and it is no less necessary today. It is without question that this is a faith journey as much as any other. Letting go, finding our way forward, and trusting trained spiritual ambassadors to stand in the gap where trained chaplains were unavailable requires faith.

Lydia: A Sterling Example of Spiritual Ambassadorship

Acts is a book detailing the history of the origins of the early Christian church. It is the story of the people of God working together to spread the gospel to the entire world. Chosen, called, inspired, and driven, the people of Acts were people of commitment to Jesus. They were a people of courage, astounding faith, hospitality, hard work, discipline, and were deeply driven to witness to what they had found in Jesus. Acts 16, tells the remarkable story of Lydia, a story steeped in hospitality. Paul and Silas, upon traveling to Philippi, a Roman colony, stayed for several days:

> On the Sabbath day we went a little way outside the city to a riverbank, where we thought people would be meeting for payer, and we sat down to speak with some women who had gathered there. One of them was Lydia from Thyatira, a merchant of purple cloth, who worshiped God. As she listened to us, the Lord opened her heart, and she accepted what Paul was saying (Acts 16:13-15).

Much like the woman at the well in John 4, Lydia does not intend this just for herself. She encourages her entire household to join her in belief. She was an ambassador to them of the gospel of Jesus. Lydia demonstrates the essence of hospitality

Lydia, who fully embraces the story and teaching of Jesus, does not keep this for herself. She shares with those within her household and sphere of influence. Eugene

Peterson states, “salvation, eucharistically defined in our worship, continues to be expressed and lived out in daily acts of hospitality”(212).

Jesus’ stories are filled with examples of shared meals and times of hospitality. Peterson goes on to say that, “Jesus frequently reinforced the centrality of hospitality by telling parables that features food and drink, meals and banquets” (Peterson, 213). These examples show a ministry and example of life shared both inside the family home and outside of it.

It is interesting that Paul almost disappears from the story. Instead, God opened her heart and her thinking (see Luke 24:32-35), so that she listens and is baptized, together with the household (Gaventa 237). There is no definite way to know whether Lydia was a freed-woman (former slave) or from a wealthy family, but in this story, it is easily seen that Lydia now found the story that told her who she was. She found the story that was Jesus and who he was and is. She understood in Jesus’ story who he was and what he was there to do for her, and like so much of the New Testament stories, this moment drove her to share, to begin mission in her corner of her world (Wright 115). She had found identity and belonging, and she invited her household and working world to join her in that identity. Lydia offered hospitality and inclusion to those who were in her community. Lydia, in offering hospitality and inclusion, represents so beautifully those who not only are people of faith, but want to share the community of faith to those nearby.

Lydia’s story is one of strong leadership in business: she is a seller of purple, she has a household and business that are her responsibility, and she is a seeker of and believer in God. She not only believes and joins a prayer community, she brings her

household with her. In Lydia's story there is an openness that goes both ways; there is mission. Paul and Silas share with her the story of Jesus and accept her as a part of the Jesus-following family. She brings her entire household into the family, and one can easily assume she continues to be a strong spiritual leader to them. A woman of leadership, courage, confidence, and hospitality took on a leadership and ministry role in the family of God.

Pauline Examples of Spiritual Ambassadors

In contextualizing church, Moynagh and Harrold observe, "Starting with Saint Paul is no accident. He is widely regarded as one of history's most fruitful church pioneers. It is natural, then, to see that his experience offers insight" (3). Within Paul's ministry, an obscure yet pertinent passage found in 1 Corinthians 16 gives some insight. Early in the book of 1 Corinthians Paul writes that Chloe's household has made him aware of problems in the church at Corinth. These problems are verified by Stephanus, Fortunatus, and Achaicus. Paul responds in this letter to a people who are surrounded by corruption, temptation, immorality, and difficulty, much as any congregation is today. After calling out their errors and calling them to faithful discipleship, Paul then acknowledges three individuals who have been instrumental in faith leadership in his absence,

> You know that Stephanas and his household were the first of the harvest of believers in Greece, and they are spending their lives in service to God's people. I urge you, dear brothers and sisters, to submit to them and others like them who serve with such devotion. I am very glad that Stephanas, Fortunatus, and Achaicus have come here. They have been providing the help you weren't here to

> give me. They have been wonderful encouragement to me, as they have been to you. You must show your appreciation to all who serve so well. (1 Cor 16:17,18).

Paul recognizes a man named Stephanas and his family from Corinth. He says they were the first converts to Christianity in Achaia, Corinth being the capital city of the Roman province of Achaia. Paul baptized Stephanas and his family. Having made the commitment to be followers of Jesus, "the language suggests that Stephanas and family set themselves aside for this specific service of meeting the needs of God's people" ("What Does").

Paul knew that all followers were called to the mission of God (Wright 24). All who believed in Jesus were engaged both believing and living and being sent, he knew and affirmed the power of spiritual ambassadors. He knew that he could not be everywhere, but faithful, life-giving leadership from the congregation was necessary for that congregation to maintain their belief and gospel-based life in his absence. Stephanas, Fortunatus, and Achaicus show the essence of lives lived as spiritual ambassadors. They understood that they were called and empowered to represent God to their community and draw their community to a life lived within the gospel, a life lived in faithfulness: spreading the word, encouraging, giving prayerful attention to the congregation, and providing in-the-gap ministry in the absence of vocational ministry providers.

John Drane beautifully describes Paul's perspective of faith-centered leadership. Speaking of the church, he says all members are responsible. This isn't just a place for the vocational minister: "Paul's concept of the church is dynamic, not static. He does not think of it is an organization that holds meetings but as an outpost of God's ways of doing things (the 'kingdom'). This means Christians do not 'go to church'—on the

contrary, they are the church, wherever they are and whatever they may be doing" (*Introducing the New* 514). The commitment of the believer to be an ambassador of faith and faithful living wherever they find themselves is developed through Paul in the early Christian church. The faith-lived responsibilities of the clergy-leader are not borne alone, they are the responsibility of the entire congregation.

Paul, a sterling example of church leadership, makes it his regular practice to appoint leaders wherever he established a Christian community (Acts 14:23, 20:17-35). He looked for the gifts and commitment needed within the congregation to maintain, delegate, and extend his work.

Billie Davis puts forward the competencies needed of a leader in the faith in today's world. Among the first criteria noted are: (1) servant leader, (2) modeler of the faith, (3) attends to spiritual development and self-development, (4) able to teach (5) equips others, and (6) embodies the spirit of love (Davis). Paul not only equipped; he had also found the reward of equipping and empowering in the results of the commitment and work of Stephanas, Fortunatus, and Achaicus.

The suggestion of sharing ministry continues in 2 Timothy, as Paul advises Timothy, "You have heard me teach things that have been confirmed by many reliable witnesses. Now teach these truths to other trustworthy people who will be able to pass them on to others" (2 Tim 2:2). The tradition of extending ministry throughout the congregation continues in Timothy's ministry

Theological Foundations

Trinity and Relationship

In a careful reading of Genesis 1, God is present and active in three expressions. Hobson finds these expressions to be God's Wind, which is the spirit, God imagines creations and speaks into the void, and God's Word, brings creatures and humans into being (8). God, God's Spirit, and God's Word are together at the very beginning.

While present at creation, the Trinity is first explicitly apparent at Jesus's baptism. At Christ's baptism, the Trinity is seen and heard, the Godhead, three in one, rejoicing in a moment of mission. Understanding God as Trinity brings hope because it comes from existence and not behavior. They are always one (Rohr 81). In the words of St. John, "God is love, and all who live in love live in God, and God lives in them" (1 John 4:16). The Trinity is seen as both self-giving and as the essence of God (Moynagh and Harrold 126). Moynagh and Harrold describe this as the Father giving to the Son not in a way that is borrowed, but rather as something that "constitutes his very being" (81). "The mutual self-giving of the Father and the Son is not just a giving to—a giving between the two of them. Thus, it is not just a two-way giving between Father and Son; it includes the third person. It is an outpouring of love for each other that flows into the eternal procession of the Spirit" (Moynagh and Harrold 82). "The spirit's gift to the Father and the Son is the gift of a life, a life that is entirely dedicated to revealing, communicating and acting on the Father and Son's behalf . . . to the total gift of self by the Father and the Son, the Spirit responds by making his own equally total gift of self" (Moynagh and Harrold 82). A thoughtful understanding of the Trinity suggests that to be filled with the Spirit is to be filled with a sharing, self-giving, centered purpose in life. Self-giving is the essence of the Trinity, the center of the life lived with God, and, therefore, the essence of mission

and the essence of mission within the world, including the world wherein Christians work.

