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Healthcare Chaplaincy:

A Study of Patient Satisfaction of African Immigrant Patients in the United States Hospitals

A Project Report

Submitted to the Faculty

In Partial Fulfillment of the Requirements

For the Degree

Doctor of Ministry

By

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Abstract

This research project aims to investigate the satisfaction of sub-Saharan African immigrant patients with health care chaplaincy services in United States hospitals. The research study was birthed by the desire to contribute to the evidence-based approach that is slowly and surely becoming the norm in the work of the health care chaplain. This research project measures the outcome of spiritual care delivered to a specific group of the United States population that utilizes the United States hospitals.

This research project verifies the assumption that chaplaincy care provided to sub-Saharan African immigrant patients in the United States hospitals from chaplains from other cultures may not achieve patient satisfaction due to religious and cultural diversity issues that may surface during a spiritual care encounter. To investigate this subject, the researcher utilized a mixed methods approach, using both quantitative and qualitative instruments. For the quantitative instrument, the researcher used surveys. Twenty people participated in the survey, while the qualitative instrument used in person interviews with an additional ten individuals. The small sample size is indicative of the challenge of identifying sub-Saharan African immigrant patients in the United States hospitals who received visits from chaplains during their hospitalizations.

The findings of the research project tentatively establish that to reach patient satisfaction in chaplaincy care with sub-Saharan African immigrant patients, chaplains must have cultural sensitivity and competence. This study reveals that without cultural sensitivity and cultural competence, it may be difficult to meet the emotional and spiritual needs of sub-Saharan African immigrant patients because of the role that cultural diversity plays during a visit. The findings of the qualitative interviews aligned with those of the quantitative survey.

Acknowledgments

Completing this research project has been a long journey. I have faced many challenges to bring it to an end. There were times when I felt discouraged and wanted to quit. But, with the grace of God, I have persevered until the end. During this journey, I have experienced Isaiah 40:31, which says, “But those who hope in the Lord will renew their strength. They will soar on wings like eagles; they will run and not grow weary; they will walk and not be faint.” Therefore, I want to thank God for being the primary source of my strength.

I want to thank Emilie, my lovely wife, for standing by my side daily. Honestly, no words really describe the role she has played in helping me make this dream a reality. Thank you, Emilie, for helping me to remain focused on this project even on those days that you needed me closer to you. Thank you to my children Don, Myriam, Afi-Elizabeth, and Grace for their patience with me and their words of encouragement when I was tired. Their daily encouragements made a difference and will always be remembered. Thanks to Jaden-Rose, my first grandchild. She came into my life during the time of the gestation of this long study. Carrying her in my arms after a long study day and playing with her was very helpful during this research study.

As I am writing this, I wish my parents were still alive because Mom and Dad stood strongly for education. My father, Bernard, was the first college graduate in his family and one of the first ten theologians in the Democratic Republic of Congo. My parents always hoped that I would one day complete a doctoral degree. I praise God because this research project has made their dream come true. I also want to express my gratitude to my brother Jean-Bernard and his spouse Angelique. They facilitated my family’s relocation to the United States of America, which many years later allowed me to enroll at Winebrenner Theological Seminary and become an alumnus of this great theological institution.

I want to thank Dr. Joel Cocklin, Dr. Kristina Gutierrez, and Dr. Kathryn Helleman for their endless support. They were always available to provide feedback, read and re-read my papers, and discuss the progress of the research when I needed them. I am indebted to them, and I hope they will find the expression of my gratitude in these words. I also want to thank Dr. John Nissley, who was the Director of the Doctor of Ministry program at Winebrenner Theological Seminary when I started my doctorate studies. May Katie Erickson also accept my words of gratitude for her endless support. Finally, I also want to thank my church, Christ for All Nations Church, for all the love, prayers, and support during this journey. May God continues to bless you all and give you peace.

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Chapter One

Introduction to the Problem

One of the fundamental human rights of every person, that the United Nations[1] tends to promote in every country of the world, is the right to health care.[2] This means that every human being on this planet should have the right to health care, which includes immigrants. Not just health care, but they also have the right to quality health care. The desire to make this right a reality in the life of every person and population group around the globe led to the development of a program called Universal Health Coverage. This program was geared to assist governments in developing research capabilities that can allow countries to extend health services to meet the growing needs of populations without discrimination.

The 2013 report of the World Health Organization, a division of the United Nations, notes, "Everyone should have access to health care they need…"[3] This means every human being; including people with disabilities, immigrants, and refugees who are being displaced from their countries of origin to escape war, natural disasters, or any form of persecution. Everyone should have access to health care whether this means preventive, curative, rehabilitative, palliative medicine or health promotion. But what does 'access' to health care mean? Before diving in depth, it is crucial to understand the meaning of this word "access" since it is

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[1] The United Nations is an intergovernmental organization founded in 1945. It is currently composed of 193 countries. The mission of the United Nations is to maintain international peace and security, promote sustainable development, protect human rights, uphold international law, and deliver humanitarian aid. "About Us," United Nations, accessed August 25, 2016, https://www.un.org/en/about-us.

[2] "Universal Declaration of Human Rights: Article 25," United Nations, accessed January 15, 2016, http://www.un.org/en/universal-declaration-human-rights.

[3] "World Health Organization Health Report 2013: Research for Universal Coverage," United Nations, accessed February 11, 2016, http://who.int/whr/en.

ubiquitously used in healthcare literature. In fact, several published studies that have aimed to provide a taxonomic definition of the word 'access' reveal that it is one of the most difficult concepts to define in health care policy. Some words that were used to describe it are: complex, confusing, and ambiguous. Penchansky and Thomas noted:

> While "access" is a major concern in health care policy and one of the most frequently used words in discussions of the health care system, most authorities agree that it is not a well-defined term…. The Discursive Dictionary of Health Care, published by the U.S. House of Representatives, should be a source of precise definitions for terms employed in federal health care legislation. However, the definition for access states that the term is very difficult to define and measure operationally....[4]

Gulliford, and those who have also discussed the definition of this concept, in one article stated, "To answer this, we discuss published work on access and suggest that access is a complex concept…."[5] William D. Savedoff goes even further by arguing, "Typically, an article that aims to discuss access will quickly move toward an indicator without even defining what it means by 'access.'"[6] Given this situation, let the reader acknowledge and consider the fact that despite the researcher's desire to elaborate a clear definition of the concept "access" to health care in this study, the same obstacles that have rendered this task almost impossible in previous studies have not yet been lifted. There are several reasons that make this task difficult. For instance, in health care policy the concept "access" could be analyzed and interpreted from several different perspectives. Four factors make it difficult to elaborate a definition of the concept "access" to health care.

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[4] Roy Penchansky and J. William Thomas, "The Concept of Access: Definition and Relationship to Consumer Satisfaction," *Journal of the Medical Care* 19, no. 2 (1981), 127.

[5] Martin Gulliford, Jose Figueroa-Munoz, Myfanwy Morgan, David Hughes, Barry Gibson, Roger Beech, and Meryl Hudson, "What Does Access to Healthcare Mean?" *Journal of Health Services* 7, no. 3 (2002), 186.

[6] William D. Savedoff, "A Moving Target: Universal Access to Healthcare Services in Latin America and The Caribbean," *Social Insights* (2009), 5.

First, “access” could be a potential entry to health care. In this context, “access” to health care means that individuals or population groups who are not ill have the opportunity to receive medical care when illness and/or injuries occur.

Second, “access” to health care could also refer to the utilization of health care when individuals or population groups are facing illness and/or injuries. Yet, in this perspective it suggests the idea that people who are ill and/or injured can enter health care for consultation and treatment.

Third, “access” to health care could also be used in the context of eligibility for health care insurance and government health care program coverage. This approach seems to have a more political perspective than operational. This is well illustrated in debates on the rights of immigrants to health care. For example, the eligibility of undocumented immigrants to health care insurance and government health care program coverage.

Fourth, the concept “access” to health care could also be used in reference to people’s perception of health care services. In other words, people’s ability and/or willingness to deliberately take advantage of health care services to them when there is an emerging health problem that needs medical attention.

As they endeavor to elaborate a clear definition of this concept, researchers have found that “access” to health care must be measured. Based on that, they have developed several models to be used to evaluate “access’ to health care. This study will refer to the work of Penchansky and Thomas, who argue that there are five factors that have to be taken into consideration to measure it.[7] Those five factors are the following: availability, accessibility,

[7] Penchansky and Thomas, 128-129.

accommodation, affordability, and acceptability. These five factors could be defined in the following terms:

Availability is the appropriateness of resources that are needed to provide quality health care to a person who is ill and/or injured. For example, the adequacy of the health care infrastructure (hospitals, clinics, urgent care facilities and emergency rooms). The involvement of health care professionals who have the appropriate training and expertise to address the health issue of the patient, such as physicians, surgeons, nurses, chaplains, and allied health professionals. The participation of health care professionals who are known as specialists in the area of the patient's illness, such as cardiologist, neurosurgeon, physical therapist, clinical nutrition, and health care chaplains, to name just a few.

Accessibility is the existing distance between the location of the health care facility and either the place of residence of the patient or the place of occurrence of the health crisis. This factor also takes into consideration things like the travel distance to reach the facility whether it means hospitals, physicians' offices, urgent care facilities, or emergency rooms.

Accommodation refers to the way the system is organized and functions to accept patients who need to be seen by the appropriate health care provider and settle how they adjust to it. This includes things like the appointment process, hours of operation of the facility, the system of communication to maintain a good flow of information between the health care provider and the consumers. The concept of accommodation refers to the consumer's ability to respond or adjust to the organizational structure of the institution to enter health care. Accommodation suggests the presence of factors that can make it difficult for someone to adjust to the health care system. Among those factors are the level of education, language barriers, and

religious and cultural diversity. These factors can have a negative influence on the patient's ability to adjust to the way a health care institution is organized and operates.

Affordability focuses on the patient's financial capacity to take care of the cost of health care provided (or to be provided) without causing a financial crisis that can cause more problems for the person. In other terms, this refers to the ability of the consumer not to be overwhelmed by the high cost of health services provided (or to be provided). For instance, the high cost of consultation, medical procedures and surgeries, use of new technologies and medications.

Acceptability refers to the reaction of the patient toward the adequacy of the facility, (hospitals, clinics, urgent care facilities, emergency rooms), the supply of health care professionals involved in patient care (physicians, nurses, chaplains), and specialized programs available (preventive, curative, rehabilitative, palliative care and health promotion). In other words, acceptability is concerned about the consumer's evaluation of the organizational structure and quality of health services provided in terms of satisfaction.

Penchansky and Thomas suggest a table that contains a series of questions that provide a better understanding of the way these five factors serve the effort of providing a taxonomic definition of the concept of "access" to health care. In this table, Penchansky and Thomas ask questions that determine the specific area of focus of each dimension of access, as discussed above. Yet, each question focuses on a specific dimension of the concept of "access" and the variety of answers to these questions make evident the fact that the concept of "access" to health is complex.

In fact, each answer to these questions provides some understanding about the way each dimension (availability, accessibility, accommodation, affordability, and acceptability) of access influences the meaning of the concept. In order to better understand the context of this table it

must be clarified that Penchansky and Thomas developed it for a study of the concept of "access" to health care in the context of its relationship with consumer satisfaction.

Table 1. Patient Satisfaction Questions[8]

Access Dimensions	Questions
Availability	1. All things considered, how much confidence do you have in being able to get good medical care for you and your family when you need it? 2. How satisfied are you with your ability to find one good doctor to treat the whole family? 3. How satisfied are you with your knowledge of where to get health care? 4. How satisfied are you with your ability to get medical care in an emergency?
Accessibility	5. How satisfied are you with how close your physician's offices are to your home? 6. How difficult is it for you to get to your physician's office?
Accommodation	7. How satisfied are you with how long you have to wait to get an appointment? 8. How satisfied are you with how convenient physician's office hours are? 9. How satisfied are you with how long you have to wait in the waiting room? 10. How satisfied are you with how easy it is to get in touch with your physician(s).
Affordability	11. How satisfied are you with your health insurance? 12. How satisfied are you with your doctor's prices? 13. How satisfied are you with how soon you need to pay the bill?
Acceptability	14. How satisfied are you with the appearance of the doctor's office? 15. How satisfied are you with the neighborhoods their offices are in? 16. How satisfied are you with other patients you usually see at the doctors' offices?

Again, the previous table provides a big picture of the way each factor influences the definition of "access" to health care. It also serves to enlighten the confusion, complexity and ambiguity that researchers on health care policy refer to when they argue about the complexity of the task of defining the concept "access" to health care.

[8] Penchansky and Thomas, 131. For authorization to use this chart, see Terms and Conditions of Use - About JSTOR, https://about.jstor.org/terms/#content-use.

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In fact, even as we acknowledge that difficulty, it is this researcher's opinion that a definition of "access" could still be elaborated regardless, and pastoral care which is provided by professional chaplains are important elements of health and healing for patients, and therefore, need to be researched for greater understanding. In this study the concept of "access" to health care will convey the following meaning that we owe to William Savedoff:

> …[A]ccess to health care is best conceived as the probability that an individual with a given condition will receive an appropriate and effective treatment for the condition. This probability will be higher to the extent that relevant health care services are physically available in proximity to population, are financially affordable, and are provided with the quality required.[9]

Context of the Problem

This research studied the impact of the pastoral care that professional chaplains provide to sub-Saharan African immigrants in the United States hospitals. It also investigated their level of satisfaction with pastoral services. Since this research was conducted in the context of the Doctor of Ministry study program, it is important to clarify that the researcher focused on two factors that aligned with the purpose of this research project. These factors were accessibility and acceptability.

First, this research examined the accessibility of pastoral care services to sub-Saharan African immigrant patients and their families in the United States hospital. In this perspective, the researcher investigated if pastoral services were available to sub-Saharan African immigrant patients and their families. Second, the researcher examined the degree of acceptability of the pastoral care provided to sub-Saharan African immigrant patients and their families. At this

[9] Savedoff, 8-9.

level, the researcher investigated how sub-Saharan African immigrant patients evaluated the pastoral care services provided to them during hospitalization in the United States hospital.

This research study sought to measure the degree of satisfaction of sub-Saharan African immigrants in the United States hospital in order to contribute to an evidence-based approach of pastoral care that will be used in future health care chaplaincy to minister to sub-Saharan African immigrants in the United States hospital. Hence, the choice of this project was in part influenced by the researcher's experience with the United States hospital system. First, as a sub-Saharan African immigrant who has lived in the United States for more than 22 years, the researcher has encountered the United States hospital system on several occasions, either for personal illness or family health concerns.

Second, as an ordained minister, the researcher has interacted with sub-Saharan African immigrants who have experienced hospitalization in United States hospitals. Third, sixteen years in the hospital ministry at Duke University Medical Center (NC), Cabell Huntington Hospital (WV), Saint Mary's Medical Center (WV), and OhioHealth-Doctors Hospital (OH) led the researcher to examine assumptions that were worth researching to promote best practices in health care chaplaincy.

According to several studies conducted on access of immigrants to health care in the United States, evidence establishes that to some extent their access to health care has always been problematic. It is documented that in the United States immigrants are an underserved portion of the population. They do not easily have access to quality health care.

In one study, Derose, Escarce, and Lurie articulated that immigrants "have lower rates of health insurance, use less health care, and received lower quality of care than U.S. born

populations."[10] Another study that has involved a large sample of participants reports the same findings. The study reports a systemic search for post-1996 population-based studies about immigrants and health care. They identified 1,559 studies but only 67 articles met the study. Among those studies 77% examined access, 27% quality, and 6% examined the cost of health care. This study also concludes that in the United States, immigrants are sadly exposed to inadequate access and poor quality of health care. The study reports that immigrants and their children were less likely to have health insurance and a regular source of care and had a lower use of health care than US born citizens which is an indicator of poor satisfaction with health care.[11]

There is a plethora of studies that confirm it. However, the researcher can only use these findings to recognize red flags that indicate that there is a problem. From one angle, these findings do not provide us with any specific information needed about sub-Saharan African immigrants in the United States hospital system. These studies are silent about the role pastoral care plays in the hospital multidisciplinary team and how sub-Saharan African immigrants respond to it as a component of the health care delivery, which is the main preoccupation of this research.

The purpose of this research is to acknowledge the problem, and most importantly, to recommend practical solutions that could help improve the situation. To be able to do that, health care needs to be seen as a big puzzle where each piece of the puzzle represents a specific discipline. To make sense of these findings, each discipline must determine one aspect of the

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[10] Kathryn Pitkin Derose, José J. Escarce, and Nicole Lurie, "Immigrants and Health Care: Source of Vulnerability," *Health Affairs* 26, no. 5 (2007), 1258.

[11] Kathryn Pitkin Derose, Benjamin W. Bahney, and Nicole Lurie, "Immigrants and Health Care: Access, Quality and Cost," *Medical Care Research and Review* 66, no. 4 (2009), 355-408.

problem (or more) that needs special focus, and to investigate that aspect according to methodological approaches that are accepted by the discipline.

Consequently, the researcher wants to explore this subject through the lens of health care chaplaincy, a field that is quickly developing as a stand-alone discipline of practical theology under the constant pressure of professional organizations such as the Association for Professional Chaplains,[12] Spiritual Care Association,[13] John Templeton Foundation,[14] and Transforming Chaplaincy,[15] that argue that health care chaplaincy needs to become more scientific.