While that may seem complicated, it is lived seamlessly within the God-formed life. Christians find themselves receiving, giving, learning, sharing, growing, participating in growth in ways that are generated and empowered by the Trinity—Father, Son and Holy Spirit.

AdventHealth is a self-giving missional community, called together around clinical care, giving, loving, serving, and caring in the name of Jesus. The meaning of missional community comes from an understanding of the Trinitarian God. Life, health, and wholeness are found in community and relationship, in what Richard Rohr describes as "the dance": "Whatever is going on in God is a flow, a radical relatedness, a perfect communion between Three—a circle dance of love" (Rohr 27). Christians are children of God, servants of Jesus Christ, and invited to pour out from the wealrh od their experience in the "circle dance of love" with the Trinity. Followers are pouring out what the Holy Spirit pours in. That is the essence of the calling of spiritual ambassadors within a healthcare system. Tuned in and accepting of a private conversation with God, a lifegiving relationship with the Son, and an ongoing infilling of the Holy Spirit, called to give and serve and love in ways that can be extraordinary.

Praying together the prayer of Francis of Assisi is a part of the training process, that as spiritual ambassadors they are agents of peace. While maintaining a non-anxious presence is part of the training of this spiritual ambassador project and being a non-anxious presence inherently helps those who are being cared for tap into their own place of calm, being an instrument of peace does not come from within caregivers themselves.

Help is required, and that help is the Holy Spirit. A transcendent experience that is the work of the Holy Spirit in observing and responding to the spiritual needs of those being cared for.

In those times when the rites and prayers that were poured over a person whose life was draining from their body, while their families observed from cars in the hospital parking lot, the certain and real presence of the Trinitarian God was with us; God alive and real at the bedside and with a grieving, struggling family a few feet away in a parking lot. Caregivers at times express that never in life was God' presence as noticeable and evident as in those moments.

From the earliest moments of creation, it has been clear that God brought all things into existence for the purpose of relationship. We are grounded in relationship. In the words of Rohr, "We're not of independent substance; we exist only in relationship" (Rohr 45). Out of this relationship, ambassadors of Jesus live in a dance or choreographed existence, incorporating relationship with others and the Holy Spirit. Much as the Trinity, three in one, moves and lives in a choregraphed and synergetic way, as Christians live into their sacred calling to extend the healing ministry of Christ, acknowledging that the Holy Spirit is embedded in all activities because surely upon engaging the name of Jesus, the Trinity—Father, Son and Holy Spirit—join that dace, and move in relationship to that transcendence.

Imago Dei

Christopher Wright points out that within the first mention of human beings in the Bible, there are two foundational identifiers: First, God made humans in His own image and, second, God intended humans to exercise dominion within creation (50). Wright

goes on to say that Psalm 145 shows that the God's rule is characterized by grace, compassion, generosity, and love. And if that is what is known of God, that is what has been entrusted to human beings as those made in His image. (51). Being made in God's image, imago Dei, asks humans to be people of compassion, generosity, grace, and love.

One of the foundational understandings that leads to excellence in patient care is seeing each person as the image of God, the *imago Dei*: "Then God said, 'Let us make human beings in our image to be like us. They will reign over the fish in the sea, the birds in the sky the livestock, all the wild animals on the earth, and the small animals that scurry along the ground.' So God created human beings in his own image. In the image of God he created them; male and female he created them" (Gen 1:26-27). The sixth day of Creation included the creation of human beings in the image of God. Genesis 1:26, has both "in our image," which is from the Hebrew *tselem*, and "in our likeness," which is from the Hebrew *demuth*. Humans, then, are the final act of Creation, the only created beings said to be brought about in the image and likeness of God and given responsibility for the earth. From the beginning of time, from the deepest ancestry all share regardless of color, culture, or belief, all are made in the image and likeness of God. Not only does the Genesis account say, "Let's do this," it also pronounces it done: "So God created human beings in his own image" (Piper).

We see "image of God" again after the fall of Adam and Eve and the beginning of sin in Genesis 9:6: "For God made human beings in his own image." The image of God continues after sin has begun. It continues today (Piper).

Steve Seamands tells the story of Katherine, a woman who had held resentment and bitterness in her heart toward her father throughout her life. After her father's death,

she realized she had been carrying a huge burden of hatred and injustice, believing she owed that to herself. Upon realizing she could forgive her father she began to realize the weight of it. One evening, she went to bed with thoughts swirling around in her head. A second-grade student had asked her that day, "How come Jesus got to be so great when we are just nothing?" Katherine's response to her student was, "We are not nothing. We are sons and daughters of God." Katherine found in hearing her answer and pondering her own situation that she could forgive her father. Though broken, we are all made in the image of God. We are children of God, a family. Her father had been a broken man, but she could forgive (Seamands *Wounds* 130).

Her story points to Paul's words in Romans 8:29 that go straight to the heart whenever we hear them: "For God knew his people in advance, and he chose them to become like his Son, so that his Son would be the firstborn among many brothers and sisters." Human beings are all children of God, brothers and sisters. All are made in the image of God, a multi-faceted family, complicated, messy, and needy. And through it all people share in this life together. In Acts, Paul reminds us, "For in Him we live and move and exist…we are his offspring" (Acts 17: 28).

Having been created bearing the image of God, it is inherent within all individuals, children of God, to point one another to God by relationships, words, actions, and the places inhabited within community. When this purpose and calling is fully lived, a calling all people have, it is living into the image of God and into the people God created all to be (Russell, 167).

Missio Dei

As followers of Jesus, we believe that Jesus is the "fullest and final expression of hope and love" (Russell, 72). Jesus's story on Earth has two parallel tracks: First, he was the culmination of the story of Israel and the beginning of a new paradigm, wherein he has prevailed over evil and ultimately seals our life within God. Second, Jesus is the living the example of how all should live and be in this world as children of God. His life was dedicated to love, care, service, forgiveness, compassion, acknowledging the value of every human being, calling us to commitment to the hurting, and showing how to love those who have failed. He lived in such a way that he saw each person he encountered was made in the image of God, a child of God, a brother or sister. Fulfillment, redeemer, guide and example, we are all called to live the mission of Jesus.

Moynagh suggests that a movement is sweeping across the world, one of commitment to church and worship found within all aspects of life, not just within the walls of a specific building on Sunday morning (Moynagh, *Being Church* 27). Missional life and church should happen wherever life is lived, not just within the structure of Sunday morning and where better than in the healthcare setting, where birth and mortality, as well as everything in between, is in stark focus.

One of the great moments of mission in history is the story of Exodus. God delivering his people from slavery was not only spiritual, but also political, social, economic, and aligned with optimum health. God the Redeemer enacted mission within the lives of God's people in an extraordinary way. Compassion and care drove God, and God was faithful. God does not just offer comfort. Rather, God shows them the way, takes their hand, and opens the possibility of relief (Wright Loc 1704). Within that understanding, Christians build their own sense of mission, one that includes a deep and

all-encompassing understanding of mission as the place that meets the needs of humankind across all demographics and faiths (-or lack thereof-), and that comes from deep concern and compassion.

"For God the Father has rescued us from the dominion of darkness and brought us into the kingdom of the Son he loves, in whom we have redemption, the forgiveness of sins" (Col 1:13-14).

God's people are to be missional. Mission is a calling every follower of Jesus has, regardless of vocation. Embedded within a Christian's baptism, the true moment of telling the world what one believes and about one's commitment, is mission.. Being a spiritual ambassador in the workplace provides an opportunity to bring mission to the margins, to practice mission where life happens.

The Exodus story of God's activity with His people beautifully shows mission. And mission is still very much alive within the Great Commission and the calling Jesus gave to every follower in Matthew 28:19-20: go into the entire world, reach every person, be the church in the world, and then will the end come. Paul continues this message in words that inspire: "So we are Christ's ambassadors; God is making his appeal through us" (2 Cor5:20). Scripture uses the word, "ambassador."

We are called, we are chosen, to be a missional presence, spiritual ambassadors, within our community, not just together with like-minded people in our church home. Mission is about seeking wholeness for our neighbors. Mission brings meaning and insight to the practice of healthcare and binds the healing of body with the healing of spirit and soul in extraordinary ways. Christopher Wright affirms this as he discusses the Christian's place in the marketplace: "Your daily work matters because it matters to God.

It has its own intrinsic value and worth. If it contributes in any way to the needs of society, the service of others, the stewardship of the earth's resources, then it has some place in God's plans for this creation and in the new creation. And if you do it conscientiously as a disciple of Jesus, bearing witness to him" (242).

Understanding Spirituality in Healthcare

New ideas and perspectives have rapidly emerged regarding how people become sick, how they heal, and how they maintain health. These new perspectives often include a very direct correlation between health and healing and spirituality, which indicates a broader scope of understanding. Historically, medicine and its practitioners have understood the value of the environment, family history, and the biological determinants that impact health. Countless articles and books about spiritual care as part of the healthcare process are available today, many of them coming directly from practitioners within medicine.

Spiritual Needs and Healthcare

For many years, medical science overlooked or dismissed the contribution of spirituality to health. Many physicians, particularly, followed the laws of nature alone in understanding medical needs and outcomes. However, that has begun to change. The study of the field of religion, spirituality and health is relatively new. However, the studies and findings around this topic have exploded in number in the last twenty years. Since 2000, hundreds of studies have been published and "it is safe to say that over one thousand research studies have quantitatively examined relationships between religion, spirituality, and health, many reporting positive findings" (Koenig 22). These studies look not only at health outcomes, but also the need to address the religious needs and

traditions that relate to health. “These beliefs affect how patients cope with illness and derive meaning and purpose when feeling bad physically or unable to do the things they used to do” (Koenig 23).

In addition to studies and research, training around spirituality in patient care has been growing within medical education. “In 1992, only three medical schools offered courses on religion, spirituality, and medicine. By 2006, over one hundred of the 141 medical school in the United States and Canada had such courses (70 of which are required)” (Koenig 24). This recognition of the role of how spirituality and physical factors interact to impact health positively has changed the perspective of physicians and science in defining the value of spirituality in medical practice.

Levin introduces what he refers to as “Theosomatic Medicine.” This refers to a view of health and healthcare outcomes based on very apparent connections between God, faith in God, and human wellbeing. He takes this beyond the mind and body approach, saying that is not enough. Rather, he insists that a spiritual factor is required.

Levin defines spiritual care as “a view of the determinants of health based on the apparent connections between God or spirit—or faith in God—and the well-being of the body” (207). He defines these precise connections in seven principles of theosomatic medicine:

1. Religious affiliation and membership benefit health by promoting healthy behavior and lifestyles.
2. Regular religious fellowship benefits health by offering support that buffers the effects of stress and isolation.

3. Participation in worship and prayer benefits health through the physiological effects of positive emotions.
4. Religious beliefs benefit health by their similarity to health-promoting beliefs and personality styles.
5. Simple faith benefits health by leading to thoughts of hope, optimism, and positive expectation.
6. Mystical experiences benefit health by activating a healing bioenergy or life force or altered state of consciousness.
7. Absent prayer for other is capable of healing by paranormal means or by divine intervention.

Awareness of and attention to the mind-body connection, in which the body and mind are inseparable, has transformed medicine over the years. “Likewise, scientific evidence for connections among body, mind, and spirit promises to further expand the scientific worldview” (Levin 14). Thus, health outcomes and processes become based on the apparent connections now realized between, God, or spirit, and the body.

Another voice in this discussion is that of Epstein, wondering about his own heritage, Judaism, and if there was a thoughtful approach to healing and theological practice and identity. Remarkably, he found that within the Hebrew scriptures a medical tradition grounded in faith. This tradition was grounded in the unity of mind and body. For healing to occur there must be a process that occurs between body and mind. He posits God as in relationship both in sickness and in health, and only within the framework of God’s work can full mind and bodily healing occur. According to Levin, this “‘requires a degree of faith on the patient’s part’ and the most effective way to evoke

such faith is by '(r)emembering God.' In this way, physical, mental or emotional, and spiritual factors work in tandem to promote health and well-being" (Levin 215).

Interestingly, the Journal of Clinical Oncology reported in 2003 that there is a "large gap between how patients value and use religion in decision making and how health professionals feel about this" (1379-82). Investigators surveyed one hundred patients with advanced lung cancer, their caregivers, and 257 medical oncologists. When asked to rank the importance of seven factors that could influence the decision whether or not to accept chemotherapy, patients and family members ranked "faith in God" second, the recommendation of their oncologist first. However, the oncologists ranked faith in God last, or seventh. Hopefully, that oncologist trend has changed in the last nineteen years.

As continuing studies come to light and the benefit in patient outcomes is consistently substantiated in peer-reviewed medical journals, nursing journals, and public health journals, long-standing trends are beginning to change. Healthcare providers and scientists alike are realizing they must begin to acknowledge the role of spirituality in health outcomes. Increasingly, clinical providers can find themselves solidly on scientific ground when they address spirituality within patient care (Epstein).

Prayer and Healing

Within the study of spirituality in healthcare, the meaning of prayer is consistently present. Frequent prayer is associated with better health and emotional wellbeing and lower levels of distress (Levin 76). In his research, Levin found that "people also turn to prayer to deal with personal crises and issues" (Levin 76), further saying that "the use of

prayer for purposes of coping depends upon the availability and closeness of others to pray with us or for us" (Levin 76).

In a startling finding, Levin reports that in investigating the effect of religious devotion in a nationally represented sample, "the intensity of devotion was a strong determinant of life satisfaction, regardless of one's level of religious attendance, religious affiliation, social interaction with others, health, or experience of traumatic life events in the past year" (77). In other words, whether patients are religious attenders or religiously affiliated or not, healthcare workers have deep opportunities to provide spiritual care that is meaningful and beneficial.

The National Institute of Health has studied the role of prayer within healing and healthcare. Between 1955 and 2001 there were ninety identified studies, forty-five of those conducted in a clinical setting, the other forty-five conducted within a laboratory setting. The study found that 71% of the clinical studies and 62% of the laboratory studies reported positive outcomes (nih.gov).

Providing healthcare is never without meaning; it is always intrinsically attached to a life given by God. And according to Daniel Sulmasy, the routine within healthcare should never be boring (Sulmasy, 13). "The mundane is never far from the transcendent within healing, and the transcendent always brings us back to the subject and reality of prayer.

Prayer within the healthcare context is not just for the patient. Ajith Fernando reminds us of Paul's requests for prayer. As a leader and facilitator of ministry, he depended upon the prayer of the people for the power within his ministry (Fernando, 45). "Brothers, pray for us" (1 Thess 5:25 and Hebrew 13:18) is a request that is appropriate

within healthcare. Whether chaplain, clinical provider, or staff member, prayer is essential within the scope of medicine.

Research Design Literature

The research project for the current dissertation began with development of a training program for healthcare-based team members to become in-the-gap spiritual providers as a part of their work life. The researcher, who is chaplain manager, designed the research materials developing a pastoral program for a large medical group.

Having completed the training materials, the researcher began training those who were interested in participating in the program. Trainings took place during work hours, both virtually and in person.

One year after implementation, the researcher stopped training for a period of time and evaluated through online survey and one-on-one interviews what the experience of the training was and if the training properly equipped the healthcare workers to function as spiritual ambassadors in their workplace.