Since professionalism in health care chaplaincy is pushing chaplains to develop research literacy to improve patient outcomes, it is the intention of the researcher to contribute to a better understanding of access to health care and quality of care of immigrants in the United States hospital system by focusing on one specific aspect of the issues: patient satisfaction of sub-Saharan African Immigrant patients with health care chaplaincy services.

The connection must be made clear here. Since the holistic approach to health care is strongly advocating for the integration of spirituality in the delivery of health care, the chaplain's role in the interdisciplinary team of the hospital is crucial. Health care chaplains have a

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[12] "Standards of Practice for Professional Chaplains: Section 3, Standard 12," Association of Professional Chaplains, accessed July 18, 2016, http://www.professionalchaplains.org/content.asp?pl=200&sl=198&contentid=514.

[13] https://www.spiritualcareassosication.org. is a multidisciplinary and international professional association for spiritual care providers. The organization provides membership, education, and certification. The organization is located in New York City

[14] The John Templeton Foundation has allocated $4.5 million to boost hospital chaplain research literacy through the program called, "The Chaplaincy Research Fellowship and Clinical Pastoral Education Development Grants." "$4.5 Million Grants to Boost Hospital Chaplain Research Literacy," Brandeis Now, April 27, 2015, http://www.brandeis.edu/now/2015/april/cadge-templeton-grant.html.

[15] Transforming Chaplaincy is a department of Rush University in Chicago that is currently focusing on research literacy in health care chaplaincy. "Entering a New Era of Transforming Chaplaincy," Transforming Chaplaincy, July 1, 2019, https://www.transformchaplaincy.org/2019/07/01/entering-a-new-era-of-transforming-chaplaincy/.

contribution to make where health and healing is at the center of the debate. By researching this subject, the researcher's intention is to help reduce ignorance that hinders people's ability to understand how practical theology in general, and health care chaplaincy in particular, can professionally contribute to public conversation about health and healing.

Many negative criticisms have been made over the years to convince people that theology, as a discipline, is not qualified to participate in public conversation about serious issues that concern human conditions. For example, "If science disappears from human memory, we will soon be living in caves again. If theology disappears from human history, no one will notice."[16] Nowadays, research on the connection between spirituality and health, the importance of the integration of spirituality in health care, and the relevant role hospital chaplains play in the process of health care delivery, demonstrates eloquently that practical theology has something to add in any given situation of the human condition. This explains why Henri Nouwen argues that "Christian leaders have the arduous task of responding to personal struggles, family conflicts, national calamities, and international tensions with an articulate faith in God's real presence."[17]

Health care chaplaincy, understood as a discipline of practical theology, has significant contributions to make to the debate on the healthcare of immigrants in the United States. In this perspective, practical theology must be the funnel where the plurality and diversity of theologies come together to give meaning to human history. This research project examined if the inadequate access to health care and poor-quality care of sub-Saharan African immigrants in the United States, as cited in previous research, extends also to the delivery of pastoral care in the

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[16] Terry Sanderson, "Theology: Truly a Naked Emperor." The Guardian, May 26, 2010, www.guardian.co.uk/commentisfree/beleif/2010/10, quoted in R. Albert Mohler, Jr. *Culture Shift: The Battle for the Moral Heart of America* (Multnomah Books: Colorado Springs, 2008), 165.

[17] Henri Nouwen, *In the Name of Jesus: Reflections on Christian Leadership* (New York: The Crossroad Publishing Company, 1989), 87.

United States hospitals as measured by the level of patient satisfaction with pastoral care services offered.

Furthermore, it is crucial to clarify that since Africa is such a vast and diverse continent, participants in the study were selected from the sub-Saharan region of Africa. This means that people's languages and religious beliefs were not the criteria for participation in the project. One of the main reasons is that selecting the sample from the sub-Saharan region was to allow a broader diversity among participants, including countries of origins, languages, culture and traditions, and religious beliefs while restricting the sample to a manageable portion of the continent. The sample used in this research is composed of sub-Saharan African immigrants who live in several locations in the United States. The researcher selected participants based on the fact that they are originally from the sub-Saharan region of Africa. In other words, participants were people originally from the sub-Saharan region of Africa who have experienced the United States hospital system for any health condition. For example, trauma, surgery, chronic illness and so on.

People who participated in this research project were naturalized US citizens, permanent residents, college students, asylum seekers, refugees, or anyone who has been in the United States on a valid visa for a long or temporary stay. In short, the most important conditions for participation in this research were: 1) to be an African from the sub-Saharan region, 2) to be in the United States during the study, 3) to have experienced United States hospital, and finally 4) to be able to provide valuable information that will be used to fulfill the purpose of this research project.

To best visualize the different countries of origin of the people who participated in this research project, the researcher suggests the map below. This map provides a clear indication of

the limits of sub-Saharan Africa, as recognized by the international community. The map shows the political divisions of countries that are part of sub-Saharan Africa. In this map, sub-Saharan African countries colored in green.

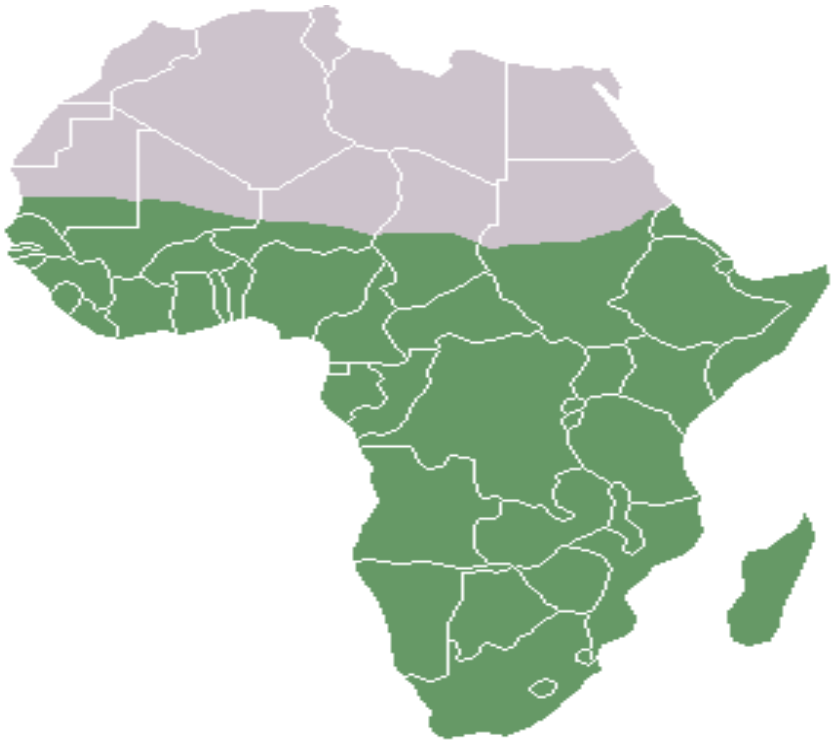

Figure 1. Sub-Saharan Africa Map[18]

Another key point that could be helpful to better understand the population group of this research is to provide some information about the immigration movement of African immigrants to the United States. According to Venters and Gany, African immigrants are currently one of the groups of immigrants that is growing most rapidly in the United States. They stated that:

> African immigrants represent one of the fastest growing group of immigrants to the United States. Between 1990 and 2000, the total number of African immigrants increased 166%. The largest areas of geographic concentration are Washington, D.C., New York City, Minneapolis-Saint Paul, and Atlanta. In New York City, Africans represent the

[18] "Sub-Saharan Africa," New World Encyclopedia, accessed March 23, 2017, http://newworld-encyclopedia.org/entry/Sub-Sahara Africa.

> most rapidly expanding group… [of the] approximately one million immigrants living in the United States, over half immigrated between 1990 and 2000.[19]

Moreover, they also indicated that the distribution of this immigrant population by region is represented as follows: the largest number of immigrants are originally from Anglophone countries such as Nigeria and Ghana. Furthermore, 35% emigrated from West Africa, 26% from East Africa, 20% from North Africa, 7% from South Africa, and 3% from Central Africa, which is mostly composed of Francophone regions.

Statement of the Problem

This research project was developed based on previous research findings that immigrants in the United States constitute an underserved group of the society that do not have adequate access to health care and quality care.

This conclusion does not clearly refer to the accessibility and acceptability of health care chaplaincy services to immigrant patients and families in the United States hospitals. But when it is considered in the context of the findings of George Handzo, one of today's most recognized voices in the area of health care chaplaincy, it suggests that there may be a problem that calls for the attention of the discipline. The finding of George Handzo concludes that, "The spiritual needs of many patients in health care institutions are not being met."[20]This researcher believes using the philosophical approach called syllogism, a form of deductive reasoning, to make sense of these two conclusions will help enlighten the problem.

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[19] Homer Venters and Francesca Gany, "African Immigrants Health," *Journal of Immigrants and Minority Health* 13 (2011), 334.

[20] George Handzo, "The Process of Spiritual Pastoral Care: A General Theory for Providing Spiritual Pastoral Care Using Palliative Care as a Paradigm," in *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplains Handbook,* ed. Rabbi Stephen Robert (Woodstock, VT: Skylight Paths, 2012), 23.

First, immigrants have inadequate access to health care and quality of care. Since sub-Saharan African people are immigrants, then sub-Saharan African immigrants have inadequate access to health care and quality care. Second, the spiritual needs of many patients in health care institutions are not being met. Since sub-Saharan African immigrants are patients, then the spiritual care of many sub-Saharan African immigrants may not be met. This said, studying the satisfaction of sub-Saharan African immigrants with the delivery of pastoral care in the United States Hospitals is an important act of exploration.

Hence, it is essential to healthcare chaplaincy, as a field that strives to be an evidence-based discipline, that such an exploration increase the satisfaction of African immigrants with the delivery of chaplaincy care in the United States Hospital. Such a study also provides perspectives on the overall contribution of the healthcare chaplains in the work of the multidisciplinary team of the hospital. As David A. Lichter noted, in one article "If spiritual struggle, or distress caused by something in one's belief, practice, or experience, is not identified and addressed, it will have an adverse effect on one's health."[21] The need to study the problem of satisfaction of sub-Saharan African immigrants with the delivery of pastoral care in the United States hospitals must be recognized and addressed, which is the reason for this research project.

Purpose of the Study

The purpose of this research project is two-fold. First, it is to collect data, analyze, and interpret it to provide a comprehensive measurement of the satisfaction of sub-Saharan African immigrant patients and their families with the pastoral care provided to them in the United States

[21] David A. Lichter, "Chaplaincy and Research. Spiritual Care Linked To Better Health Outcomes," *Health Progress,* March-April 2013, accessed April 15, 2016, www.f761c4147687414ba9b12cabb8da034b1-pdf.pdf (chausa.org), 64.

hospital. Second, it is to formulate practical recommendations from an evidence-based approach that may contribute to the development of best practice in the delivery of pastoral care to sub-Saharan African immigrant patients and their families in the United States Hospitals.

Research Methodology to Study the Problem

The researcher used a mixed methods research model. To complete this research study, the researcher used two different instruments drawn from: quantitative and qualitative methodologies. The selection of these instruments were related to the nature of the research project. This research project studied the meaning made by sub-Saharan African immigrants as a group related to health care chaplaincy services provided to them. The research also sought to understand how these services made sense to them in the context of patient experience.

Furthermore, the researcher used the survey to develop the questionnaire that was used for the qualitative study. The relation behind the survey and the questionnaire was clearly defined. The quantitative instrument's role was to provide statistical data while qualitative instrument aimed at colleting quality information for analysis and interpretation.

The researcher recruited participants from people he had encountered in different locations in United States. For example, sub-Saharan African immigrant churches, community or tribal organizations, US post offices, banks, malls, international markets, African-owned barber shops, restaurants, and tailors' shops. Many people who agreed to participate in this research project also spread the information about the study to their circle of friends and family members. This allowed the researcher to increase the number of participants in this research project. Each participant provided an email address that the researcher used to send the electronic survey used for the quantitative study.

Research Questions to Guide the Research Project

This research project sought to answer the three following major questions:

1. When sub-Saharan African immigrants are hospitalized in the United States hospital, how satisfied are they with their knowledge of how to receive chaplaincy services?
2. What was the satisfaction level of sub-Saharan patients and families with chaplaincy services that was provided by the United States hospital?
3. What can the study on African patients' and families' satisfaction with pastoral care in the United States hospital teach us about the way pastoral care is delivered to them?

In fact, the researcher's preoccupation with these three questions was to collect data that was analyzed and interpreted in order to formulate practical recommendations for best practices in the delivery of pastoral care to sub-Saharan African immigrants, patients, and their families in the United States hospital. Moreover, by using these questions the intention of the researcher is to allow sub-Sahara African immigrant patients and their families to speak up and be their own voices instead of listening to other sources that could negatively influence the accuracy of the research.

Significance of the Research Project for the Hospital Ministry

As of today, there have been several studies conducted in the area of health and the health care of immigrants in the United States. However, these studies have mostly focused on policy development to regulate immigrant access to health care.[22] There is a shortage of studies that discuss issues such as how sub-Saharan African immigrants experience the delivery of health

[22] Leighton Ku and Sheetal Matani, "Left Out: Immigrants Access to Health Care and Insurance," *Health Affairs* 20, 1 (2001): 247-256.

care in United States hospitals. A helpful example of such a study is reported in the article "Somali Immigrant Women and the American Health Care System: Discordant Beliefs, Divergent Expectations, and Silent Worries."[23] This article reports findings of a study that involved six community-based focus groups where 57 Somali women and 11 Somali health care professionals were interviewed to examine the experience of Somali women in United States hospitals.

In this research project, the researcher wanted to take such research a step further and engage health care chaplaincy in a new journey because of the need for better health for the growing population of the sub-Saharan African people in the United States which cannot escape the focus of the profession. As other disciplines are actively involved in improving the quality of the delivery of health care so too, health care chaplaincy is called to also engage in the journey. This justifies the importance of this research study.

However, this research seeks to establish the theological basis of patient satisfaction that must be integrated to an evidence-based approach to pastoral care to sub-Saharan African immigrants in United States hospitals. This will have a strong influence on a chaplain's understanding of the concept 'access to health care', and its meaning and application in the practice of ministry. On the pastoral level, this research project will enhance professionalism in health care chaplaincy and promote best practices. The research will also create awareness on patient satisfaction of sub-Saharan African immigrants with chaplaincy care received in United States hospitals.

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[23] Carol Paylish, Sahra Noor, and Lynn and Joan Brandt, "Somali Immigrant Women and the American Health Care System: Discordant Beliefs, Divergent Expectations, and Silent Worries," *Social Science & Medicine* 71, no. 2 (2010): 353–361.

Assumptions/Limitations in the Research Project

Assumptions

Most sub-Saharan African immigrant patients and their families experience a sense of disconnection between their cultural background and the way health care is delivered in western medicine, especially in the United States hospitals.

There is a gap between "diversity" and "inclusion" in health care institutions that affects the delivery of pastoral care to sub-Saharan African immigrant patients and their families in the United States hospitals. This needs to be acknowledged, explored, and addressed to promote patient satisfaction.

Research on patient experience in this research project can produce new knowledge that can significantly improve outcomes in the delivery of pastoral care to sub-Saharan African patients and their families in the United States hospitals and promote best practices.

Limitations

There is a lack of studies available in the area of health care chaplaincy that examines patient satisfaction issues of sub-Saharan African immigrant patients and their families in the United States hospitals that can be used for literature review in this research.

This research specifically involved sub-Saharan Africans who have some kind of experience with United States hospitals.

This study does not pursue the objective of addressing theological issues that emerge in the delivery of pastoral care. Instead, it intends to contribute to evidence-based practice in health care chaplaincy by exploring and recommending strategies that could promote best practices of pastoral care in the United States hospitals.

Definition of Terms

"Patient satisfaction" is a reaction of a patient to the delivery of health care that is provided to him or her. In other terms, it is the evaluation of the resources and emerging medical services provided in a healthcare setting. Patient satisfaction can be positive or high or it can be negative or low. In this perspective, patient satisfaction is an experience that could be measured, analyzed, and interpreted to describe how the patient feels about the delivery of pastoral care during an encounter in the United States hospital.

"Evidence-based pastoral care" is an approach or a model of pastoral care that is developed upon a special inclination to research literacy. In other terms, this concept refers to the practice of ministry developed upon any methodological conclusive studies. This approach to pastoral care places the emphasis on research findings that methodologically demonstrate the approach used (or to be used) in a particular situation of pastoral care that has been studied and proven to be efficient in the practice of ministry.

"Best practice" is a method or a technique that demonstrates the capacity to provide a better result than other methods or approaches that are used in the field and have consequently gained a widespread recognition as a benchmark in assessing a particular aspect of health care delivery. Best practice is the approach that has been methodologically recognized to provide the best result among many other approaches in pastoral care.

"African patients and their families" apply to people from Africa who have immigrated from the sub-Saharan region of Africa. In fact, this term is not exclusively used to identify African immigrants who have chosen the United States as their second land, but mainly refers to African people who are in the United States for a temporary stay and who need to benefit from health care to attend to an emerging medical condition.

"Pastoral care" refers to the variety of interventions and techniques provided by chaplains in health care settings such as crisis intervention, active listening, pastoral presence, clinical ethics consultation, and many more interventions provided by the chaplains as a member of the hospital's multidisciplinary team. Every time this term is used it will refer to a specialized discipline of practical theology that focuses on the ministry that is provided in the diversity of health care. Pastoral Care is a specific intervention or action an individual chaplain provides to a patient and his or her family.

"Clinical pastoral care" is used interchangeably with "Pastoral Care". When the word "clinical" is used before "Pastoral Care" the researcher wants to put a special emphasis on the set of skills learned in Clinical Pastoral Education (CPE). CPE is a special program required by the chaplaincy certifying bodies to educate and train chaplains in health care settings.

"Health care chaplaincy" is used to refer to the profession. In this perspective the researcher refers to the department that delivers the hospital's pastoral care services. At this level, the researcher puts the emphasis on the structural aspect of the ministry as it is represented in the organizational chart of the institution.

"Pastoral services" is used to refer to the variety of activities offered to the patient and his or her family by the department of Pastoral Care. For example, providing pastoral presence, ministering to trauma patients or those who are at the end-of-life, addressing patient and family needs related to life and the ethical decision-making process, and bereavement pastoral care. Typically, the chaplain works with the medical staff to help improve communication with the patient and his or her family and the list goes on. Technically, this concept is used in reference to competencies and code of ethics of the Association of Professional Chaplains.

"Professional healthcare chaplains" are persons who have the credentials to serve as chaplains in a health care setting. Professional healthcare chaplains are ordained ministers who are in good standing with their respective churches. They are board-certified in chaplaincy care with one of the major accredited organizations on chaplaincy care in the United States. They are required to have a graduate degree in theology or related discipline, and at least four units of clinical pastoral education earned at an accredited center.

To provide a study on the concept of patient satisfaction and how it applies in the health care chaplaincy within the context of a Doctor of Ministry project, it is necessary to establish the biblical basis for patient satisfaction. It is also important to elaborate on the theological basis for patient satisfaction and the relevance in the research project in the context of the ministry of the church. The chapter that follows uses the Wesleyan Quadrilateral of scripture, reason, tradition, and human experience as a frame from this discussion.

Chapter Two

Biblical and Theological Foundations

In his book, *The Social Transformation of American Medicine,* Paul Starr provides an interesting study that presents the progressive development of the concept of "hospital" in America. The author establishes that hundreds of years ago, hospitals were not what they represent in the present era. The book argues that in pre-industrial societies, for instance, hospitals were places owned by religious and/or charity organizations. They were built to serve as a refuge, a place to take care of the poor, homeless, sick, and the insane. The first hospitals that were built were not built with the unique intention of fulfilling a medical purpose, as is the case in today's world.[24]

Paget and McCormick noted that it was not until later that those hospitals became institutions for the curing of the sick.[25] Specifically, this occurred during the time when the more respectable class in society recognized and accepted that illness is a significant experience in human history. Since then, hospitals have begun to change. They gradually began to undergo a radical metamorphosis in the sense that they moved from being a refuge for the poor to becoming places where religious institutions were providing health care to their own members.

According to research, transformations that have changed the nature, structures, and functions of hospitals in the world, giving these health care institutions the sophisticated form they have today, started at the beginning of the twentieth century. Paul Starr, professor of

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[24] Paul Starr, *The Social Transformation of American Medicine, The Rise of Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books Publishing, 1982), 335-346.

[25] Naomi K. Paget and Janet R. McCormick, *The Work of the Chaplain* (King of Prussia, PA: Judson Press Publishers, 2006), 3.

sociology at Princeton University, who wrote extensively on the history of the development of American medicine noted that:

> The moral assimilation of the hospital came at the end of the nineteenth century with its scientific redefinition and incorporation into medicine. We now think of hospitals as the most visible embodiment of medical care in its technically most sophisticated form, but before the last hundreds of years, hospitals and medical practice had relatively little to do with each other … The hospital took on a more activist posture; it was no longer a well of sorrow and charity but a workplace for the production of health.[26]

This new way of defining the concept of "hospital" gave hospitals a brand-new identity; a workplace to produce health. Since then, hospitals have become subject to endless transformation. For example, on the functional level, they have developed a more bureaucratic style involving heavy administration, complex policies, and protocols than when they were operating as charities. From the structural level, they embraced a scientific approach that quickly influenced the integration of medical education and research, giving birth to hospitals' new focus today.

Furthermore, changes constantly occurring in the medical field have led to the professionalization of health care. Since the rise of professionalism in health care, several different fields have been recognized for undeniably impacting the medical profession. Health care chaplaincy is one of these fields of impact. As the medicinal field has recognized the existing connection between spirituality and health, the profession of health care chaplaincy has become more attentive to its mission alongside medicine and has become a more research-oriented field.[27] It is in this perspective that the following research project was developed.

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[26] Starr, 145-146.

[27] Institutions such as the Association of Professional Chaplains (www.professonalchaplains.org), Transforming Chaplaincy of the Department of Religion, Health and Human Values at Rush University (www.transformingchaplaincy.org), Association for Clinical Pastoral Education (www.acpe.edu), and Healthcare Chaplaincy (www.healthcarechaplaincy.org) are among organizations that are playing an instrumental role in promoting evidence-based chaplaincy care.

The desire to improve the delivery of health care has given rise to the importance of measuring patient satisfaction in health care institutions. Therefore, several disciplines in the health care industry are actively researching this topic. The number of studies on this topic in medical literature indicates that patient satisfaction is currently subject to active research. Over the past few decades, patient satisfaction has also caught the interest of health care chaplaincy. The literature in health care chaplaincy shows that there are few studies available on patient satisfaction with pastoral care in hospitals.[28] This is an indication that the field of pastoral care is also involved in research on this subject, even though the discipline has more research to do.

Patient Satisfaction: Definition

What is patient satisfaction? A review of the literature shows that defining patient satisfaction is a difficult task. It is a difficult task because the concept of patient satisfaction can be used in reference to different things depending on the context. Rashid Al-Abri and Amina Al-Balushi have also discussed that matter and stated that:

> There is no consensus between the literature on how to define the concept of patient satisfaction in health care. In Donabedian's quality measurement model, patient satisfaction is defined as patient-reported outcome measure while the structures and process of care can be measured by patient-reported experiences. Many authors tend to have different perceptions of definition of patient satisfaction. Jenkins C and al. (2002) and Ahmed et al. (2011) pointed out that patient satisfaction mostly appears to represent attitudes toward care or aspects of care. While Mohan et al. (2011) referred to patient satisfaction as patients' emotions, feelings and their perception of delivered health care services. On the other hand, other authors defined patient satisfaction as a degree of congruency between patient expectations of ideal care and their perceptions of real care received.[29]

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[28] For example, Larry VandeCreek and Majorie A. Lyon, "Ministry of the Hospital Chaplain." *Journal of Health Care Chaplaincy* 6, no. 2 (1997): 1-61, and Debra B. Marin, Vanshdeep Sharma, Eugene Egorova, Rafael Goldstein, and George F. Handzo, "Relationship Between Chaplain Visits and Patient Satisfaction," *Journal of Health Care Chaplaincy* 21 (2015): 14-24.

[29] Rashid Al-Abri and Amina Al-Balushi, "Patient Satisfaction Survey as a Tool Toward Quality Improvement," *Oman Medical Journal* 1, no. 29 (2014), 3-7.

This citation provides a good description of the challenges associated with the task of formulating a definition of patient satisfaction. Knowing this is not the aim of this research project; the researcher considers it more important to establish that definitions of patient satisfaction could be organized into two major categories. The first group is composed of definitions that articulate patient satisfaction as a measurement technique used to evaluate the quality of health care delivery in health care institutions. This approach is clarified in the article Patient *Satisfaction: Defining, Measuring and Improving the Experience of Care.*[30] Concato and Feinstein provide good insights that may help understand this point of view in the following terms:

> Patient satisfaction is usually studied with psychometric strategies in which responses to an array of multiple questionnaire "items" are mathematically combined to integrate scores. … The responses to the multiple items are then arranged with algebraic models, such as factor analysis, into a smaller number of factors or "dimensions" that are given names such as satisfaction with the humanistic aspect of care.[31]

As a measurement instrument, it is a tool that allows professional organizations to gather data, perform analysis, and eventually provide a measurement of the quality of care provided in health care institutions and determine areas that need improvement to promote excellence. Currently, many professional organizations require health care institutions to perform patient satisfaction studies to measure the quality of services provided. Irwin Press, who is known as a pioneer in this field said it in the following words:

> The Joint Commission says you have to monitor patient satisfaction. … The National Committee for Quality Assurance (NCQA) requires HMOs to monitor it. The Center for Medicare & Medicaid Services (CMS) has developed the Hospital Consumer Assessment Health Plans Survey (HCAHPS) that it wants hospitals to use as a public satisfaction

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[30] Irwin Press, *Patient Satisfaction: Defining, Measuring and Improving the Experience of Care* (Chicago: Heath Administration Press, 2002), 77-79.

[31] John Concato and Alvan R. Feinstein, "Asking Patients What They Like: Overlooked Attributes Patients Satisfaction," *The American Journal of Medicine* 102, no. 4 (April 1997), 399.

> report card. State hospital associations are including patient satisfaction in their report cards. Increasingly, purchasing coalition and business will require providers to monitor it too.[32]

The second category is composed of definitions referring to the experience of the patient within health care institutions. This category does not focus on patient satisfaction as an instrument but on the relational aspect that constitutes the experience of the patient with health care institutions. In this context, asking the question, "How did you experience the attending doctor in the Emergency Room or the chaplain who prayed with you before the surgery?" is asking the person about patient satisfaction. That means that the concept of patient satisfaction is not always used in reference to its technical meaning, as discussed in the previous page. Asking such questions is a quest to know the level of satisfaction or dissatisfaction of the patient with the service provided in health care institutions. It is an evaluation of a person's experience with health care services. In this perspective, patient satisfaction could be defined as a patient's judgment on the quality of care provided before, during, and after an encounter in health care institutions.

According to Bobbie Berkowitz, the concept "patient experience" is generally linked with patient satisfaction and is sometimes also used interchangeably in the literature.[33] She noted that there are several studies that demonstrate the interchangeability and variability of these terms in the literature, and argues that this is because each term seems to be defined by the factors used to measure it.[34] At times, these terms are also used interchangeably in the present research project.

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[32] Press, 1-2.

[33] Bobbie Berkowitz, "The Patient Experience and Patient Satisfaction. Measurement of a Complex Dynamic" Medscape, accessed February 17, 2018, https://www.medscape.com/viewarticle/865166.

[34] Berkowitz.

Furthermore, it must be understood that patient satisfaction can be expressed in two distinct ways. According to research, patient satisfaction could be either a positive experience or a negative one. Bodenheimer and Grumbach, who have also reflected on this in previous writings, argue that: "In every year in the United States, millions of people visit hospitals, physicians, and other caregivers and receive medical care of superb quality. But that is not the whole story. Some patient interactions with the health care system fall short."[35]

The narratives that will be examined in this section provide evidence that in both the Old and New Testament, the sick person was not always satisfied with the health care system of the time. But there are also times when they were exposed to poor experiences resulting in dissatisfaction with the health care systems of their times.

Patient Satisfaction: Biblical Approach

This endeavor to establish the biblical foundations of patient satisfaction is huge and difficult. One of the difficulties is that the concept of "patient satisfaction" is not literally mentioned in the Bible. The term "patient satisfaction" and how it is used in the medical literature was not part of the language of the people who wrote the Bible. There is no place in the Bible where the concept of "patient satisfaction" was used in reference to its meaning in the medical literature. Based on the methodology of this project and the above literature review, data collection for measurement is not possible; however, patient experience is possible to illustrate in the biblical narratives. This is an important detail that needs to be acknowledged.

This remark raises the question: how to establish the biblical foundation of "patient satisfaction" if the concept is not concretely evident in the Scriptures? To solve the puzzle,

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[35] Thomas Bodenheimer and Kevin Grumbach, *Understanding Health Policy: A Clinical Approach* (Columbus: The McGraw-Hill Companies, Inc., 2012), 115.

Jacques Poujol reminds us that in the Bible, great truths are not set forth as a doctrinal statement, but they come out of the life of the people of Israel or personal stories of men and women.[36] Even though the concept of "patient satisfaction" is not literally used in the Bible, there is a way to establish the biblical foundation. Biblical theology provides approaches to research on the meaning of words and concepts that are used in the Old Testament and the New Testament. One of those approaches is the study of biblical narratives. In fact, it is the most common approach used to study health and the curing of diseases in the Bible:

> The most common method for describing health in Scriptures is to study narratives concerning illness and the curing of diseases. … Studies of illness and healing in biblical texts are valuable resources for understanding the varieties between God, God's agencies of healing, and human health. Several caveats, however, should be noted. Scriptures present a wide spectrum of relationship that result in health or the loss of health. Careful relational and theological readings of individual texts of illness and healing are required.[37]

There are many accounts in the Bible where authors talk about sick people, and their experience of health care systems of their times. The researcher proposes to study four narratives. These narratives were not chosen randomly. The criterion of selection was the ability to illustrate positive and negative experiences of sick people with the health care systems in the Old and the New Testament times.

Positive Patient Satisfaction Narratives in Scripture: Case One

In the book of 1 Samuel the Old Testament author tells the story of a woman who suffered from the incapacity to produce offspring for many years. That woman went to the house

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[36] Jacques Poujol, *L'Equilibre Psychologique du Chrétien* (La Begude de Mazenc, France: Editions Empreinte, 2008), 12.

[37] James K. Bruckner, "Health," in *Dictionary of Scripture and Ethics* (Grand Rapid: Baker Academic, 2011), 351.

of the Lord to pray and cried out to God so that He has mercy on her and cure her. The Bible records:

> Whenever Hannah went up to the house of the LORD, her rival provoked her till she wept and would not eat. Her husband Elkanah would say to her, "Hannah, why are you weeping? Why don't you eat? Why are you downhearted? Don't I mean more to you than ten sons?" Once when they had finished eating and drinking in Shiloh, Hannah stood up. Now Eli the priest was sitting on his chair by the doorpost of the LORD's house. In her deep anguish Hannah prayed to the LORD, weeping bitterly. And she made a vow, saying, "LORD Almighty, if you will only look on your servant's misery and remember me, and not forget your servant but give her a son, then I will give him to the LORD for all the days of his life, and no razor will ever be used on his head." As she kept on praying to the LORD, Eli observed her mouth. Hannah was praying in her heart, and her lips were moving but her voice was not heard. Eli thought she was drunk and said to her, "How long are you going to stay drunk? Put away your wine." "Not so, my lord," Hannah replied, "I am a woman who is deeply troubled. I have not been drinking wine or beer; I was pouring out my soul to the LORD. Do not take your servant for a wicked woman; I have been praying here out of my great anguish and grief." Eli answered, "Go in peace, and may the God of Israel grant you what you have asked of him." She said, "May your servant find favor in your eyes." Then she went her way and ate some-thing, and her face was no longer downcast.[38]

This pericope reports an encounter between two people that took place in the house of the Lord. It must be noted, in that time the house of the Lord was a place where the sick would come for healing. The house of the Lord was also playing the role of a place where health care would be provided to sick people because the society of the time considered that prophets and priests were also agents of the health care system.[39] In today's medical terminology, one would identify Hannah as the patient, and Eli as the clinical chaplain. It is not clear if Hannah's health concern

[38] 1 Samuel 1:1-18 [NIV].

[39] Madeline S. Miller and J. Lane Miller, *Harper's Encyclopedia of Bible Life* (New York: Castle Books, 1996), 65-88.

was infertility[40] or sterility.[41] The text does not suggest if Hannah's problem could be caused by something like a damaged Fallopian tube, hormonal problems, or a cervical issue that western medicine would recommend to the expertise of a gynecologist.

However, it clearly says that because of that, Hannah was feeling miserable. Expressions such as "a loss of appetite," and "great anguish and grief" provide a clear description of her emotional state. According to the medical literature, it is not unusual for women who have problems bearing children to develop strong emotions that can make a person feel like this. One study on women who have infertility issues show that they could be as anxious and depressed as women who are diagnosed with cancer, hypertension or those who are recovering from a heart attack.[42]

According to the narrative, Eli used three basic approaches that any skilled chaplain would use in a crisis to minister to a person who is at the most vulnerable time of life. Charles Taylor provides a good description of those approaches in his book entitled *The Skilled Pastor*: active listening, theological assessment, and the giving of religious resources.[43] First of all, Eli attentively listened to Hannah. He listened to her with compassion and a non-judgmental attitude. Second, he reacted to the story Hannah told him in a way that shows his ability in critical thinking and theological reflection. Eli was able to assess her spiritual need and

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[40] Infertility means "diminished or absence of the ability to produce offspring; in both the male and the female, not as irreversible as sterility." *Stedman's Medical Dictionary,* 28th ed. (Baltimore: Lippincott Williams & Wilkins, 2006), 970.

[41] Sterility means "the complete inability to produce offspring." *Dorland's Illustrated Medical Dictionary,* 31st ed. (Philadelphia: Sanders Elsevier, 2007).

[42] "The Psychological Impact of Infertility and its Treatment," *Harvard Health Publishing* 25, no. 11 (May 2009).

[43] Charles W. Taylor, *The Skilled Pastor: Counseling as Practice of Theology* (Minneapolis: Fortress Press, 1991), 61-125.

understand the theological significance of her presence in the temple, which allowed him to validate her feelings and encourage her faith. Third, Eli authorized Hannah to use the facility and resources that were available in the temple to meet the spiritual needs she had expressed to him during her defense. The text indicates that at the end of the day, Hannah was relieved from her pain. The text reveals Hannah's experience with Eli, who perfectly illustrates the role of the health care chaplain in this encounter was concluded with a positive outcome.