For design, implementation and evaluation of the project, I followed closely Tim Sensing's book, *Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses*. Sensing's book also created an awareness of the Hawthorne Effect, which is "a theory that questions research dependability due to cases when subjects know they are being studied" (Sensing 4). Throughout the training and during the evaluation, participants were well informed that they were part of a research project.

During the evaluation process, I encouraged the participants to answer honestly and openly, and not be concerned about my goals or feelings. They were fully aware that the paramount goal of the project and process was to bring spirituality into their

workplace, with a focus on both patients and their colleagues. There were no participants who were concerned about being in the project, most were delighted to be involved in research.

Summary of Literature

The premise of the spiritual ambassador in the healthcare setting is embedded deeply within mission. Jesus clearly modeled mission and lived in the places where life is lived. Further, the role of spirituality in healthcare has long been accepted and embraced. Increasingly physicians and allied health professionals are seeing a deepening need for spirituality both in patients and team members as society experiences increasing mental health and psycho-social issues.

In faith-based healthcare, the role of prayer and spiritual support bring comfort, strength, and healing. As put forward by Levin, the impact of devotion strongly determines life satisfaction (Levin 77), and throughout healthcare chaplains support and encourage devotion experienced through active listening and prayer. However, chaplains are not able to be everywhere they are needed. Training an engaged and vibrant team of lay providers as spiritual ambassadors potentially brings the function of spiritual care into every workplace and every patient encounter.

In seeing the image of God, *imago Dei,* in each co-worker, patient, and patient's family member, the function of one's work takes on a deeper and more impactful meaning. That meaning is derived for the spiritual ambassador equally with the person they are encountering. Within AdventHealth, we live under the mission statement, "Extending the Healing Ministry of Christ," and our CEO has often said that "every patient encounter is a spiritual encounter." Spiritual Ambassadors not only bring the

expertise of their role to the workplace each day, they also bring their overwhelming sense of mission, *missio Dei,* and a willingness to provide care in Jesus' name.

CHAPTER 3

RESEARCH METHODOLOGY FOR THE PROJECT

Overview of the Chapter

This chapter covers the research methodology that was used for this project with an analysis of the methods used to both choose the participants for this project and conduct the research necessary to complete the project. The chapter details the step-by-step procedures for the project, including how each research tool was used to fulfill the project's purpose and answer the research questions. In addition, the chapter examines the unique context of AdventHealth Medical Group, and lays out a timeline for the project and presents the factors contributing to the validity and reliability of this study.

Nature and Purpose of the Project

AdventHealth Medical Group is an ever-growing large medical practice encompassing more than three hundred physician offices and including the full scope of medical care. It is embedded in an organization that is not-for-profit and mission driven. AdventHealth, throughout all its work and facilities, believes that all medical care should extend the healing ministry of Christ in all places and encounters, whatever the function within the practice.

The physician practice is a where patients and their families seek help, often when they have run out of the ability to help themselves and other times when they are seeking preventive care. Patients range in age from newborn to end of life; and mission can be and should be embedded in all stages of life.

In Central Florida, AdventHealth encompasses people from all socio-economic and cultural backgrounds, providing care for immigrants, celebrities, sports heroes,

families, young adults, and elderly individuals. Many of the patients have no insurance, and AdventHealth has developed creative ways to help them. Pastoral Care is deeply embedded in all the work AdventHealth does, both inpatient and outpatient. The purpose of this project is to extend the work of the vocational ministry provider, equipping, and empowering all team members, clinical and non-clinical, to know how to provide in-the-gap spiritual presence and care in the absence of a chaplain.

Research Questions

RQ #1. What portions of the orientation were helpful? What portions were not particularly helpful?

This research question assesses the viability of the training process AdventHealth Medical Group spiritual ambassadors found educational and helpful, which aspects should be continued, and which, if any, should be discontinued in future training.

Feedback on this research question came primarily from the interviews. Interview questions one and two asked about the validity of the training process. Question 1 asked if they found the training effective in preparing them to be a spiritual ambassador, and question 2 asked if they felt anything was missing in the training process. In the online survey, question three asked if the training indicated what was expected of them as a spiritual ambassador.

RQ #2. Did the orientation process provide you with a sense of empowerment and blessing to function as a spiritual ambassador in your work setting?

This research question addresses the purpose by studying the training that AdventHealth Medical group team members received in their orientation and training process to become a spiritual ambassador and if they were adequately prepared and ready

when they completed the training. This was answered with the online survey questions, "I understand why AHMG needs spiritual ambassadors," and, "I am currently able to serve others as a spiritual ambassador."

RQ #3. What disparities exist between training, your ability to access spiritual support from a chaplain, and the needs that you have in your setting?

This research question addresses the purpose statement in the exploration of equipping and preparing AdventHealth Medical Group team members to create an environment of interaction and support between spiritual ambassadors and the vocational ministry team. The online survey question, "I know what is expected of me as a spiritual ambassador," and the interview question, "Does your leader encourage you in the spiritual ambassador role by providing or approving opportunities to function in the role" answered this question.

RQ #4. Do you have the support of your manager and administration to be a fully functioning spiritual ambassador?

This research question determines if the AdventHealth Medical Group spiritual ambassador was functioning within an environment that supported their role and provided them the empowerment and blessing to fully integrate spirituality into the focus of their work. The online survey question, "I am currently able to serve others as a spiritual ambassador," and the interview question, "Does your leader encourage you in the spiritual ambassador role by providing or approving opportunities to function in the role" answered this question.

Ministry Context

The ministry context was the entire team of AdventHealth Medical Group in Central Florida. This group is unique in that many are highly educated and work in specialized fields while others are uneducated and serve in baseline employment. No distinction was made for the role of the spiritual ambassador in terms of location, education, or role. Spiritual ambassadors work autonomously within the practice in this role, accessing and including trained chaplains as requested.

Participants

All oriented and trained spiritual ambassadors were included in this project. They were free to decline to be involved in the process.

Criteria for Selection

The criteria for selection included all participants employed as team members of AdventHealth Medical Group in Central Florida, all participants had completed spiritual ambassador training, all participants had had at least one month to begin functioning as a spiritual ambassador in their work setting, as no new training opportunities were provided for one month prior to the survey, and all participants were over the age of eighteen.

This criterion insured that participants fit the purpose statement and research questions. First, the participants had status as team members within AdventHealth Medical Group in Central Florida. Second, the participants had status as fully trained spiritual ambassadors, having completed the virtual training at least one month prior to survey. Third, the participants met the requirement to have had experience in integrating being a spiritual ambassador in their workplace for at least one month. This was facilitated by ending all orientation opportunities one month prior to the survey.

Description of Participants

All who were surveyed were team members of AdventHealth Medical Group in Central Florida. All had been fully trained and had functioned as a spiritual ambassador for at least one month prior to the survey. They were all over the age of eighteen. Otherwise, there was no limit on age, but all were employees of AdventHealth Medical Group in either a part-time or full-time status. The candidates were both male and female, and they came from a variety of ethnicities and faith backgrounds. Within faith backgrounds, participants were predominantly Christian. The participants were in good mental and physical health.

Ethical Considerations

The first section of the online survey included informed consent. By agreeing to the study, participants stated their consent and received access to the questions.

Using privacy protocols of the online survey tool, Survey Monkey, ensured confidentiality for the survey. The privacy statement and protocols are laid out at https://www.surveymonkey.com/mp/policy/privacy-policy/. Furthermore, all survey responses were strictly confidential and data from this research was reported only in the aggregate. Survey Monkey coded the information which remained confidential, and was only accessible by using a login and strong password on the site. Participants signed an informed consent agreement that assured confidentiality and specified that answers were confidential and only accessible to the research team. All electronic data was stored in a secure, encrypted folder on a Hewlett Packard Elitebook using encryption with a complex password. In addition, researchers secured all other data via password to the account. Only members of the research team knew the password. I secured any data printed in hard copies in my small, locked office safe. Six to twelve months after completion of the dissertation and its final approval, all data was deleted from the website. Data saved on

the researcher's computer was securely deleted, and all hard copies of data were shredded and burned one year after the date the dissertation is completed and approved.

Using responses in the aggregate to form a composite of responses ensured anonymity for the survey. Reporting for the study was secured and did not refer to individual responses. For personal interviews, each candidate was identified using a code beginning with the letters "SA" and a number between one and 10.

Instrumentation

Two researcher-designed instruments collected data in this study. The first one was the online survey, and the second one was the personal interview.

The online survey was designed to assess the effectiveness of the spiritual ambassador training that had been provided. The survey had five questions and some binary questions and allowed participants to assess not only the effectiveness of their training, but also the ongoing support that they received. All questions had forced choice on the Likert Scale of 1-5 and the option of "undecided."

The in-person interview was a research-designed, semi-structured, qualitative instrument used to allow a randomly picked group of five participants to further explain questions used in the survey and dig deeper into other aspects needed for the research questions. The rationale for this instrument was to allow the participants to develop any ways that they could receive better training, better follow up support, or deeper support from their supervisors. There were four questions in the interview and a fifth question which allowed the participant to clarify any of his or her answers and gave an opportunity to express any further thoughts on the spiritual ambassador program.

Expert Review

The research methods were sent to my dissertation advisor, Ellen Marmon, Director of the Doctor of Ministry Department as Asbury Theological Seminary in Wilmore, Kentucky, and Jorge Aguero, Administrative Director for Outpatient Ministry within, AdventHealth Central Florida. Both were sent the survey and interview questions, along with an introduction letter with an explanation of the problem being addressed, the purpose of the research project, and the research questions. A rubric was created for each of the instruments, which asked whether each question was needed or not needed, clear or unclear, and suggestions to clarify.

The expert reviewers gave positive reviews, offering some minor points of clarification on a few questions and suggestions to clarify some things for participants in the study.

Reliability & Validity of Project Design

The use of the survey for the entire sample of spiritual ambassadors within AdventHealth Medical in Central Florida assessed the effectiveness of the education process for spiritual ambassador training. The interview enabled deeper research with a smaller sample of the larger group to investigate specific information about the ongoing challenges that spiritual ambassadors face. It revealed information about the equipping provided for the spiritual ambassadors and their ability to effectively integrate ministry into their daily work. The instruments were reliable as the survey followed best practices for a survey. In addition, the interview followed the best practices for semi-structured interviews that included a consistent order and reading of questions and was positively reviewed by the expert reviewers.

Both instruments were administered to the participants on a consistent basis. The survey was available on the internet for one week. After two days, potential participants received a reminder to encourage spiritual ambassadors to complete the interview. In the interview, all questions were asked in the same way each time. The researcher was intentional not to make any comments to indicate approval or disapproval of answers to the questions. In addition, the findings of the two studies were trustworthy and generalized, because there was a mixed-method approach of a quantitative survey and a qualitative interview.

Data Collection

The project used a mixed-method, post-intervention design. Participants took a spiritual ambassador survey using Survey Monkey. The survey was sent out to every trained spiritual ambassador in AdventHealth Medical Group. To facilitate a quick response, participants were given one week to complete the survey. To add credibility to the survey, the administrative director for outpatient ministry for AdventHealth provided a letter of endorsement. These methods achieved a 19.8% response rate from potential participants.

To further enhance the process, I randomly chose five individuals from those who responded to the survey. The choice followed Sensing's admonition that "quality is more important than quantity" in the interview process (Sensing 85). These five individuals received an email immediately after the survey closed, inviting them to be interviewed and laying out the purpose of the interview. I asked them to respond by email within one week if they were willing to be interviewed. Five individuals agreed to be interviewed. I

then contacted by telephone those who were willing to be interviewed to schedule as soon as possible a time for a virtual one-on-one interview on Teams.

The quantitative survey sought answers to the research questions from a large group of the trained spiritual ambassador team within AdventHealth Medical Group. The purpose of the interview was to deepen understanding of what the training experience had been and to find out what is "in and on someone else's mind" (Sensing 104), in this case, the minds of those who were trained and actively functioning as spiritual ambassadors within their workplace.

Data Analysis

In determining what kind of information and documentation would be most valuable for this research project (Sensing 207), an online survey sent to the entire group of trained spiritual ambassadors promised to provide the most information with the least intrusion into busy work lives, the best possible response, and systematic answers. In addition, a few personal interviews could deepen the insights required for this project.

Survey Monkey provided quantitative data, and a member of the research team created written manuscripts from those audio recordings. Team members listened carefully to the audio recordings multiple times. I carefully reviewed the written transcripts looking for themes that developed. I then created a document assessing the outcomes and details.

The semi-structured one-on-one interview protocol provided qualitative audio data, and written manuscripts were created a member of the research team from those audio recordings. Audio recordings were listened to carefully multiple times. The written

transcriptions were also carefully reviewed, looking for themes that developed. A document was then created assessing the outcomes and details.

Once I received this information, I tried to ascertain that I had received all the available responses by sending email reminders to participants. Having received all possible responses, and having found that the information covered the effectiveness of the spiritual ambassador training, data analysis began.

CHAPTER 4

EVIDENCE FOR THE PROJECT

Overview of the Chapter

The spiritual care needs of patients and healthcare team members in both inpatient and outpatient settings are increasing. The availability of vocational pastoral support individuals, including chaplains, is not increasing and may even be in diminishing availability. The lack of ministry support in areas of immense need is an ever-increasing conversation among healthcare leaders in the faith-based setting.

The purpose of this study was to evaluate the effectiveness of a spiritual ambassador training program in the outpatient setting to determine if effective training could be provided to empower and engage team members in in-the-gap ministry care in an outpatient setting.

Participants

Two hundred and fourteen individuals completed the spiritual ambassador training as a part of this project. Forty-one of those who completed the training participated in the survey. The criteria for the survey included: (1) all participants were employed by AdventHealth Medical Group, (2) all participants had completed the spiritual ambassador training at least one month prior to the survey, and (3) all participants were over the age of eighteen.

Research Question #1: Description of Evidence

Are spiritual ambassadors able to be of help in this role within their workplace?

The online survey contained one question which fully addressed this research question. It is more fully developed in the personal interview instrumentation. The

research shows that the spiritual ambassadors are challenged by the lack of time. In their work settings, few can take the time to fully address their role as spiritual ambassador. Some indicate that the role provides more sense of empowerment to stop and pray or to ask a question assessing a person's state of mind. However, the noticeable challenge is tome that keep them from adequately following through with anything other than a quick prayer, word of care, or word of blessing. Several acknowledge that being a trained spiritual ambassador does provide a deeper awareness of their tone and their mindset as they go about their work activities.

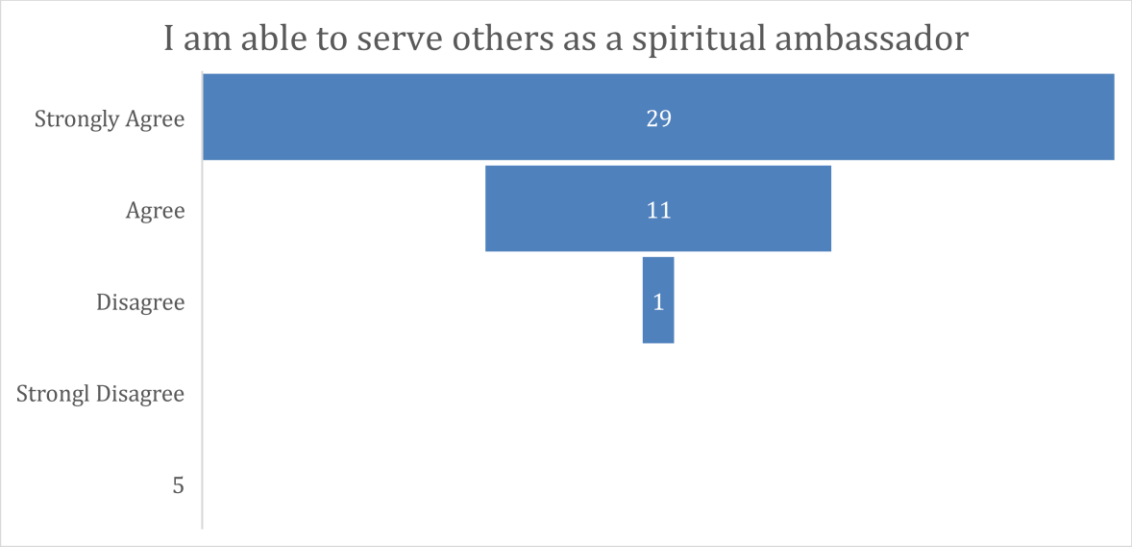

Figure 4.1 I am able to serve others as a spiritual ambassador.