The Bible noted that she regained her appetite after Hannah's encounter with Eli. She also lost the mask of anguish and grief that was on her face. In other words, Hannah was comforted, her strength was renewed, and she returned to her home with faith and hope that allowed the miracle she prayed for to be realized. This description of Hannah establishes her satisfaction with the ministry Eli provided to her.

Positive Patient Satisfaction Narratives in Scripture: Case Two

Another case of positive patient satisfaction is reported in Matthew 15:29-31. This is the story of a healing ministry Jesus performed along the Sea of Galilee. Hence, it must be noted that in this pericope the Sea of Galilee was the location where healing took place. Somehow, this could be a representation of a medical ward, because of the presence of the multitude of sick people who came to Jesus for healing, and the specific nature of the ministry Jesus was performing at the moment in this specific location. To quote the Bible:

> Jesus left there and went along the Sea of Galilee. Then he went up on a mountainside and sat down. Great crowds came to him, bringing the lame, the blind, the crippled, the mute and many others, and laid them at his feet; and he healed them. The people were amazed when they saw the mute speaking, the crippled made well, the lame walking and the blind seeing. And they praised the God of Israel.[44]

[44] Matthew 15:29-31 [NIV].

The text reports that a large crowd was present at the scene. It also indicates that the crowd was composed of people suffering from different health conditions. Among them the biblical author identifies blind, crippled, and mute people. In addition, the text also mentions the presence of another group of sick people but does not convey any clear information about the illness of these people. Madeleine and Lane Miller, who have written on medicine in the Old Testament, stated that "The medical knowledge of the writer of the Old Testament books is so primitive that it is difficult to determine beyond reasonable doubts what diseases are meant by Hebrew terms underlying our English translations."[45] The researcher believes that this challenge could also be true to the writer of the New Testament, that one must also acknowledge the seriousness of the illness of these people even though almost nothing is known about their illness. Yet, they are identified as sick, and their experience with pain and suffering must be acknowledged.

The Bible says that at the end of the day, Jesus had healed them all. Because of that, everyone began to praise him. In this pericope, the indicator of patient satisfaction is praise. The fact that the people praised Jesus after he had healed everyone ascertains some degree of satisfaction among the multitude. There is indeed no evidence in the text that it was only the people who were healed in this encounter that praised Jesus. Besides, there is no evidence to support the argument that the people who praised him in the crowd did it specifically to express satisfaction. Yet, according to crowd psychology theory, when people act in a group, some behaviors are only influenced by the crowd effect.[46]

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[45] Miller and Miller, 65-88.

[46] "Crowd Psychology" in *APA Dictionary of Psychology*, ed. Gary R. VandenBos (Washington: American Psychological Association, 2007), 247.

This means that in a crowd, some people act as immature people showing behaviors that demonstrate a lack of a sense of responsibility. Equally, in that crowd, there were people who praised Jesus because they had experienced divine healing, people who were amazed by what they had witnessed, and people from the community who probably joined the multitude and started to act in the crowd as an entity without any connection with reality. Crowd psychology provides enough grounds to support this hypothesis.

However, from a theological perspective it does make sense to believe that the people who were healed in that encounter praised Jesus to express their satisfaction. First, because they had a personal experience of divine healing with Jesus. Second, they were emotionally and spiritually fully engaged with the power of the experience. This point of view is theologically supported by the fact that in the Christian faith praise is defined as "an act of worship or acknowledgment by which the virtues or deeds of another are being recognized and extolled."[47] Praising Jesus for those who were healed was nothing else than the outward expression of the inward experience of the divine healing that was performed. Hence, by praising Jesus, the people in the crowd communicated the level of excitement that healing brought to their experience of illness. Thus, their overall patient satisfaction was high.

Negative Patient Satisfaction Narratives in Scripture: Case One

There are several stories that could be used to illustrate negative patient satisfaction in the Bible. One of them is the narrative in Mark 9:14-18. The pericope talks about a father who brought his son to Jesus' disciples with the hope that they will heal him from a health condition that was believed to be caused by demonic forces:

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[47] Herbert Lockyer, F. F. Bruce, and R. K. Harrison, eds., *Illustrated Dictionary of the Bible* (Nashville: Thomas Nelson Publishers, 1986), 866.

> When they came to the other disciples, they saw a large crowd around them and the teachers of the law arguing with them. As soon as all the people saw Jesus, they were overwhelmed with wonder and ran to greet him. "What are you arguing with them about?" he asked. A man in the crowd answered, "Teacher, I brought you my son, who is possessed by a spirit that has robbed him of speech. Whenever it seizes him, it throws him to the ground. He foams at the mouth, gnashes his teeth, and becomes rigid. I asked your disciples to drive out the spirit, but they could not."[48]

According to the text, the disciples were not able to heal him. It seems like the failure to heal the young boy caused an argument in the crowd. It is possible that after the failure to heal the boy the crowd questioned the disciples' competence, which may have put them on the defensive causing this argument. There is no way to prove it, but it is a possibility. However, there is no doubt that in any health crisis when a therapy fails to heal or to release some level of comfort, it can easily trigger negative feelings toward the physician, nurses or chaplains that can lead to unpredictable behaviors such as an argument. Any uncomfortable feelings that add to a health crisis have the propensity to grow in intensity and create arguments or acts of violence.

In Mark 9:14-18, for instance, the failure to heal the young boy reinforced the patient's father's dissatisfaction. From a psychological perspective, in a situation like this, dissatisfaction with the care provided could easily increase tensions in the midst of the crisis and cause an argument, even violence. This is a typical case of a negative patient satisfaction in the biblical literature. The crowd's argument with the disciples, and the persistence of the father to ask Jesus to intervene in the situation after his disciples had failed to heal the boy, indicate that something went wrong in the process. By asking Jesus to heal the boy, the father shows that he was in the pursuit of better care which is an indication of a poor patient satisfaction in the previous encounter with Jesus' disciples.

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[48] Mark 9:14-18 [NIV].

Negative Patient Satisfaction Narrative in Scripture: Case Two

In John 5:1-9, the Bible reports the story of a man who suffered a long affliction. This man was paralyzed for thirty-eight years and was constantly in search of healing. There was in Bethesda a pool where people were going to be healed. People believed that an angel comes to that pool and stirs up the water. They also believed that after the disturbance of the water caused by the manifestation of the angel, the first person who gets into the pool after the water was stirred up would be healed from his/her illness. Therefore, all kinds of sick people come there every day. The Scriptures report:

> Sometime later, Jesus went up to Jerusalem for one of the Jewish festivals. Now there is in Jerusalem near the Sheep Gate a pool, which in Aramaic is called Bethesda and which is surrounded by five covered colonnades. Here a great number of disabled people used to lie the blind, the lame, and the paralyzed. One who was there had been an invalid for thirty-eight years. When Jesus saw him lying there and learned that he had been in this condition for a long time, he asked him, "Do you want to get well?" "Sir," the invalid replied, "I have no one to help me into the pool when the water is stirred. While I am trying to get in, someone else goes down ahead of me." Then Jesus said to him, "Get up! Pick up your mat and walk." At once the man was cured; he picked up his mat and walked.[49]

The text is silent about how long this man had been coming to this pool with the determination to enter in the water to be healed. But it underlines that the person has been coming there long enough to miss the stirring of the water several times. The text suggests that this man was exposed to a lot of stress that made his experience with the pool of Bethesda difficult. There are five psychological factors that support this point of view. These factors are the stress caused by life events, frustration, conflict, pressure, and environmental conditions.[50]

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[49] John 5:1-9 [NIV].

[50] Benjamin B. Lahey, *Psychology: An Introduction* (New York: McGraw-Hill Companies, Inc., 2007), 496-502.

First, the life event that identifies as the stressor in this story is illness. It must be remembered that this person suffered from this condition for thirty-eight long years. Second, there is the frustration that comes along with the physical inability to be the first to jump in the water. Third, the inner conflict going on in his mind that opposes the desire to jump in the pool, and the capacity to make that happen. Fourth, the pressure caused by the fact that he must be the first to jump in the water to be healed. Finally, the lack of environmental accommodation that could make it easy for a person who suffered his condition to be the first to jump in the water. These five factors underline some degree of discomfort the person experienced that has the propensity to cause dissatisfaction.

These narratives show that even in the biblical society, there was a time that sick persons would also face the challenge of conditions that can cause either a positive or a negative patient experience. It is true that these encounters did not take place in facilities such as modern hospitals. The story of Hannah in 1 Samuel 1:18 occurred in the house of the Lord. The healing ministry of Jesus in Matthew 5:29-31 took place at the Sea of Galilee. Mark 9:14-18 narrates the healing of the boy possessed by the evil spirit in an open-air location. In John 5:1-9, the healing of the person who suffered an affliction for thirty-eight years happened at the pool of Bethesda. Since the culture of the time recognized those places as appropriate for healing ministry, the researcher considers that somehow those locations could be considered a typical representation of modern health care institutions. Patient satisfaction is a part of the biblical experience.

Patient Satisfaction: A Theological Approach

Does patient satisfaction have a theological basis that justifies its importance in health care chaplaincy? This question requires special attention. According to the researcher, patient satisfaction has a theological foundation; it has its roots in the life and healing ministry of Jesus.

His love for the people, and the way he stepped into the situation of sick persons to heal indicates that his healing ministry was built upon a patient satisfaction-centered approach.

A patient satisfaction-centered approach is a model of pastoral care that considers that the satisfaction of the sick person with the delivery of health care is the priority of the chaplain. This approach considers that in a crisis situation the theological value of the human being is the only factor that justifies the urgency and the quality of the pastoral response to be provided. This approach is built upon the premise that the human being is God's masterpiece of the creation; therefore, there is nothing that has more value than humankind in the whole creation of God.

Jacques Poujol suggests there are three ways that indicate how God values the human being in human history. First, God created the human being in his own "image" (*imago Dei*). Second, he sent his "… one and only Son"[51] to the cross to die as the sacrificial lamb of God to pay the ransom for humanity. Third, he made the human body the temple of the Holy Spirit.[52] These three facts involve the Triune God in the existence of the human being and set the net worth of the human creature as very high in the eyes of God. From this perspective, the human creature is more important than the crisis that may be affecting the quality of life. Consequently, this approach focuses on the person instead of the illness because the value of the human being comes before the nature of the illness.

Jesus introduced this approach for the first time to his disciples in a didactic entitled The Parable of the Good Samaritan (Mark 9). The parable depicts a caregiver who understood that in God's perspective the value of a human being could not be evaluated in terms of money, that in the event of a tragedy, one should do whatever it takes to contribute to the welfare of the person

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[51] John 3 :16 [NIV].

[52] Poujol, 14.

in crisis because that person has a high value in the eyes of God. To be pragmatic, the good Samaritan took care of this unknown person not only because he was in a critical condition but mostly because he understood that the spiritual value of the human being is the first motivation for any crisis care. The good Samaritan did everything that was in his capacity to help this unknown person: he modified his schedule, changed his plans for the day, sacrificed his time, and even engaged in expenses that were not in his budget regardless of the color of skin, religious background, gender, social, and marital status because of his understanding of the real value of the human creature in God's eyes.

Yet, this approach is characterized by a sort of obsession with helping the sick person find the road to satisfaction with life which is enabled by the quality of care that is to be provided in the healing process. This kind of obsession was described in the biography Jesus provided in the synoptic gospels and Johannine writings of the New Testament. The Scriptures show that because he wanted people to be satisfied with life, Jesus healed every sick person who came to him regardless of the time, place, and circumstance. In the pursuit of the satisfaction of these people with life, Jesus performed individual healing as well as mass healing. He healed the sick in private places (houses) as well as in public places (synagogues, pools, streets).

The Bible shows in many ways that God wants human beings to be satisfied with life. Several scriptures prove that human satisfaction is an important concept in Christian theology. Some of them are: "You open your hand and satisfy the desires of every living thing."[53] Psalm 91 states, "With long life I will satisfy him and show him my salvation."[54] The New Testament provides Scriptures, such as in the book of Matthew one reads "Blessed are those who hunger

[53] Psalm 145 :16 [NIV].

[54] Psalm 91:16 [NIV].

and thirst for righteousness, for they shall be filled."[55] In addition, the Gospel of John also shares the idea of satisfaction with life in the following words: "Until now you have not asked for anything in my name. Ask and you will receive, and your joy will be complete."[56]

Furthermore, every encounter Jesus had with a sick person ended with a note of satisfaction. In most narratives, the healed person would express satisfaction through praise, worship, or a strong desire to stay with Jesus and become a member of his team. In the Bible, stories that report complaints of a sick person who has encountered Jesus, the healer, in his healing ministry are still to be found. Unless proven otherwise, there is no such comment in the Bible. In other words, there is no evidence of any negative patient experience in the ministry of Jesus to the sick in the entire New Testament. Instead, every story reports that every person whom Jesus had ever healed, and the many witnesses of those healing miracles, were always amazed by his wonders. These kinds of reactions are clearly an indicator of what modern medicine calls patient satisfaction.

One may ask, what caused the high level of people's satisfaction in the healing ministry of Jesus? In fact, the most reasonable answer to this question is the quality of his ministry. Yet, everything Jesus did, he did for the glory of God, and that sets the standards of his ministry high. His commitment to "give glory to God" in everything he did was best expressed in John 17:4: "I have brought you glory on earth by finishing the work you gave me to do."[57] Yet, this verse of the sacerdotal prayer refers to a job well done. Explicitly, the expression "I brought you glory"

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[55] Matthew 5 :6 [NIV]. The word "χορτασθήσονται" translated as "filled" in this version also means satisfied. Compare with Matthew 5:6 [KJV].

[56] John 16:24 [NIV].

[57] John 17:4 [NIV].

that is used in this verse suggests the idea of "quality." God is a God of perfection, consequently, anything that gives glory to his holy name is associated with the idea of perfection, quality, holiness and/or beauty. This brings up the issue of "quality" in Jesus' healing ministry into the discussion.

Experts in quality improvement in health care have already discussed this question. According to them, "quality" is another difficult word to define because its meaning depends on the context in which the word is being used:

> According to Thomas Pyzdek (1990: chapter 1), even the quality experts do not agree on a consistent definition of quality. For example, Dr. Joseph Juran's definition of quality revolves around his concept of "fitness for use." … Philip Crosby defines quality in terms of performance that produces "zero defects." Dr. Edouards Deming defines quality as a "never-ending cycle of continuous improvement.[58]

Acknowledging this taxonomic dilemma gives the advantage to formulate a definition that has a more theological resonance, and that also fits better within the context of this research. To give it a theological connotation that fits the context of this research, "quality" could be defined as a measure of excellence that is determined by the standards of God, best articulated in these words: "…Whatever you do, do it for the glory of God."[59]

By seeking the "glory of God" in everything he did, Jesus operated on a very high ethical standard. With there is no shadow of doubt that Jesus' healing ministry was a ministry of high "quality," and this explains the reason patient satisfaction was high in his healing ministry. Positive patient satisfaction in his ministry was always the direct result of the "high quality" of

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[58] Raymond G. Carey and Robert C. Lloyd, *Measuring Quality Improvement in Healthcare: A Guide to Statistical Process Control Applications* (Milwaukee: Quality Press, 2001), 4.

[59] 1 Corinthians 10:31 [NIV].

his work. Professionally speaking, this statement sets forth the ethical principle that high quality of care produces a high degree of patient satisfaction.

In fact, it was efficiently demonstrated in his healing ministry. What are the components of a patient satisfaction-centered approach? What are the underpinnings of positive patient satisfaction in the ministry of Jesus? These questions lead to a discussion on factors that have influenced positive patient satisfaction in the healing ministry of Jesus. Three major factors could be identified: love, compassion, and the ability to pay attention to details. These three factors determined the quality of the healing ministry of Jesus and will have a tremendous impact on the patient satisfaction with pastoral care of patients and families in health care settings.

Love: Jesus loved the people who came to him for healing, regardless of their illness. His heart was with people who suffer from any kind of illness whether it had a biological etiology such as blindness,[60] paralysis,[61] leprosy,[62] hemorrhagic condition,[63] epilepsy,[64] or a mental illness which was mostly believed to be caused by a demonic possession.[65] Yet, the parable of the Good Samaritan in John 10:25-37 provides the best description of this kind of love. Jesus' love of people was so profound that it crossed every racial, ethnic, and religious boundary.

This kind of love reveals the way God values the "image of God" that is in humankind from the creation of the world as reported in Genesis 1 and Genesis 2. True love nurtures a sense

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[60] John 9:1-12 [NIV].

[61] Matthew 9:1-8; Mark 2:1-12; Luke 517:26 [NIV].

[62] Mark 1:40-45 [NIV].

[63] Luke 8:43-48 [NIV].

[64] Matthew 17:14-16 [NIV].

[65] Mark 1-20 [NIV].

of quality in ministry because it is built upon ἀγάπη; the perfect love of God. Doing pastoral care under the influence of "ἀγάπη," love or the perfect love of God, always causes satisfaction because:

> Love is patient, love is kind. It does not envy, it does not boast, it is not proud. It does not dishonor others, it is not self-seeking, it is not easily angered, it keeps no record of wrongs. Love does not delight in evil but rejoices with the truth. It always protects, always trusts, always hopes, always perseveres.[66]

Compassion: Jesus demonstrated compassion for people. This is a spiritual disposition that arouses within a person in response to a crisis that poorly affects another person's quality of life. The Bible depicts many situations that have moved Jesus to heal a person because of compassion. There are several biblical references that indicate it. The Gospel of Matthew notes: "When Jesus landed and saw a large crowd, he had compassion on them and healed their sick."[67] In the same perspective, Chapter 20 of the book of Matthew reports "Jesus had compassion on them and touched their eyes. Immediately they received their sight, and they followed him."[68] Another example of this is in Mark 9:22, "It has often thrown him into the fire, or water, to kill him. But if you can do anything, take pity on us, and help us."[69] Jesus' compassion had a communal context. In every encounter he had with the sick, Jesus' compassion was an expression of his community life because, as Henry Nouwen et al. noted, compassion can never

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[66] 1 Corinthians 13:4-7 [NIV].

[67] Matthew 14:14 [NIV].

[68] Matthew 20:34 [NIV].

[69] Mark 9:22 [NIV]. The Greek word "σπλαγχνισθεὶς" translated as "pity" in this version also means compassion. Compare with Mark 9:22. [KJV].

be separated from community.[70] This explains the quality of the interactions in Jesus' healing ministry.

These three illustrations show that compassion played a major role in Jesus' healing ministry. In addition, the ministry of Jesus also shows the power of compassion. Yet, his healing ministry shows that when God fuels compassion, a caregiver can only engage in actions that reflect the love of God. In the New Testament there are even circumstances where Jesus' compassion led him to confront the authority of his time. For example, Jesus protested against the dominant culture of the society that prohibited the healing of a sick person on a Sabbath day, which made them say, "There are six days for work. So, come and be healed on those days, not on the Sabbath."[71] This is an example that "Jesus Christ himself is and remains the most radical manifestation of God's compassion."[72]

This Scripture indicates the power of compassion that flows out of God's perfect love, and the effect it may have in the personal experience of the chaplain and those who work in the helping profession. Compassion is a spiritual disposition that arouses within a person to produce quality ministry, theologically perceived as "good deeds." There is a link between compassion and patient satisfaction.

The ability to pay attention to details: This is the third component of the patient satisfaction centered approach. It refers to the chaplain's capacity to identify other means of healing that could be used in the healing ministry to reinforce the healing process. The Scriptures

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[70] Henri J.M. Nouwen, Donald P. McNeill, and Douglas A. Morrison, *Compassion. A reflection On the Christian Life* (New York: Doubleday Image Book, 1966), 52

[71] Luke 13:14 [NIV].

[72] Nouwen et al, 52.

show that after an encounter with the sick, many times Jesus would also recommend to the person to do other things that reinforce the healing process. There are plenty of Scriptures that illustrate cases where Jesus "paid attention to details." For example, in the story of the resurrection of the daughter of Jairus, the Bible notes:

> When he arrived at the house of Jairus, he did not let anyone go in with him except Peter, John and James, and the child's father and mother. Meanwhile, all the people were wailing and mourning for her. "Stop wailing" Jesus said. "She is not dead but asleep." They laughed at him, knowing that she was dead. But he took her by the hand and said, "My child, get up." Her spirit returned, and at once she stood up. Then Jesus told them to give her something to eat. Her parents were astonished, but he ordered them not to tell anyone what had happened.[73]

Another example is in John 9:1-12. The Bible reports an event where Jesus spit on the ground, and made mud with his saliva that he applied on the eyes of a blind person to treat his blindness. After doing this, he recommended the person go to the pool of Siloam to wash his eyes. There is another occasion where Jesus recommended the healed person to go the synagogue and see the priest with the sacrifice that was prescribed by the Law of Moses.[74] These kinds of recommendations provide an indication that Jesus had a holistic approach to health care. His commitment to excellence led him to a multidisciplinary approach to healing. He made use of different approaches and resources to release healing which indicates a detail-oriented approach to illness.

This is an important dimension of the patient satisfaction-centered approach since it anticipates the dissatisfaction of the sick person with the health care provider in cases where the next clinical step that could enhance the treatment and support the healing process was not completed to improve the situation. As said earlier, the expression "ability to pay attention to

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[73] Luke 8:51-56 [NIV].

[74] Luke 8:40-56 [NIV].

detail" that is used in this research refers to several instructions that Jesus has given to many sick persons after he had healed them that are also applied in modern medicine and recognized as best practices in the delivery of health care.

The following are a few examples that could provide more clarity to this point of view. After he had resurrected the daughter of Jairus, Jesus commanded them to give her food, and to not to tell the people what had happened in the room. This introduces the notion of clinical nutrition, and patient confidentiality in patient care.[75] Sending the blind person to wash his eyes in the pool of Siloam after he had applied mud on them to treat him, speaks to the use of alternative medicine in medical practice.[76] Recommending the leper he had healed to go to the priest to be examined, and bring the offering ordered in the Law of Moses represents a referral to another professional, and an illustration of the integration of spirituality in patient care.[77] Telling the person he had healed at the pool, "Now you are well; so stop sinning, or something even worse may happen to you"[78] is an example of a post-discharge education in health care.

There are only a few occurrences where Jesus did not give further instructions after he had healed a person. Among those are two cases that involved a loss of blood; the case of the bleeding woman who was healed after she had touched his garment in the crowd,[79] and the case of the high priest that Peter cut off the ear with his sword to prevent the arrest of Jesus in the

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[75] Luke 8:4-46 [NIV].

[76] John 9:1-12 [NIV].

[77] Matthew 8:4 [NIV].

[78] John 5:14 [NIV].

[79] Matthew 9:29; Mark 5:25; Luke 8:43 [NIV].

garden of Gethsemane.[80] The ability to pay attention to details not only contributes to good health, and healing but, it also contributes to positive patient satisfaction.

Dr. Irwin Press, noted that until this day many people in health care have not fully understood the value and importance of patient satisfaction in the delivery of health care. He stated: "In spite of the books, articles, and hypes, possibly no element in health care is so little understood as patient satisfaction. Many still view it as a soft phenomenon, a happy camper index that reflects medically uneducated perceptions as opposed to serious evaluations of real quality."[81]

This could be a true statement for many health care professionals today, but as discussed in the previous pages, Jesus' encounters with sick people reveals that he had a strong sense of the quality of the patient's experience. Scriptures that were discussed in this chapter show that he had some consideration for the patient's experience. Bringing satisfaction to the healing experience of the sick person was important in Jesus' ministry because it created the space for a reflection on God's omnipresence, omniscience, omnipotence, and how he continues to express his love in human history.

It is theologically an aberration to reduce patient satisfaction to a simple philosophy of improvement that is justified as moral obligation. Patient satisfaction with health care is not only a moral obligation; it is a theological imperative that has its roots in the life and the healing ministry of Jesus. The life of Jesus is the first demonstration of the patient satisfaction-centered approach in the sense that he died on the cross to redeem humanity and restore the value of the human being that was corrupted at the fall. The cross of Calvary is the culminant point of this

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[80] Matthew 26:51; Mark 14:47; Luke 22:50-51; John 18:10-11 [NIV].

[81] Press, 2.

approach because it is the place where Jesus satisfied the justice of God. In his ministry, Jesus spent all his life preaching, teaching, and healing people to create conditions that bring more satisfaction to life.

Jesus modeled this approach, and because of that, health care institutions, and health care professionals should be concerned about the quality of the patient experience, whether this means inpatient experience or outpatient experience. Therefore, patient satisfaction should not be regarded merely as another great accomplishment in health care institutions that need to be celebrated, because in every positive experience of a patient with health care there is also a theological resonance; patient satisfaction satisfies the justice of God.

Churches' Healing Ministry and Health Care Chaplaincy in Africa: Historical Perspectives

In his book entitled *An Introduction to Ecclesiology*[82] Karkkainen established that there are several distinct ecclesiological traditions that shape the structures of the church. Hence, to quote him, Karkkainen noted:

> First, there are several more or less established traditional approaches that are related to specific denominations, such as Eastern Orthodox, Roman Catholic, Lutheran and Reformed. Each of them approaches the church from a distinctive perspective, based on its overall theological program. To these traditional approaches have to be added some others that in the contemporary world have become significant, namely Free church ecclesiologies, which mostly go back to Baptistic views and even further to Anabaptist from the time of Reformation. Also, some newer and statistically overwhelmingly important ones are the ecclesiologies of Pentecostalism and later charismatic movement.[83]

Each of these traditions, states Karkkainen, have doctrines and a view of the church that are officially written in the official magisterium or the teaching office of the church that

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[82]Veli-Matti Karkkainen, *An Introduction to Ecclesiology: Ecumenical, Historical, and Global Perspectives* (Downers Grove: InterVarsity Press, 2002), 13.

[83] Karkkainen, 13.

articulates their theologies.[84] Hence, the intriguing fact is that even though ecclesiologies may differ from one church to another, in every ecclesiological tradition the healing ministry of the church is defined as the extension of the ministry of Christ in the world. Each tradition believes that when Christ ascended to heaven, he commissioned the disciples to pursue his healing ministry, as a part of God's will, so that sick people will experience good health as a manifestation of the grace of God in their lives. According to the Evangelical Dictionary of Theology:

> The healing ministry of Jesus was continued through his commissioning and sending out of the twelve Matthew 10:1-5; Mark 6:7-13). … The book of Acts and the epistles provide a clear evidence of the continuance of divine healing throughout the apostolic church, and James 5:13-16, placed the healing of the sick through the prayer of faith as a permanent provision and promise of the "righteous man." There is also abundant evidence through the early church father (e.g. Irenaeus, Origen, Justin Martyr, Tertullian, Augustine) to verify the continued widespread practice of divine healing after the time of the apostles.[85]

Therefore, every church practices a form of healing ministry that is adapted to its particular ecclesiological context. For some churches, the healing ministry of the church means a gathering of sick people in the church facility under the pastoral leadership of an ordained minister who offers a liturgical service for the sick; a service that may include administration of sacraments, singing, proclamation, laying of hands, and the use of anointing oil as suggested in James 5:13.

For other churches, it may mean sending trained laypeople to visit sick congregants at home or in hospitals, whether it means nursing homes, assisted living or any form of long care facility. Besides, there are also churches involved in health care on a larger scale. These churches

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[84]Karkkainen, 15.

[85] *P. G. Chappell, "Heal, Healing" The Evangelical Dictionary of Theology*, Editor Walter A. Elwell, 2nd edition, (Grand Rapid, MI: Baker Book House Company), 540.

have the tradition to build hospitals, manage health care institutions, and provide medical services at a professional level in the context of their theological commitment to health care. Thus, this is the case of the Catholic church, and several churches from the Protestant tradition that have established a significant number of faith-based health care systems in the United States and around the world.

The history of the expansion of Christianity in sub-Saharan Africa reports that the Catholic church, and churches from the Protestant tradition began to build hospitals and deliver health care services in sub-Saharan Africa several decades before colonial governments. Protestant and Catholic churches played a major role in pioneering western medicine in colonial Africa. Charles Good stated:

> The introduction of Western medicine and public health in colonial Africa was nearly everywhere undertaken first by Christian missionary societies during the last quarter of the nineteenth and early decades of the twentieth centuries. … This was the "Age of Empire" and the classic period of missionary initiatives that variously spearhead, encouraged, accommodated, and benefited from the advance of European imperialism and capitalism across African territorial and cultural frontiers.[86]

Some of the missionary agencies that actively contributed to this endeavor in the nineteenth century were the London Missionary Society, Universities Mission's to Central Africa, Free Church of Scotland, La Société des Missionaires d'Afrique, to name just a few. In addition, there were also many protestant denominations that participated in this endeavor such as Methodist, Presbyterian, Mennonites, and Pentecostal, especially churches from Europe and North America that evangelized the sub-Saharan region of Africa. They are recognized for establishing some forms of healing ministries in Africa during the colonial, and missionary time. But it must be noted that during those years the primary mandate of the church was to preach the

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[86] O. Akerele, I. Tabizadeh and J. McGilvray, "A New Role for Medical Missionaries in Africa," *World Health Organization Chronicles* 30 (1976), 175-180.

Gospel and win souls for Jesus according to Matthew 28:19-20. The first generations of missionaries who evangelized Africa did not have a strong commitment to the delivery of health care. In his book *The Steamer Parish,* Charles Good noted:

> Ask a thoughtful person today about the purpose and activities of foreign missionaries in colonial Africa and it is almost certain that medical care (together with evangelization and education) will rank among the top three roles mentioned. In fact, for a long time the reality was quite different. In most missionary circles there was little motive or acceptance of a connection between medicine, healing and evangelization until the closing decade of the nineteenth century. Certainly, there was no mandate to do more than evangelize.[87]

This does not suggest that in the nineteenth century missionaries did not consider the healing ministry to be an important responsibility of the church. Neither is it to say that the church was engaged in the healing ministry with negligence. Instead, it means that even though missionaries believed that Jesus commissioned the church to heal the sick, they also believed that caring for the soul was the most eminent priority of the church in the mission field. in the early days of the penetration of Christianity in the African continent, the dominant theology of the church emphasized winning the indigenous to Christ. The healing ministry of the church was perceived as a secondary function of the church. Although "salvation of the soul" was the dominant theology that influenced the pastoral ministry of the church, missionaries were also involved in the healing ministry. The church- built hospitals and provided medical services to heal the sick, even then. This point of view was also articulated in the article entitled "The Pioneer Medical Missions in Colonial Africa" in the following words:

> Regardless of their time of arrival on the scene, in most territories it was the missions, not the colonial administrations, who first introduced western education, medicine and public

[87] Charles M. Good, *The Steamer Parish* (Chicago: The University of Chicago Press, 2004), 34.

> health and initiated, for better or worse, profound changes in the organization and quality of social and economic life.[88]

The Catholic and the Protestant church were both engaged in the medical work in the African continent for more than one century. Charles Good provided the following details to support this statement: the earliest missionary hospital that was found in sub-Saharan Africa was reported to be dated from 1518. In 1774, the Franciscans discovered the ruins of a hospital built by Capuchins in Angola in 1640. Yet, in Eastern Africa, the Universities Mission's to Central Africa began its medical missions in 1887. In 1895, a Catholic mission built- Nigeria's first hospital in Abeokuta. In Kenya, the Church of Scotland provided health care service to the population until 1914. Catholic missions such as the White Fathers/White Sisters also expanded their medical work into intensive areas of Uganda, Tanganyika, eastern Congo-Kinshasa, Rwanda, Burundi, and Malawi.[89] Bahelele K. Ndimisa who published on the history of the Communaute Evangelique au Congo reports on the work of the Svenska Mission Forbundet, the Protestant Swedish missionary society that evangelized central Africa saying they built many hospitals in remote regions.[90]

There are interesting statistics that provide evidence to the volume of the work accomplished by medical missions in sub-Saharan Africa during the colonial and missionary time. These statistics indicate that even though missionaries concentrated more on winning souls for Christ, they were also somehow engaged in the healing ministry of the church. To quote Good:

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[88] Charles M. Good, "Pioneer Medical Missions in Colonial Africa," *Social Science & Medicine* 32, no. 1 (1991), 3.

[89] Good, "Pioneer Medical Missions in Colonial Africa," 3.

[90] Bahelele Kapita Ndimisa, *Mavanga ma Nzambi Mu Kongo* (Congo-Kinshasa: Centre de Vulgarisation Agricole, 1989), 89.

> In 1896-97, the White Fathers reportedly treated 344,615 sick within their network of 46 stations and 60 "hospitals, dispensaries, and leper homes, orphanages, etc.," and by 1910-11 they had 120 stations and 289 hospitals and dispensaries, and related facilities in which they have claimed to have treated 1,219,869 sick persons during the year.… By 1911 in their vicariate of Upper Congo alone (west Lake Tanganyika), the White Fathers had "20 asylums or orphanages and 16 hospitals or refuges" and reported treating over 200,000 patients a year…. Holy Ghost Fathers, Jesuits and Benedictines maintained over 200 hospitals in tropical Africa.[91]

This citation indicates that during the colonial and missionary time, the church was also engaged in the healing ministry. John Baur, who has extensively written on the history of the church in Africa, stated that the healing ministry was the second main activity of the church during the colonial and missionary time.[92] Furthermore, he noted that in 1930, for instance, there was 1,100 dispensaries that had provided 11 million consultations to sick people. Twenty years later, the number of dispensaries increased to 30 million consultations.[93] The contribution of medical missions in the construction and establishment of hospitals in Africa, discussed in the previous pages, and the statistical report quoted above provides strong evidence of the volume of the work provided to promote health of the people during the colonial and missionary time.

There is much to discover about how the delivery of health care was provided in those hospitals, raising questions about their approach to pastoral care. As of this day, there is a significant shortage of materials available to inform the discipline in this matter, which suggests the need for further studies.

However, it must be recognized that there is a large variety of resources that have been created over the years to reduce the limits of ignorance in the healing ministry of the church in

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[91] Good, "Pioneer Medical Missions in Colonial Africa," 3.

[92] John Baur, *2000 ans de Christianisme en Afrique: Une histoire de l'Eglise Africaine* (Paris: Paulines, 1994), 451.

[93] Baur, 451.

Africa. Since the second half of the last century there have been several efforts made to bring light to this need. Several opportunities were created to study illness, healing, and the delivery of pastoral care in Africa. This endeavor has created a significant wealth of knowledge that could be sorted into three categories.