Among those interviewed two indicated that their leaders had reached out to them to either take leadership on a project for the team, such as a toy drive for children for Christmas or collecting blankets for an area homeless shelter. In addition, each person interviewed indicated they had been asked, specifically because they had received the spiritual ambassador training, to help when there was a sentinel moment with a patient that suggested prayer or simple emotional support might be helpful.

Several stories emerged as I interviewed the members of the spiritual ambassador team. One medical assistant told of rooming a patient and sensing that there was tension. The spiritual ambassador said that she had an "internal discussion with herself" about whether to say something and decided she was called to ask the patient if she was okay. When asked, the woman broke into tears and shared that she had come to the previously scheduled appointment not planning to share that her son had taken his life a few days before. Because the spiritual ambassador asked and cared, the patient was surrounded in prayer and efforts were made to find resources to help before she left that day.

Another spiritual ambassador told me she had asked her manager if the team could come together for a shared lunch, either brown bag or potluck, to become better acquainted. Because they are a distributed team and do not work together in an office, they do not know one another or have times of community. To her surprise, her manager agreed, and that lunch was so enriching, the manager has approved a monthly lunch where the team is together, around the table, sharing life together.

Throughout the interview process and after, stories emerged of times when spiritual ambassadors stepped outside their comfort zone to care, to serve, to pray, and to love on those around them. They are empowered by the calling to be a spiritual ambassador.

All of those interviewed indicated that they feel a stronger tie to the chaplain team and had reached out to a chaplain in moments of need rather than through the charting referral process that is normally used.

In addition, the chaplain team has noticed that there were times when a patient had a significant life problem and expressed a lack of desire to live, a patient was

deciding whether to end a pregnancy, or a patient expressed severe grief and, upon learning the life problems the spiritual ambassador made personal contact with a chaplain for follow up support. In these kinds of situations, a referral is typically made through the charting system to request chaplain follow-up. However, because the spiritual ambassador felt a deeper connection to the chaplain team, they made immediate contact with a chaplain requesting help. Both the chaplain and the spiritual ambassador found this provided better care for the patient in need. This is an unexpected outcome and a very welcome one.

In addition, many situations come up that were related to a team member. Rather than being a patient in need, a situation with a team member arose or a conflict among team members that needed resolution. In conversation with a member of the chaplain team, one spiritual ambassador shared the story of bringing in coffee and a few breakfast items to bring the team together briefly before the start of their workday. This allowed a moment to bring camaraderie between the various individuals and began a healing process. Another spiritual ambassador who is part of a distributed team, a team who does not work together in one setting, asked her manager if they could begin a monthly potluck or brown bag lunch together. The manager agreed to a one-time trial, it was so successful that it is now a monthly event that the entire team looks forward to and because of the effort of that spiritual ambassador they now are acquainted with one another and work more fully as a team.

Qualitatively, no specific requirements were asked of spiritual ambassadors other than commitment. Rather, they were asked to make it their own and bring a sense of spirituality and the presence of Jesus to the practice in ways that fit their personalities and

gifts. In follow up to this assessment process, a future addition to the training will be a spiritual gifts analysis that may help the newly trained spiritual ambassador assess and consider opportunities that they would resonate with.

Research Question #2: Description of Evidence

Did the newly trained spiritual ambassadors find the training deeply embedded in the teachings of Jesus?

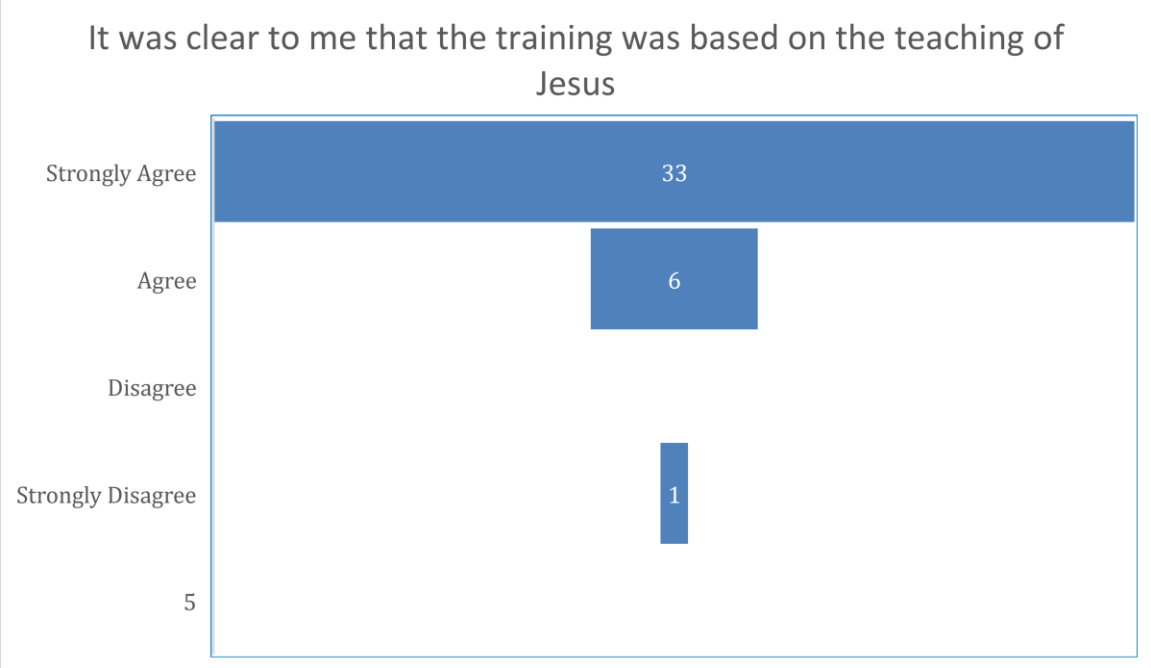

Fig 4.2 The training was deeply embedded in the teachings of Jesus.

The online survey results indicate that 82.5% or 33 of the individuals responding, strongly agreed that the training is deeply embedded in the teaching of Jesus. Another 14.6% or 6 of the individuals responding agreed that that training is deeply embedded in the teachings of Jesus. Only 2.4% or one individual did not find the training embedded in the teachings of Jesus.

At the time of training, several individuals expressed frustration that the training did not single out Christians, but was open to those of any faith. While AdventHealth Medical

Group is a faith-based organization that clearly states that they "Extend the healing ministry of Christ," many team members are adherents to faiths other than the Christian faith. The spiritual ambassador training was open to anyone on the team who expressed a commitment to faith, including those of Muslim, Hindu, and Jewish faith. Some spiritual ambassadors felt the training did not single out prayer as a requirement, and they were surprised or disappointed by that. aWhile prayer is strongly encouraged, and written prayers were provided as a part of the training, some felt that there should be a strong expectation of spiritual ambassadors being prayer providers.

Research Question #3: Description of Evidence

Did the spiritual ambassadors understand their role?

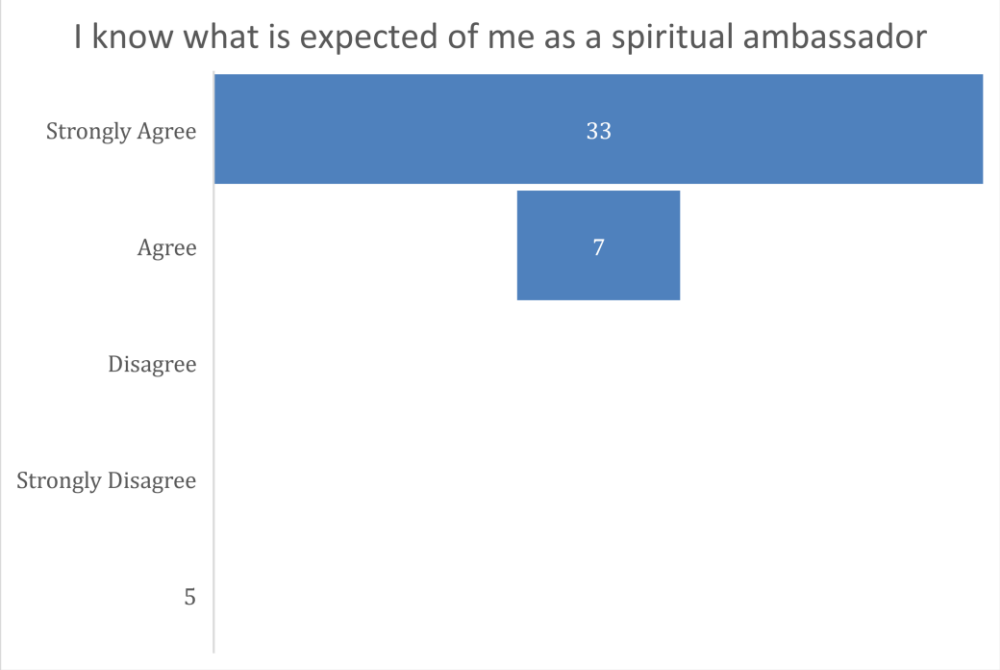

Fig 4.3. I know what is expected of me as a spiritual ambassador.

In the personal interviews, the respondents commented on knowing what they should be doing in the moment when something arose. However, having time to adequately respond was a continuing challenge. Each of these respondents indicated that

their leaders understood their role and were either strongly supportive or somewhat supportive, and appreciative of the process. They indicated that their leaders encourage them to live into the role. However, at the same time, their work is task-oriented and any time they stop for a few moments, it negatively impacts the rest of the team and the patient wait time. While empowered to be a spiritual ambassador, they have a sense that their time use reflects on the entire team and that in turn impacts the amount of time patients wait, which is a tracked statistic that reflects on their overall performance. They expressed a continued sense of calling and opportunity, while also experiencing the challenge of inadequate time.

Qualitatively, four of the spiritual ambassadors interviewed indicated that the training made them more aware of their attitude and persona that is deeply embedded in the expectations that others have of them.

Although the spiritual ambassadors are challenged with time constraints, in response to the training, they are more focused on each person with whom they interact, and they are more aware of the way they speak to the patient, their expression, and how they are perceived. One team member indicated, “I notice that I look people in the eye and smile more frequently than I did before this training, and I think that is what is expected of us as spiritual ambassadors.”

The spiritual ambassador team is supportive of the program and revealed that they would recommend that others join them as spiritual ambassadors.

Fig 4.4 I would recommend becoming a spiritual ambassador to others.

This study revealed four major findings in the spiritual ambassador program.

Summary of Major Findings

1. The spiritual ambassadors faced significant time constraints in providing any in-the-gap spiritual care
2. The spiritual ambassadors found that their training made them more aware of their attitude and the way they respond to those around them.
3. Trained spiritual ambassadors feel a stronger tie to chaplain support and feel that they are an extension of the pastoral care program.
4. All of those interviewed indicated a desire to see the program continue and perhaps even grow.

CHAPTER 5

LEARNING REPORT FOR THE PROJECT

Overview of the Chapter

A continuing challenge in the healthcare setting is providing adequate spiritual care and support to team members, patients, and patients' families. While chaplains are available, in the AdventHealth Medical Group setting the diaspora of multiple counties and long distances makes it impossible to provide a chaplain's care in an immediate way. A process is in place to chart a request for pastoral care support for a patient with an expected turn-around time of 48-hours, but this process is often inadequate and does not meet the needs of the patient's family or of the team. It only helps the patient. This research project assessed the viability of spiritual ambassador training of those team members who desired to bring a spiritual presence to their workplace, and who wanted to work to bring a stronger sense of spiritual support to all those for whom and with whom they work.

This chapter identifies four findings from this project and details how they correspond to my personal observations, my literature survey, and the theological and biblical framework established for this project. In addition, this chapter explores the limitations of the study and makes recommendations for further assessment and study.

Major Findings

First Finding: Significant Time Constraints

Spiritual ambassadors faced significant time constraints in providing any in-the-gap spiritual care. The time restraints that spiritual ambassadors report limit their ability to fully integrate the process into their workplace. While their desire is significant, they

must continue their workday tasks even when observing a need for emotional or spiritual support. This observation became apparent both in the online survey and the personal interviews.

Most leaders are aware that the spiritual ambassador training offers value to the practice, both for patients and team members. However, they are faced with extraordinary time restraints brought on by heavy schedules and, in many practices, staffing shortages. The tracking that is done of patient wait times and the turn-around time goals they must meet to stay in good standing, and in some cases to earn bonuses exacerbates time constraints.

In understanding the role of spiritual ambassador from a Biblical perspective, earlier mention was made of Stephanas, Fortunatus, and Achaicus and their story found in 1 Corinthians 16. They were ambassadors of Jesus, carrying on Paul's work within their community. While the Biblical record does not comment on their work or family life, they had made a commitment of time to their community in furthering Paul's work. The effort and experience of the spiritual ambassador likewise requires time and commitment.

My literature review found that the National Institute of Health has studied the role of prayer within healing and healthcare. Between 1955 and 2001 there were ninety identified studies, forty-five of those conducted in a clinical setting, the other forty-five conducted within a laboratory setting. The study found that 71% of the clinical studies and 62% of the laboratory studies reported positive outcomes (nih.gov). Providing spirituality within healthcare is never without meaning. It is always intrinsically attached to a life given by God.Therefore, one is left to wonder if the time restraints might be

overcome by increased patient satisfaction and patient experience. If in the tracking that is done, patients expressed a higher level of care and satisfaction with their care, that could that overcome potentially increased weight times.

Second Finding: Increased Self-Awareness.

Spiritual ambassadors found that their training made them more aware of their attitude and the way they respond to those around them. Most of the spiritual ambassadors.

Most of the spiritual ambassadors interviewed commented on having greater awareness of their countenance, attitude, and person having a positive or negative impact on those for whom they are caring for and with whom they interact, whether patient or team member. They expressed a deepening desire to be careful of their attitude, some even saying they start their day by working on their attitude before beginning their workday.

As I talked to leaders and spiritual ambassadors throughout the organization, they reported that this training has been life-changing in understanding the value of "withness." Withness describes how they come alongside those they work with and for in ways that show warmth, welcome, embrace, and inclusion; practicing being fully with and fully aware of those around them Several reported that it has changed the way they live within their family structure, and they have found blessing and inspiration in that.

In the literature review, Christopher Wright's comment that God's rule is characterized by grace, compassion, generosity, and love" (51). Therefore, being made in God's image, imago Dei, asks humans to be people of compassion, generosity, grace and love. When spiritual ambassadors spoke of the change in their acceptance of people,

their countenance, their awareness of the sound of their voice and the expression on their face, they were relating to being people known for compassion, generosity, grace, and love to all those they encounter. Imago dei became the essence of their response to the training. While not always having time to stop and have a conversation, they were able to practice a presence of acceptance, warmth, and love.

The Biblical story of Lydia records this same experience. Lydia as an active and busy within her household and business, still had an influence that made her team want to follow her and understand her love of Jesus. Spiritual ambassadors practice Lydia-style workplace attitudes and engagement.

Third Finding: Stronger Ties to Chaplain Team and Extension of Pastoral Care

Spiritual ambassadors feel a stronger tie to the chaplain team and feel that they became an extension of the pastoral care program. This finding was a surprise. The survey and conversations clearly showed that the spiritual ambassador team felt a stronger tie to the chaplain team. They indicated a willingness to contact a chaplain for care often making arrangements to do so by Teams or by text so that the chaplain had immediate access to the person in need. This may be the most strategic change brough about by the presence of spiritual ambassadors within the organization because when a spiritual ambassador contacts the chaplain, the chaplain can then immediately carry on a telephone or virtual conversation with the person in need. It allows for chaplain follow up without delay. The spiritual ambassadors felt empowered to make those connections and it has been life changing in the workplace, both for patients and the team. The chaplain team expressed a sense of satisfaction that they have better ties to those who are in need than they did when they only responded through the charting process.