The first category regroups resources that have historical and anthropological connotations. It is composed of materials that serve as a witness to the work of missionaries and provides the historical background upon which the healing ministry was developed. The writers' objective was probably to leave the imprints of the work and sacrifices of those who have devoted their lives to pioneer the establishment of the healing ministry in Africa. Books such as *Missionary Travels and Research in South Africa*,[94] *The Church and Healing*,[95] and *Answering the Call: The Doctor Who Made Africa his Life*[96] are good illustrations of resources from this category. Their contributions are likely to be more historical than theological.

The second category regroups materials that assist in the understanding of aspects of the African religions, medical systems, and healing traditions. In addition, it also provides comparative studies that contribute to a better understanding of the African experience of illness and healing. The objective of the resources is to empower the delivery of health care in African context. Masamba ma Mpolo, who is recognized as one of the most productive African pastoral theologians of the twentieth century, has extensively written on pastoral care issues in Africa. In one article he provides a panoramic view of a number of initiatives that took place in Africa in

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[94] David Livingstone, *Missionary Travels and Research in South Africa: Sketch of Sixteen Years of Residence in the Interior of Africa* (New York: Cambridge University Press, 2011).

[95] W. J. Sheils, ed., *The Church and Healing* (Oxford: The Ecclesial History Society, 1982).

[96] Ken Gire, *Answering the Call: The Doctor Who Made Africa His Life: The Remarkable Story of Albert Schweitzer* (Nashville: Thomas Elson, Inc., 2013).

the second half of the twentieth century. For instance, the 1958 Bukavu and 1959 Tananarive Pan-African conferences on mental health disorders and psychiatry were the first initiatives to address issues related to psychological problems and personality traits of the people of Africa and Madagascar. These conferences were followed by three conferences on psychiatry characterized by a heavy participation of African psychiatrists in 1961, 1968, and 1977.

The article pursues that in 1955 a conference on Christianity and African culture was held in Accra that emphasized the quest for a contextual theology and ministerial praxis for the church in Africa. The 1963 All Africa Conference focused on African homes, specifically, on issues related to marriage and family. The 1967 consultation on practical theology in Yaoundé, and the first consultation on Biblical Revelation and African beliefs challenged African theologians to deal with issues of diseases, health, and healing from an African perspective. Research in this category has largely contributed to the helping profession in Africa.

The third category is still in gestation. As said earlier, there is a shortage of materials in this category. Yet, this category should regroup resources that articulate on personal pastoral caregivers' development, skills, and resources that contribute to promotion of professionalism in the pastoral ministry in African context. For example, materials that contribute to the development of pastoral care in specialized ministries such as: health care setting, correctional and prison institutions, military sectors, workplace, and other specialties.[97] This type of documentation is almost non-existent even though there is more than one hundred years that pastoral care was established in the ministry of the African church.

Somehow, this research hopes to serve this cause, but at the same time it confronts the risk of raising more questions than answers, and bringing about more confusion to the present

[97] Paget and McCormick, 14-86.

situation, which could also be a positive way of giving another evidence of the vulnerability of professional chaplaincy discussed by Larry VandeCreek in his preface to the book titled *Professional Chaplaincy: What is Happening to it During Health Care Reform?* He noted:

> Professional chaplaincy profession is vulnerable in unique ways when compared to the rest of health care. However, these vulnerabilities have existed for decades. … For example, professional chaplaincy lack national statistical descriptions of itself and how managed care efforts are affecting it. That is, professions such as medicine, nursing, and those in the allied health fields possess studies that provide baseline information concerning the size, shape, and character of their professions. This is also true of psychology, social work, as well as marriage and family therapy. They can quickly provide information concerning the basic characteristics of their professions and answer the question, "Who we are."[98]

Pastoral care is not a new ministry in Africa. As Masamba ma Mpolo indicated it was part of the missionary's agenda during the colonial and missionary time. Speaking of psychiatry and the delivery of pastoral care in Africa, he stated that:

> While both were part of the colonial and missionary medical and theological heritage, they have aroused the interest of researchers, governments, and the church institutions only within the last century. Recently, both disciplines have become subjects of university and seminary study, though both were, in essence, aspects of the indigenous African religious and medical systems.[99]

As said in this citation, the delivery of pastoral care was also provided during the missionary time in Africa. But, the development of this field shows that, from the colonial and missionary time until today, hospital pastoral care ministry has not been provided the same way it is delivered in hospitals in Western countries where Clinical Pastoral Education (CPE) is the skeleton of the profession since Antoin Boisen[100] has established its relevance in the healing

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[98] Larry VandeCreek, *Professional Chaplaincy: What Is Happening to It During Health Care Reform?* (New York: The Haworth Pastoral Press, 2000), xi.

[99] Masamba ma Mpolo, "African Pastoral Care Movement" in *Dictionary of Pastoral Care and Counseling* (Nashville: Abingdon Press, 2005), 11.

[100] Antoin Boisen is the father of Clinical Pastoral Education movement. E. Brooks Holifield, "Anton Boisen (1876-1965)" *Dictionary of Pastoral Care and Counseling* (Nashville: Abingdon, 2005), 104.

ministry. For many years, pastoral care in Africa has been the reproduction of the colonial and missionary model.

The researcher has no reservation to say that even until this day, hospital pastoral care in Africa has not made significant progress in terms of embracing changes that are taking place in the field. The problem is theological. Because any pastoral care approach that is used in ministry is the direct emanation of the dominant theology of the time. It must be acknowledged that the way pastoral care has been practiced in African health care institutions is a consequence of the theology the African church has inherited from the colonial and missionary time. The literature about the context of the transference of Western medicine in Africa indicates that when David Livingstone, the first missionary doctor to visit central Africa, traveled to the Africa continent in 1841, his first intention was to explore the area and minister to the sick. It is missionary doctors and nurses who came to Africa after him who were preoccupied with the idea of winning souls for Christ. In that process, they used the practice of medicine as a deliberate tool to reach their objective.[101]

At the beginning of the medical expeditions in Africa exploring the new continent and taking care of the sick was the agenda of David Livingstone. But later this agenda was modified by the influence the theology of the missionary church had on the praxis of ministry. African theologians identify two trends in the missionary theology: the theology of the Salvation of Souls and the Theology of Implanting of the Church.[102] The main concern of the theology of the salvation of the soul was the conversion of the indigenous to Christianity. This theology was

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[101] Akerele, Tabibzadeh, and McGilvray, Ibid.

[102]A. Ngindu Mushete, "An Overview of African Theology," in *Path of the African Theology*, ed. Rosino Gibellini (New York: Orbis Book, 1994), 9-26.

built upon the conviction that the worldview, cultures, and religious beliefs of the indigenous were evil. In his book, *The Origins and Development of African Theology*, Muzorewa wrote:

> The principal target of the missionary in Africa was the devil. According to Aylward Shorter, "Early missionaries saw the devil everywhere" in Africa. In missionary eyes the missions were the Empire of Satan (1974, 21). Thus, the central message brought by the missionary to Africa was salvation from, first, an unchristian cultural lifestyle, second, bondage by the devil, and third, the darkness of not knowing God and Jesus. In short, Africa needed to be redeemed from being the "Empire of Satan."[103]

This theology of the missionary church informed the praxis of the ministry in an unchallenged way for centuries, right up to the beginning of the twentieth century, noted Ngindu.[104] During all those years the main goal of the missionary church was to lead the people to the acceptance of Jesus Christ as their Lord and Savior by denying their own worldview. Besides, Ngindu also established that the theology of the implanting of the church arose around the 1920's. This theology of the missionary church was mostly characterized by both an ecclesiastic and ecclesiocentric perspective. It was all about planting churches on African soil for the new convert to Christianity. According to Ngindu Mushete:

> For the theologians of the implanting of the church, the mission ought to strive to "plant" the church in regions where it does not yet visibly exist. That is, it should endeavor to organize there, in stable, permanent form, the means of salvation: clergy, laity, religious, and Christian communities.[105]

These two forms of mission theologies described above dictated the praxis of ministry of the missionary church and are still influencing the way pastoral ministry is being practiced in Africa until this day. In the missionary times the way pastoral care ministry was being delivered

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[103] Gwinyai H. Muzorewa, *The Origin and Development of African Theology* (New York: Orbis Books, 1987), 30.

[104] Mushete, 3.

[105] Mushete, 15.

in the mission field was strongly determined by the theology of the missionary church. It appears that one of the most significant consequences of those trends in the development of pastoral ministries in Africa is the lack of a holistic approach to the problems of illness and suffering. This statement does not deny the fact that missionary theology did not engage the church in the healing ministry, but that healing was not the leading cause of missionary expeditions on African soil.

In other words, less consideration was given to the problem of illness and healing because at one time, the main focus of the missionary church was to convert people to Christianity, and later to create visible churches where the indigenous will gather around the cross of Jesus for *κήρυγμα* (kerygma), *κοινωνία* (koinonia) and *διακονία* (diakonia). Baur clarifies that during the early days of the missionary church in Africa, western medicine was used as "miracle enabler,"[106] to attract more people to the new faith. It was an instrument to win more people to Jesus, and not as a way to heal the sick as it is in faith-based health care institutions of the third millennium.[107] In other terms, evangelism was the dominant purpose of the healing ministry at the time.

In one research study entitled "L'Evolution de la Pastorale de la Communaute du Congo" conducted at the Congo Protestant University, there are many documents that provided evidence

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[106] Baur, 451.

[107] This means the evolution of pastoral ministries in the Communauté Evangelique au Congo. Translated from French by Kitete Dido Ntontolo, "L'Evolution de la Pastorale dans la Communcaute Evangelique du Congo." (master's thesis, Congo Protestant University, 1991), 46-49.

of this.[108] In a number of archives of the church, and other official documents, dating back to the year 1893, materials including the Nsansulu (or Kinsansulu); a compilation of decisions of missionary meetings, synods, and other important gatherings of the church that took place in the mission field from 1893 to 1955 were located. These documents are among the oldest resources of the church that can inform research on the certain aspects of the history of the Communaute Evangelique du Congo.

Another important document that was examined was an article written by Levi Miaviangi in 1910, and published in the *"*Minsamu Mia Yenge Journal,"[109] historically known as the first journal published in the Democratic Republic of Congo. Other documents included the 1953 edition of the constitution of the church. It provided important information that strongly supported the hypotheses. The writings of Makanzu Mavumilusa, international evangelist, who was from the first generation of Congolese pastors in the postcolonial era, were also very helpful in this study.

Findings confirmed that during the missionary time salvation was the central theme in the mission field, which influenced the whole spectrum of the pastoral life, such as preaching and pastoral care. The primary task of the pastoral caregiver was to resolve the problem of sin in society by preaching to abandon a sinful lifestyle. The mentality of the time was that the African culture was sinful. Consequently, laypeople and ministers who served as chaplains in hospitals were responsible for winning souls for Christ. Back in those days, it was a serious problem

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[108] Communaute Evangélique au Congo is the twenty-third member of the Association of Christian Churches (denominations) in the Democratic Republic of Congo. The church was founded by Swedish missionaries who evangelized the western part of Central Africa in 1889. This church was founded in 1889 by the Svenska Mission Forbundet (SMF), a Swedish missionary society. The Commaunte Evangelique au Congo is a member of the Alliance of Reformed Churches and World Council of Churches. The headquarters of the church is in Luozi, Democratic Republic of Congo.

[109] Levy Mavianga, "Mavanga ma Tombe" *Minsamu Mia Yenge* (Matadi: EEMM, 1910), 6.

because even after conversion, people who were converted to Christianity were still practicing African religion. John Mbiti, one of the most popular African Roman Catholic theologians of the twentieth century, who published extensively on African religions, wrote:

> Since African religion belongs to the people, no individual member of the society concerned can stand apart and reject the whole of his people's religion. To do so would mean to cut himself off from the total life of his people. Even if the individual is converted to another religion, this should not mean abandoning his culture altogether. Where there is no real conflict between African Religion and other religions, the convert retains much of his cultural and religious background as long he remains with the traditional set-up of life.[110]

The researcher believes that this situation influenced the praxis of ministry in the way that helped missionaries determine the direction pastoral care should take, and the role it had to play in the whole process. In other words, missionaries not only sought to convert souls, but they also sought to dismantle traditional African religion and, therefore, African culture and how pastoral care was provided also had that as its goal. This historical background influenced the whole spectrum of pastoral care to the point that even in hospitals the ministry of pastoral care became centered around the problem of sin. Although many years have passed, the context of the delivery of pastoral care in many sub-Saharan countries has not experienced significant changes. Yet, the expansion of Christianity in the continent is undeniable, but as of today, the theology of hospital pastoral care has not really grown.

The visible evidence of this is the fact that in most African health care institutions today, chaplaincy is still regarded through the lens of the colonial and medical missionary time. While many public institutions do not utilize chaplains to attend to the emotional and spiritual needs of patients, faith-based institutions appoint ministers who do not have the appropriate training and qualifications to serve as health care chaplains. The function of the health care chaplain is still

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[110] John Mbiti, *Introduction to African Religion* (London: Heinemann Educational Books, 1986), 14.

perceived as a random spot to be filled by a person who has a minimum of pastoral training; meaning someone who has enough compassion and biblical knowledge to minister to and visit people in hospitals, encourage their faith with the word of God, administrate sacraments, and offer prayer support.

The health care chaplaincy ministry in North America is changing at breakneck speed. What was known yesterday as a ministry that any ordained pastor could easily do, has currently become a growing and sophisticated profession that requires continual adjustments as the discipline is constantly responding to new challenges to the advancement new technologies are daily imposing to the science of medicine. Hence, hospital chaplaincy ministry has reached new heights, as stated by the central theme of the Association for Professional Chaplains held in Pittsburgh in 2007. Here is a short description of the health care chaplain ministry at the beginning of the third millennium as formulated by Jerry Nussbaum:

> Chaplains make significant contributions to interdisciplinary teams that provide care throughout the hospital. Chaplains respond along with other medical professionals to crisis and trauma. When a death occurs, chaplains provide resource and assistance with decedent care that may include follow-up through community professionals or clergy. Chaplains may serve on ethics committees and Critical Incident Stress Management (CISM) teams, or work with education departments to teach physicians, nurses, and other hospital staff about issues surrounding death, cultural diversity, faith, stress, or spiritual assessment.[111]

The problem today is that the transformation of health care chaplaincy, as a standalone discipline, has changed the whole spectrum of pastoral care in the United States. In African countries in general, these changes are far from being understood. While in the western countries, such as in the United States, the integration of spirituality is supported by the Joint

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[111] Jerry Nassbaum, "Interdisciplinary Teamwork: Role for Chaplaincy" *Spiritual Caregiving in Hospital: Window to Chaplaincy Ministry,* ed. Leah Dawn Bueckert and Daniel S. Chapini (Kitchener: Pandora Press Publishing, 2006), 41.

Commission.[112] In most African countries, health care chaplaincy is not known yet as a profession. As a consequence, most of African patients who come to the United States hospital do not have any personal experience with the hospital chaplain. That makes it difficult for someone who has no prior experience with health care chaplaincy to relate to a chaplain in the United States hospital.

Patient Satisfaction of Sub-Saharan African Immigrants in the United States Hospitals: Personal Perspectives

Two major circumstances have empowered the researcher's desire to accomplish this research study. What are those circumstances? How have those circumstances influenced the development of the following research project? Answering these questions will certainly provide some historical background about the origin of assumptions that are guiding this study.

First, the researcher has been an immigrant most of his life. Being a child of a minister, who completed his theological and pastoral education in Sweden and Belgium, gave the researcher the opportunity to experience life in those countries. In addition to living in those country for many years, the researcher immigrated to the United States in 1994, and made this country his homeland. The present geography context, which characterizes the researcher's life, qualifies him to provide some perspectives on this issue from a sub-Saharan immigrant standpoint.

Second, while living in these foreign countries, the researcher has also had the privilege to access different health care systems. In any region of the globe, when a person is sick, it is a matter of common sense that the person goes to the nearest health care institution to seek medical

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[112] Wendy Cadge, *Paging God. Religion in the Halls of Medicine* (Chicago: The University of Chicago Press, 2012), 45.

treatment. The researcher has also experienced the delivery of health care in those countries where he has lived as an immigrant. His twenty-four years in the United States suggests that the researcher has a wealth of personal experiences with the topic that is at the center of this research project. Below are two interesting stories that will help the reader to understand how personal experiences have contributed to the development of assumptions that are driving this research project.

The first time that the researcher reported to the United States hospital was in 1994. At that time, the researcher was not fluent in English, and was taking ESL classes at Wake Technical and Community College in Fayetteville, North Carolina.[113] He was very reluctant to go to the hospital because of the stress that causes language barriers in public places. He resisted the idea of going to the hospital even though the county hospital was in the community where he was living. One night, the pain started to become so excruciating that the researcher quickly realized that going to the hospital to seek medical assistance was an immediate need.

After self-reflection on that experience, the researcher sadly concluded that he was not satisfied with the care that was provided to him. The medical staff failed to provide him with appropriate accommodation, such as an interpreter, to allow him to provide an accurate description of how he was really feeling. The worst part was that there was a department of pastoral care in that hospital, but the researcher's emotional and spiritual needs were not taken into account during all of the time he spent at the emergency room. The researcher was hoping to have a chaplain's visit for emotional and spiritual support. At the time his mind was tormented by all kinds of questions that needed to be asked and answered.