My research and assessment found this to be a significant benefit of the program. In talking to leaders and asking questions of spiritual ambassadors, it was obvious all parties felt a much deeper and more immediate connection to pastoral care. Chaplains expressed a sense of belonging that they did not have before, and they appreciated having more immediate contact with patients, much as they would in a hospital setting.

Within an understanding of missio Dei, all Christians are engaged in the process of mission. Mission is not only for vocational chaplains; it is the work and responsibility of all. God's people are to be missional. Mission is a calling every follower of Jesus has, regardless of vocation. Within the Christian understanding mission is embedded within baptism, the true moment of telling the world what we believe Christians are committed to. Being a spiritual ambassador in the workplace provides an opportunity to bring mission to the margins, to practice mission where life happens. Being a spiritual ambassador has provided a personal and powerful attachment between the vocational pastoral provider and the person, connected by the spiritual ambassador, who is there in the moment.

The Biblical story of Moses and Jethro also called for a greater connection for ministry from within the multitude, the ministry of reconciliation and invitation into the presence of God.

Fourth Finding: Desire for Program to Continue

The spiritual ambassadors expressed a desire to see the program continue despite the challenges and obstacles, the spiritual ambassador team would like to see the program continue. Both leadership and the spiritual ambassador team expressed a desire to overcome the obstacles, or at least do the best work possible around the obstacles if the

obstacles continue. The organization's chief executive recently suggested that every physician practice have one or more spiritual ambassadors and has made that known publicly. Leaders want to overcome the obstacles. Chaplains want the process to continue. Every area of the team has expressed a desire to continue the spiritual ambassador program.

The research showed that while the spiritual ambassadors feel pressure not to take time, and in places where they don't feel completely empowered, they still want to continue. Their sense of meaning and accomplishment exceeded the difficulties. Their newly formed relationships with the chaplain team have provided deeper meaning to their work.

The literature review studies from JAMA Network, John Ehman, and Harold Koenig., clearly showed that spirituality within healthcare is something patients indicated they want and need. Patients facing difficult decisions or ongoing chronic illness are looking for ways to make faith-sense of their experience. Research showed that patients who select faith-based healthcare providers have greater expectations for emotional and spiritual care and hold the healthcare team to a higher standard. Spiritual ambassadors are prepared and willing to meet that standard.

The earlier discussion in the biblical foundations found that Jethro advised Moses to delegate. When faced with overwhelming time pressure, the answer was to bring in help and to do so by delegating to the larger community. That is the model established for this project, to empower the spiritual ambassador team to join chaplains in providing spiritual presence and spiritual care to those they are called to serve.

Ministry Implications of the Findings

The significant ministry finding is the attachment and connection that the spiritual ambassadors felt to the vocational ministry team, the chaplains. Spiritual ambassadors have created their own pathways to provide pastoral care to their patients and team members. Prior to this process, the provider would chart a need for pastoral care and there was a forty-eight-hour turnaround time for a call to the patient. Within this project, the spiritual ambassadors developed close relationships with their chaplains and have immediate access when they feel an immediate response is needed. This has brought deeper meaning and satisfaction to the chaplain team in their ministry experience and has created a more personal and immediate care for patients and team members. The most significant finding was not at all an expected outcome.

Limitations of the Study

An assessment of on-sight leaders would have provided a more well-rounded study. Also, a survey of the chaplain team would have provided more insight into their experience of the spiritual ambassador presence and process in the workplace. It was unexpected to find the spiritual ambassador team so deeply tied to chaplains. Had that been known in advance, the researcher would have included a survey of chaplains as part of the research process.

Because of time pressure, there were limited responses to the online survey. If another fifty or more individuals had responded, more robust research findings might have emerged.

Unexpected Observations

A huge, unexpected outcome was the correlation and synergy with the vocational chaplain team. An additional surprise was that in trying to keep newly trained spiritual

ambassadors from being fearful about a requirement to pray, the importance of prayer was understated in the training. Most spiritual ambassadors wanted to pray. The training does include several written prayers. However, the assessment process clearly shows that they want prayer to be a significant part of what they do. Future training will spend more time on finding comfort in praying aloud and offering help for those who are uncomfortable, while also making it more obviously a part of the expectation of spiritual care. In addition, the deep ties formed between spiritual ambassadors and chaplains, and the significance that brings to patient and team care, was an unexpected and positive result.

Recommendations

This spiritual ambassador process could be adapted to any corporate setting. The need for spiritual support is always present and there are seldom enough chaplains to cover all of the need. Any chaplain could lead this training and begin a process of extended spiritual care through the work of team members.

The next steps for this project include the following: (1) providing opportunities to increase and deepen the bond between chaplains and spiritual ambassadors, (2) adding a spiritual gifts analysis to the spiritual ambassador training process, (3) beginning a thoughtful and systematic process of educating leaders on the importance and impact of the spiritual ambassador team, (4) increasing an understanding of the role of prayer in the spiritual ambassador's presence.

In addition, a follow up to this project an annual discussion process, will be implemented with leaders, chaplains, and spiritual ambassadors to assess opportunities for improvements and added depth within the program.

Postscript

Taking on this project has been hard work, but it has been fulfilling, and the encouragement that it has provided me, and our chaplain team, has been immense. Wherever we go from here, all of us who have been involved have been aware that we were on holy ground as this project and process was launched. It was a surprise to those in the outpatient setting to have this depth of spiritual presence supported and encouraged. They are accustomed to the hospitals in AdventHealth promoting and encouraging spirituality within the team and the patient care experience. However, taking on this level of spiritual integration in the outpatient setting was unexpected. It was encouraging to me to see it so fully embraced and supported by our senior leaders.

Overall, the project has been a success and it will grow from here. Not only is AdventHealth Medical Group providing more immediate care from pastoral care because of it, but chaplains and spiritual ambassadors are bonded and finding a depth of meaning in working together that was a surprise outcome of the project. It is not perfect. It is not even streamlined. But it has begun, and it will grow. My regret in the survey process is that leader responses were not assessed, and I believe we will do a survey of the leadership team sometime in the future to understand the impact they observe and to fully assess their commitment to the program and process.

APPENDICES

A. Confidentiality Agreement

B. Interview Questions

C. Survey

Appendix A – Confidentiality Agreement

Project Title: Equipping the Healthcare Team for Spiritual Care

I, _____, have been asked to participate in a one-on-one interview to discuss the advocacy and experience of the spiritual ambassador program at AdventHealth Medical Group. I understand that I will be interviewed directly by Chaplain Donna Burske, the Researcher.

1. I agree to keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format with anyone other than the Researcher.

2. I agree to allow any information or opinions I disclose to be used in the research project noted above.

_____	_____	_____
(Researcher - print name)	(signature)	(date)

_____	_____	_____
(Transcriber - print name)	(signature)	(date)

Appendix B – Interview Questions

Project Title: Equipping the Healthcare Team for Spiritual Care

1. Did you find the training effective in preparing you to be a spiritual ambassador?
2. Do you feel anything is missing from the training process?
3. Does your leader encourage you in the spiritual ambassador role by providing or approving opportunities to function in the role?
4. Does the spiritual ambassador program/process make a noticeable difference in your workplace?
5. Is there anything you would like to clarify in your answers or anything you would like to add? Should the program continue?

Appendix C – Survey

Project Title: Equipping the Healthcare Team for Spiritual Care

1. It was clear to me that the training was based on the teachings of Jesus.
2. I understand why AHMG needs spiritual ambassadors.
3. I know what is expected of me as a spiritual ambassador.
4. I am currently able to serve others as a spiritual ambassador.
5. I would recommend becoming a spiritual ambassador to other team members within AHMG.

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