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[113] ESL stands for English as a Second Language, a free English program offered in community colleges to provide to immigrants the opportunity to learn English at no cost.

The second encounter of the researcher with the United States hospital system was in 2008. On this occasion the researcher was not the primary patient. Instead, it was the researcher's wife who was the patient. The hospital admitted her for a few days after a full hysterectomy surgery. A few hours after the surgery, the chaplain came to the patient's room for a post-surgery pastoral care visit. The patient was sleeping and the researcher, her husband, went outside to relax and get fresh air. When the researcher came back to the room the patient began to complain about the visit of that chaplain. "I wish he had never come here," she said. In other terms, the patient was a little upset by the visit of the chaplain.

In this encounter, the problem was different. The chaplain who visited the patient did not have a strong foundation of cultural diversity and inclusion and how that knowledge can affect the quality of the entire pastoral care visit in health care institutions. This is what happened on this visit: the patient was sleeping, and the chaplain woke her up. After she woke up, he gave her some flowers her church sent her. Then, he told the patient that he was going to pray for her, and quickly left because there were more people that he needed to visit.

In this encounter, a culture shock experience expended in two different categories. First, the patient wondered: "Why will a chaplain come and wake up a patient when he knows that he has no time to sit and be there with the hurting patient?" In the shadow of this question is the idea that if your time is more important than me, you should not come see me. Second, the chaplain brought the patient beautiful flowers. But what he did not know was that in sub-Saharan Africa, flowers are not something fascinating. They do not represent much. Waking up the patient, giving her flowers, and being in a hurry to go to the next appointment was upsetting for the patient.

These two illustrations come out of the life experience of the researcher. They show that there are times that the delivery of pastoral care in the United States hospitals can also be confronted by a number of realities that can have a poor effect on optimal pastoral care to be provided to patients and families. With these experiences note, research on the satisfaction with pastoral care of sub-Saharan immigrants in the United States hospital is an important endeavor as the health care chaplaincy field is developing "best practice."

Summary

This chapter has discussed the biblical and theological foundation of patient satisfaction. Solid arguments were provided to demonstrate that the concept of patient satisfaction has a theological and pastoral foundation. In this chapter, the researcher has also discussed the role the missionary church has played in the development of the healing ministry in sub-Saharan Africa and provided some reflections on the state of the hospital pastoral care in sub-Saharan African hospitals today. The chapter ends with an interesting discussion where the researcher shares personal perspectives on this issue and share stories that inform the reader how personal experiences have influenced guiding assumptions of the research project.

Chapter Three

Literature Review and Other Sources

This chapter provides a review of the literature on patient satisfaction and the purpose is to propose a panoramic overview of the current state of research on patient satisfaction. The chapter is composed of three major segments. First, information about the work of the hospital chaplain. This is imperative because before the reader understands the relevance of patient satisfaction to health care chaplaincy, the reader must have a clear understanding of what health care chaplaincy is all about. It is obvious that without a good understanding of it, it will be very difficult to grasp its relevance to patient satisfaction.

Before diving in depth let it be clear that this chapter is not preoccupied by presenting the historic development of the field of health care chaplaincy. Nor will it provide a semantic study of words such as "chaplaincy," or the concept as "health care chaplaincy." As of this day, the pastoral care literature has plenty of studies that have completed this task. Instead, in this chapter the discussion specifically focuses on the nature and substance of this pastoral ministry. For instance, what chaplains do, with special attention to current changes that are occurring in the field and therefore giving the profession a new shape.

Second, the chapter also discusses some philosophical, anthropological, and sociocultural factors that characterize life in Africa. It provides a portrait of the African worldview. But, as mentioned in previous chapters, the focal point remains the African population that lives in the sub-Saharan region of the continent. The purpose of this is to give an overview of the African life and establish how different it could be from the worldview of other regions of the globe; for example, the western world. Providing this background is important because it allows the reader to gain a better understanding of certain aspects of diversity that make the African worldview

unique. Furthermore, it shows how diversity can influence the delivery of health care in the United States hospital and the experience of sub-Saharan African patients and families in American hospitals.

Concepts such as illness, pain and suffering, healing and many more are examined to clarify their meaning in the context of the cultures of the people from the sub-Saharan region of Africa. This chapter also provides a description of the context of hospitals in sub-Saharan countries. This is an important step because understanding the current state of hospitals in sub-Saharan Africa and what they represent for the average person in this part of the world sets the stage for a better understanding of the way sub-Saharan African immigrants experience hospitalization in the United States. Studies available in anthropology, sociology, African religions, African theology, and African philosophy were found to be the most informative resources to portray the worldview of sub-Saharan African immigrants being studied in this research project.

At this point, one may wonder how the religious and sociocultural diversity of the sub-Saharan African described in this chapter speaks to the findings of this research project. Of course, it is interesting to see how the findings of this research project may verify the researcher's assumptions. Concepts such as illness, pain, suffering, and healing were examined to clarify their meaning in the cultures of the people from the sub-Saharan region of Africa. Moreover, this chapter also provides a description of the context of hospitals in sub-Saharan countries.

Third, the chapter provides a literature review on patient satisfaction studies. The intention is to review the contribution of other disciplines and professions on this specific subject. As stated earlier, this topic has been subject to active research since the second half of

the twentieth century. Several professions and disciplines have recognized the importance of satisfaction studies to stay in business. Consequently, patient satisfaction studies have found a strong voice in the professional world. It is an aberration to think that this study alone provides an exhaustive literature review on this subject.

The literature review that is provided in this chapter is very selective. There is no way to complete a literature review on patient satisfaction that covers contributions of every discipline in the world in a study like this. In addition, claiming such an undertaking is unrealistic and nothing else than a pure digression. Therefore, the literature review that is provided in this chapter covers a few fields such as medicine, nursing, and business. These fields were selected not only because they interconnect with health care chaplaincy, but mostly because, like in health care chaplaincy, in these professions patients and families are the epicenter of all activities.

However, since this research study subscribes to the effort of reducing the limits of ignorance in the discipline of clinical pastoral care, it must be clear that this chapter gives special attention to the literature available on this topic in the field of health care chaplaincy. How relevant is patient satisfaction to health care chaplaincy? What does the pastoral care literature say about research on patient satisfaction in a health care setting? Is there any study available on patient satisfaction in health care chaplaincy? What have those studies focused on over the years? Are there any studies in health care chaplaincy that have researched the satisfaction of sub-Saharan patients and families with pastoral care provided in the United States hospital? These are some pertinent questions that the researcher intends to answer in this chapter.

Health Care Chaplains and Their Work

Health care chaplaincy is a growing field. The main objective of this profession is the integration of spirituality in the delivery of health care. Practically, it is performed by attending

to the emotional, religious, and spiritual needs of patients and families in health care institutions. The professional who provides this service is called "chaplain." According to the Association of Professional Chaplains, the chaplain is an ordained member of clergy who has a graduated degree in divinity or related sciences and has completed extensive training in Clinical Pastoral Education.[114]

Health care chaplaincy is a sub-specialty of religious professionals. Technically, the configuration of pastoral ministries recognizes this type of ministry as a "specialized ministry." In fact, there are several resemblances within both ministries, but it is also true that there is a clear distinction in their nature. The most remarkable distinction between these two ministries is that the pastor, sometimes also described as the "shepherd of the flock" performs the pastorate within the religious entity theologically known as *ἐκκλησία* (ekklesia). Practically, this word *ἐκκλησία* refers to an assembly of people who share the same beliefs, doctrine, and abide by the same by-laws under the same pastoral leadership.[115]

The hospital chaplaincy ministry does not function within the *ἐκκλησία*. This kind of pastoral ministry operates in "specialized settings" called hospitals. This is a specific environment that exists in any human society intentionally created to care for the sick and the dying. Somehow, it is a strange environment. One of the most remarkable characteristics that make hospitals a strange place is the diversity of health care. Yet, hospitals are public places and because of that they have the vocation to be open to people from any religious background which

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[114] "Common Qualifications and Competencies for Professional Chaplains," Association for Professional Chaplains, accessed December 12, 2018, http://www.professionalchaplains.org/files/2017%20Common%20Qualifications%20and%20Competencies%20for%20Professional%20Chaplains.pdf.

[115] 1 Cor. 1:2; Rev. 1:11.

is contrary to the pastoral ministry performed within the *ἐκκλησία*. Hospitals are places marked by a strong sense of ecumenism.

The pastor is the shepherd of the *ἐκκλησία* and the hospital chaplain is the pastor who serves in health care institutions. Academically, the chaplain is a highly trained professional who works alongside health professionals such as physicians, nurses, and pharmacists on one hand, and on the other hand, allied health professionals such as clinical dieticians, physical therapist, public health specialist, and others.[116]

Nowadays, pastoral care literature indicates that this field is undergoing many significant changes. A few years ago, the well-known professor H. Tristram Engelhardt, made this point in a critical article on this subject. The title of the article was "The Dechristianization of Christian Hospital Chaplaincy."[117] Not long ago this remark made a comeback in the discussion about the evolution of health care chaplaincy. A certified supervisor in Clinical Pastoral Education and member of the Association for Clinical Pastoral Education, named Timothy A. Thorstenson, stated that in a recent article as well. Thorstenson noted that, "The professional field of pastoral care is undergoing a seismic shift in both its identity and its practice."[118] In fact, what does this really mean? How will those changes transform the whole spectrum of health care chaplaincy? To answer these questions, it is important to provide a panoramic overview of the landscape of health care chaplaincy.

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[116] Richelle C. Russell, "Professional Chaplains in Comprehensive Patient-Centered Care," *Rhode Island Medical Journal* 39 (2014), 39-42.

[117] Hugo Tristram Engelhardt Jr., "The Dechristianization of Christian Hospital Chaplaincy: Some Bioethics Reflections on Professionalization, Ecumenization, and Secularization," *Medical Morality* 9, no. 1 (2003): 39-160.

[118] Timothy A. Thorstenson, "The Emergence of the New Chaplaincy: Re-Defining Pastoral Care for the Postmodern Age," *Journal of Pastoral Care and Counseling* 66, no. 2, (2012): 17.

At the beginning of the last century, health care chaplaincy was predominantly a parochial endeavor. The makeup of the work of the hospital chaplain was grounded upon a religious-based model of presence that has its roots in Judeo-Christian sources.[119] The work of the hospital chaplain was understood in the context of the continuity of the ministry of Jesus-Christ in the world, best described in the words "I was sick and you visited me" as recorded in the New Testament.[120] Many years ago the hospital pastoral care ministry was pragmatically a religious-based model that was not concerned about many questions clinical pastoral care asks in public conversation about health and healing today.

Clinical pastoral care does not always ask questions like: Is the patient saved? Is the patient baptized? These questions or any other kind of questions that only have an evangelistic connotation may surface during a spiritual assessment, however, they are mostly discussed when patients bring them up during the chaplain's visit. It drills down deeper asking questions that go beyond the limits of the traditional model of pastoral care described above. Clinical pastoral care asks questions that have an evangelistic nature as well as humanistic and organizational. One of the best examples of this kind of question is: "Can chaplains reduce a hospital's readmission rate?" This question is the title of an interesting research that studied the impact of the delivery of pastoral care in health care institutions on the reduction of the readmission rate in two hospitals in New York which also has an organizational connotation.[121]

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[119] Thorstenson, 17.

[120] Matthew 25:36 [NIV].

[121] Roberta Holley, David Keehn and Jess Geevarghese, "Can Chaplains Reduce a Hospital's Readmission Rate?" *Vision* 24, no. 3 (2013): 10-11.

As Paget and McCormick noted, in the early days of the hospital ministry the role of the chaplain was essentially limited to the "caring of the soul" of the sick and the dying, making pastoral care strictly an evangelistic ministry in a health care setting.[122] The orthopraxy of the church consisted of making sure that the sick and the dying are saved and actively embracing the Christian lifestyle. In this perspective, the hospital was more considered as an extension of the local church where patients were spiritually cared for to prevent them from going to hell after this life on earth. Salvation was the ultimate mandate of the hospital ministry. In terms of the Vine's Expository Dictionary the responsibility of the chaplain was "to save, keep safe and sound, rescue, to preserve one who is in danger of destruction, or to deliver from the penalties of the Messianic judgement."[123]

The evangelistic approach discussed above does not concern factors such as psychological effects that could poorly impact patients' experience of hospitalization. For instance, the role chaplains' play in helping a chronic pain patient who threatens to leave the hospital against medical advice because he or she is unhappy with the physician who refuses to prescribe more pain killer pills to feed the patient's addiction, regardless of the risks that are associated with such harmful behavior. As a matter of fact, from the evangelistic perspective, the chaplain would mainly be concerned about patient's salvation.

Engelhardt, an American philosopher and one of the strongest voices of the traditional model of hospital chaplaincy, provides a description of attributions of chaplains in a pastoral care

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[122] Paget and McCormick, 3.

[123] "σώζω," *Vine's Expository Dictionary of the New Testament Words*, accessed December 15, 2018, https://www.blueletterbible .org/lang/lexicon/lexicon.cfm?t=kjv&strongs=g4982.

encounter with patients in a health care setting. Yet, Engelhardt describes the job description of the health care chaplain in the following words:

I. Aiding hospital patients to recuperate right belief in their spiritual struggles, meaning:
   A. encouraging members of the chaplain's own denomination to live an authentic Christian life,
   B. inspiring members of all denominations and religions through conversion to live an authentic Christian life,
   C. helping patients to step out of immoral relationships such as sexual liaisons outside of the marriage of husband and wife.

II. Aiding hospital patients to rightly worship God through:
   A. recognizing the truth of the claims of Christ as the Son of God and the Messiah of Israel,
   B. leading the wholehearted repentance and conversion in tears and sorrow,
   C. providing the basis for a right-ordered participation in the mystery of the church.

III. Aiding hospital physicians in using medicine and biomedical sciences through:
   A. Refusing the use of medical science in sinful ways (e.g., abortion),
   B. Approving the use of medicine only when it will not distract from the primary goals of repentance and conversion (e.g., recommending to patients that they should refuse treatment which would consume their life in the pursuit of a cure and the restoration of health),
   C. Refusing to collaborate with or refer for diagnostic and therapeutic interventions prohibited by traditional Christian norms (e.g., amniocentesis when unconnected to medical interventions directed to preserving the health or life of the unborn child).

IV. Aiding physicians, nurses, and hospital administrators to act in accordance with the norms of the right to worship, right to belief and right conduct by:
   A. Encouraging health professionals and health care institutions not to participate in interventions forbidden by traditional Christian norms (including refusing to refer to those who would provide such interventions),
   B. criticizing an inclusive institutional ethos that implies approval of health care choice incompatible with traditional Christian norms,
   C. recognizing the standards of good health care (e.g., salvation is more important than health),
   D. recognizing that the chaplain's role can only be fully understood in the terms of transcendent commitments to the Trinity.[124]

[124] Engelhardt, 145-146.

Nowadays, several things have changed in the health care chaplaincy profession. One of the most significant changes that has occurred in this field over the years is the fact that the health care chaplain is slowly and surely moving toward a more humanistic approach. Current studies on spirituality and health have shifted the attention of the field to a holistic perspective on health and healing. While some professionals are worriedly interpreting it as the downfall of the religious-based model of pastoral care, other people are celebrating it in the context of a progressive transformation in the field. Thorstenson stated that the ministry of the health care chaplain:

> . . . is becoming a field that seeks to transcend escalating social and religious complexities and barriers to community while tending more effectively to the well-being and resilience of the individual. This shift is a welcome true postmodern phenomenon. The symbols, language and foundational concepts in 20th century religious thought are being replaced in clinical ministry by post-Holocaust theologies, process thoughts, new scientific theories and discoveries.[125]

This statement indicates that the functions and activities of professional health care chaplains have crossed the limits of the evangelical approach discussed above. Yet, this approach is supported by the main organization that regulates the delivery of health care in the United States, which is The Joint Commission, an independent, not-for-profit organization that accredits and certifies health care institutions in the United States.[126] Yet statistically, there are more than 22,000 health care organizations that are accredited and certified by The Joint Commission. The Joint Commission's accreditation and certification is accepted nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.[127]

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[125] Thorstenson, 1.

[126] "History of the Joint Commission: Providing You Patient Safety and Quality Improvement Solutions for over Six Decades," The Joint Commission, accessed January 23, 2019, https://www. Joint Commission.org/about-us/facts-about-the-joint-commission/history-of-the-joint-commission/.

[127] Ibid.

Furthermore, the humanistic approach of pastoral care is also strongly supported by the five endorsing organizations of Clinical Pastoral Education in North America: Association for Clinical Pastoral Education, Association of Professional Chaplains, Canadian Association for Pastoral Education, National Association of Catholic Chaplains and the National Association of Jewish Chaplains.[128] These five organizations have embraced this approach and developed the new landscape of the work of the hospital chaplain in a document jointly developed in Nashville (TN) in 2002. Yet, this document was approved and published under the title: "The Professional Chaplaincy: Its Role and Importance." This document describes the functions and activities of the professional hospital in the following terms:

> The activities of professional chaplains include diverse interactions with patients and families, professional staff, volunteers, and community members. While a chaplain cannot perform every function, they can be classified as follows:
>
> 1. Religious beliefs and practices are tightly interwoven with cultural contexts, chaplains constitute a powerful reminder of healing, sustaining, guiding, and reconciling power of religious faith.
>
> 2. Professional chaplains reach across faith group boundaries and do not proselytize. Acting on behalf of their institutions, they also seek to protect patients from being confronted by other, unwelcome forms of spiritual intrusion.
>
> 3. They provide supportive pastoral care though empathic listening, demonstrating, and understanding of persons in distress. Typical activities include: grief and loss care, risk screening (identifying individuals whose religious/spiritual conflicts may compromise recovery or satisfactory adjustment.), facilitation of issues related to organ/tissue donation, crisis intervention/critical incident stress debriefing, spiritual assessment, communication with caregivers, facilitation of staff communication, conflict resolution among staff member, patients, and family members, referral and linkage to internal and external resources, assistance with decision making and communication regarding decedent affairs, staff support relative to personal crisis or work stress, institutional support during organizational change and crisis.

[128] There are several other organizations that are leading changes in this field that have also adopted this approach. For example, Transforming Chaplaincy (www.trasnformingchaplaincy.org) and Healthcare Chaplaincy (www.healthcarechaplaincy.org).

4. Professional chaplains serve as a member of patient care teams by: participation in medical rounds and patient care conferences, offering perspectives on the spiritual status of patients, participation in inter-disciplinary education, charting spiritual care interventions in medical charts.

5. Professional chaplains design and lead religious ceremonies of worship and rituals such as: prayer, meditations and reading of holy texts, worship and observance of holy days, blessings and sacraments, memorial services and funerals, rituals at the time of birth or other significant life cycle transitions and holiday observances.

6. Professional chaplains lead and participate in health care ethic programs by: assisting patients and families in completing advance directives, clarifying value issues with patients, family members, staff and the organization, participating in Ethics Committees and Institutional Review Boards, consulting with staff and patients about ethics concerns, pointing to human value aspects of institutional policies and behaviors, conducting in-service education.

7. Professional chaplains educate the health care team and community regarding the relationship of religion and spiritual issues to institutional services in the following ways: interpreting and analyzing multi-cultural traditions as they impact clinical services; making presentations concerning spirituality and health issues; training of community religious representatives regarding the institutional procedures for effective visitation; training and supervising volunteers from religious communities who can provide spiritual care to the sick; conducting professional clinical education programs for seminarians, clergy, and religious leaders; developing congregational health ministries; educating students in the health care professions regarding the interface of religion and spirituality with medical care.

8. Professional chaplains act as mediator and reconciler, functioning in the following ways for those who need a voice in the health care system: as advocates or "cultural brokers" between institutions and patients, family members, and staff; clarifying and interpreting institutional policies to patients, community clergy, or religious organizations; offering patients, family members and staff an emotionally and spiritually "safe" professional from whom they can seek counsel or guidance; representing community issues and concerns to the organization.

9. Professional chaplains may serve as contact persons to arrange assessment for the appropriateness and coordination of complementary therapies. Patients increasingly demonstrate interest in healing from many sources not represented within traditional health care disciplines. Many of these complementary healing traditions are grounded in the world's religious traditions and the chaplain may utilize or make a referral for complementary therapies such as: Guided imagery/relaxation training, meditation, music therapy, healing touch.

10. Professional chaplains and their certifying organizations encourage and support research activities to assess the effectiveness of providing spiritual care. While many serve in settings with little interest in conducting research, others are employed by centers with a research mission. Increasingly, chaplains attend to research in the following ways: developing spiritual assessment and spiritual risk screening tools; developing tools for bench-marking productivity and staffing patterns that seek to increase patient and family satisfaction; conducting interdisciplinary research with investigators in allied fields; publishing results in medical, psychological, and chaplaincy journals; promoting research in spiritual care at national conventions.[129]

The ten functions provided in the quote above summarize the content of the job description for professional hospital chaplains in North America. Furthermore, in order to ensure the professionalism and effectiveness of clinical pastoral care in health care settings there are a number of competencies that chaplains must demonstrate to be certified. Thus, those competencies are the following:

A. Integration of Theory and Practice Competencies:
    1. Articulate an approach to spiritual care, rooted in one's faith/spiritual tradition that is integrated with a theory of professional practice.
    2. Incorporate a working knowledge of psychological and sociological disciplines, religious beliefs and practices in the provision of spiritual care.
    3. Incorporate the spiritual and emotional dimensions of human development into one's practice of care.
    4. Incorporate a working knowledge of different ethical theories appropriate to one's professional context.
    5. Articulate a conceptual understanding of group dynamics and organizational behavior.
    6. Articulate how primary research and research literature informs the profession of chaplaincy and one's spiritual care practice.

B. Professional Identity and Conduct Competencies.
    1. Be self-reflective, including identifying one's professional strengths and limitations in the provision of care.
    2. Articulate ways in which one's feelings, attitudes, values, and assumptions affect professional practice.
    3. Attend to one's own physical, emotional, and spiritual well-being.

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[129] Larry VandeCreek and Laurel Burton, eds., *Professional Chaplaincy: Its Role and Importance in Healthcare* (Nashville: Bristol-Myers Squibb Company, 2002), 8-9.

4. Function in a manner that respects the physical, emotional, cultural, and spiritual boundaries of others.
5. Use one's professional authority as a spiritual care provider appropriately.
6. Advocate for the persons in one's care.
7. Function within the Common Code of Ethics for Chaplains, Pastoral Counselors, Clinical Pastoral Educators, and Students.
8. Communicate effectively orally and in writing.
9. Present oneself in a manner that reflects professional behavior, including appropriate attire and grooming.

C. Professional Practice Skills Competencies:
   1. Establish, deepen and conclude professional spiritual care relationships with sensitivity, openness, and respect.
   2. Provide effective spiritual support that contributes to the well-being of the care recipients, their families, and staff.
   3. Provide spiritual care that respects diversity and differences including, but not limited to, culture, gender, sexual orientation and spiritual/religious practices.
   4. Triage and manage crises in the practice of spiritual care.
   5. Provide spiritual care to persons experiencing loss and grief.
   6. Provide religious/spiritual resources appropriate to the care recipients, families, and staff.
   7. Develop, coordinate, and facilitate public worship/spiritual practices appropriate to diverse settings and needs.
   8. Facilitate theological/spiritual reflection for those in one's care practice.
   9. Facilitate group processes, such as family meetings, post trauma, staff debriefing, and support groups.
   10. Formulate and utilize spiritual assessments, interventions, outcomes, and care plans in order to contribute effectively to the well-being of the person receiving care.
   11. Document one's spiritual care effectively in the appropriate records.

D. Organizational Leadership Competencies.
   1. Promote the integration of spiritual care into the life and service of the institution in which one functions.
   2. Establish and maintain professional and interdisciplinary relationships.
   3. Understand and function within the institutional culture and systems, including utilizing business principles and practices appropriate to one's role in the organization.
   4. Promote, facilitate, and support ethical decision-making in one's workplace.

5. Foster a collaborative relationship with community clergy and faith group leaders.[130]

It is strange that pastoral care literature does not describe the current situation between the two approaches discussed in the previous pages as a crisis in the field that needs special attention. In one article entitled, "Good Practice Chaplaincy: An Explanatory Study Identifying the Appropriate Skills, Attitudes and Practices for the Selection, Training and Utilization of Chaplains,"[131] the authors recognize the differences in these approaches, but they did not engage the subject in terms of a crisis in the field. Perhaps it was not the main concern of the article which, somehow, shows that little interest has been given to this issue in pastoral care literature. However, the researcher believes that it is a silent crisis in the profession.

There are chaplains who have left the profession because of that crisis. Unable to digest the fact that in the present days the humanistic approach to pastoral care has taken over the evangelistic model and become the leading principle of the delivery of pastoral care in health care settings, some have quit the profession, or some have decided on early retirement. This is the case of a friend of the researcher who anticipated her retirement after she came to the realization that "...chaplaincy was not like this when I came to this ministry. It has become something else."[132]

This crisis has not gained much attention in the health care professional circles because, statistically, changes occurring in the clinical pastoral care field are bringing satisfaction to the

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[130] "Common Qualifications and Competencies of Professional Chaplains."

[131] Lindsay B. Carey and Bruce Rumbold, "Good Practice Chaplaincy: An Exploratory Study Identifying the Appropriate Skills, Attitudes and Practices for the Selection, Training and Utilization of Chaplains," *Journal of Religion and Health* 54 (2015), 1416.

[132] Vicky Yoder is a Board-Certified Chaplain in the Association of Clinical Pastoral Care. She decided to retire after 15 years of ministry in the healthcare setting. Conversation on health care chaplaincy with the researcher, February 4, 2019.

science of medicine on one hand, and to the stakeholders of the health care industry on the other hand. The researcher believes that it is a theological crisis that goes unnoticed in spite of statistics that confirm the success of the humanistic model of health care chaplaincy in the process of the integration of spirituality in the delivery of health care.

Decades ago, there were physicians who were adamant that hospital chaplains were not qualified to be a part of every interdisciplinary team of the hospital and do rounds with every patient as a full-fledged member of the team and access the patient's chart and report on pastoral care visits.[133] This is the case of Roberta S. Loewy and Erich H. Loewy who stated that:

> We reiterate that hospital chaplains may, in appropriate cases, serve a critically important function in a patient's care. However, we are deeply concerned about the demands on the part of the chaplains and chaplaincy associations to be treated as full-fledged members of every patient's health care team and/or to have complete access to patient's medical records whether to gather patient information or to make notations of their own.[134]

However, in the present day, physicians and chaplains work hand-in-hand in the palliative care team. They sit side by side at the roundtable to discuss ethical issues related to the dying patient in the Intensive Care Unit. They perform clinical rounds with the multidisciplinary team of the hospital which is a new trend in the collaboration between physicians and chaplains that research available on the relationship between religion, spirituality and health have influenced.[135]

However, the situation remains critical. In several regions of the globe, chaplaincy services are still the missing piece of the puzzle in health care institutions. In sub-Saharan Africa,

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[133] Roberta Springer Loewy and Erich Loewy, "Healthcare and the Hospital Chaplain," *Medscape General Medicine* 9, no. 1, (2007): 53.

[134] Loewy and Loewy, 7.

[135] Arnold G. Koenig, *Medicine, Religion and Health: Where Science and Spirituality Meet* (West Conshohocken: Templeton Foundation Press, 2008), 22.

for instance, health care chaplaincy is not yet established in health care institutions the way it happens to be in the western world. This should not be a surprise to anyone because even in the United States health care, chaplaincy remains relatively a new profession to many people.

As of today, most hospitals in sub-Sahara Africa do not have a department of pastoral care where chaplains work alongside the multidisciplinary team of the hospital to provide care to patients and families. The few hospitals that employ chaplains utilize pastors who have a theological background, including some basic training in the ministry to the sick and hospital visitation. But they are not required to have training in Clinical Pastoral Education as The Joint Commission and the five accreditation organizations cited earlier stress in the United States.

When they come to the United States hospital most of sub-Saharan patients and their families are not familiar with the hospital chaplain. They do not know who the chaplain is, and they do not know what the chaplain does. There are almost no doubts that the few of those who have some knowledge about the chaplain consider the chaplain as a pastor who comes to the hospital to visit patients and pray for them, which is currently just one aspect of the numerous responsibilities of the health care chaplain in the humanistic model of hospital pastoral care, as discussed earlier. This must be acknowledged to best understand the experience of sub-Saharan African patients and families with chaplaincy services in the United States hospital.

Understanding the African Worldview: Considerations for Patient Satisfaction of Sub-Saharan African Immigrants with Pastoral Care in the United States Hospital

The book of Genesis talks about the tower of Babel.[136] The story is about generations that lived in the land of Shinar (שִׁנְעָר) after the Great Flood recorded in Genesis 6. The people wanted

[136] Genesis 11:1-9.

to build a great city and a high tower that would reach heaven. But God interrupted their project by causing a major communication crisis among the people that created a language barrier making it impossible for them to understand one another and continue to pursue the development of the project. Biblical scholars use this narrative to explain the origins of the different languages that are spoken in the world.[137] But the researcher believes that this narrative also helps to understand the origin of the different cultures of the world which is also the point of view of many scholars.[138]

According to the narrative, the confusion in the language that was caused by God forced the people to scatter around the world and, wherever they geographically went, they engaged in building new communities on a spoken language-basis and began to reorganize the society. This led to the development and establishment of diverse cultures. Hence, the researcher refers to culture as the way of life of individuals or groups of people within a society that have developed over a number of generations that establish their identity, including things such as values, norms, material goods, worldview, languages and symbols, customs and traditions, and others.

In other words, this narrative explains the origin of the diversity that characterizes human societies in general, and the sub-Saharan region of Africa in particular, whether this means religious or sociocultural diversity. Therefore, the African populations are remarkably diverse and composed of populations that have worldviews that are, somehow, different from other parts of the world. Hence, let it be reminded that understanding the African worldview influences a

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[137] Klaas-Jan Duursma, "The Tower of Babel Account Affirmed by Linguists," accessed February 13, 2019, https://creation.com/images/pdfs/tj/j16_3/j16_3_27-31.pdf.

[138] Theodore Hiebert, "The Tower of Babel and the Origin of the World's Cultures," *Journal of Biblical Literature* 126, no. 1 (2007): 29-58.

better understanding of certain behaviors that are associated with sub-Saharan African immigrants who come to the United States hospital.

The Conception of the Person in African Traditional Thoughts

There is a big difference between the Western and the traditional African conception of the person. Several studies provide a clear distinction between those two conceptions. For example, Ifeanyi Menkiti, an African philosopher, wrote about this in one article entitled "Person and Community in African Traditional Thoughts."[139] John Mbiti has brilliantly clarified this concept in his famous book *African Religions and Philosophy.* J. Dubois and Van Den Wijngaert also talked about it in their book entitled *Initiation Philosophique.* There is also a good discussion on the subject in the article, "La conception traditionnelle de l'individu, de la famille et du mariage et ses implications dans la pastorale du mariage en Afrique noire," published in the Revue Zairoise de Théologie Protestante.[140]

However, some conflicts observed between health professionals and patients that take place in health care institutions give the impression that there are physicians, nurses, and health care professionals who are still not aware of this reality. Yet, the difference between these two conceptions is remarkable and needs to be clarified.

In the Western conception of the person, the individual is an independent entity of society. This means that the person has a special status that gives the individual some degree of autonomy in society. Western culture recognizes the person as the sole entity. In this perspective,

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[139] Ifeanyi Menkiti, "Person and Community in African Traditional Thoughts," in *African Philosophy: An Introduction*, R. Wright, ed. (Lanham, MD: University Press of America, 1984).

[140] Kitete D. Ntontolo, "La Conception Traditionelle de l'Individu, de la Famille et du Mariage et ses Implications sur la Pastorale du Mariage en Afrique Noire,*" Revue Zaire de Theologie Protestante* (Kinshasa: Cedi, 7-8, 1993-1994), 113-125.

the person has rights that society recognizes and has the responsibility to promote and protect. Consequently, the whole society is organized around the rights of the individual, which suggests that the person is really the center of gravity within society. According to Mekinti, this is the reason the protection of human rights is the priority in Western societies. In addition, it clarifies the reason patients are also the center in the decision-making process in western medicine.[141]

The African conception contrasts with the Western conception of the person in the way that the person is not an independent entity of the society. This explains why African life is community-based. The African view of the person is that the individual is not the sole entity or an isolated atom of the society. As Menkiti said, in the African conception of the person it is the community which defines the person as person, and not some isolated static quality of rationality, will or memory.[142] In other words, from the western view a person is an abstract entity who possess physical and psychological features that characterize him as a lone individual which is not the same in African cultures. African cultures reject this conception. That means that in African countries, especially in the sub-Saharan region of Africa, the idea of seeing an individual as a lone individual is nonsense. In this part of the globe, it is a person's community and the social circumstances that shape the individual's existence that give a person meaning.

In sub-Saharan Africa the person has no value outside of the web of relationships that constitute his social network.[143] Contrary to the Western view, the African society is organized around the requirements of duties instead of the notion of individual rights. It is the community

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[141] In this study, the concept of decision making refers to the cognitive process of choosing between two or more alternatives, ranging from relatively clear to the complex. *APA Dictionary of Psychology* (Washington, DC: American Psychological Association, 2007), 259.

[142] Ibid.

[143] Menkiti, 171-181.

that shapes the individual and gives meaning to the person's life. To make the African conception of the person more understandable to those who are not familiar with this conception some authors utilize the illustration of a chain.[144] They argue that in the African view, the person is like a particle of a chain.

In this perspective, a single link of the chain does not make up the chain. But the chain is made up by the interconnection of every single particle of the chain. In other terms, it is the interconnection of the existing person with the previous generations (dead and alive) and the future generations that establishes the identity of the person and defines the status of the individual in the society. To render this even more understandable, John Mbiti uses Rene Descartes' principle of philosophy, saying that in African, a conception of the person *cognito ergo sum* could be interpreted as "I am because we are, and since we are I am."[145] This explains why in the medical decision-making process, for instance, African patients tend to involve other people from the community before verbalizing personal choices.

The Conception of Illness, Suffering, and Death in the African Traditional Thought

In the traditional African thought, illness has a social and cultural dimension rather than biological.[146] This means that back in the days, African people did not believe that illness can have biological roots as western medicine argues in present days. The notion of biological roots of illness was introduced to the African worldview during the transference of Western medicine in Africa that took place during the time of missionary medicine.

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[144] J. Dubois and Van Den Wijngaert, *Initiation Philosophique* (Kinshasa: Centre de Recherches Pedagogiques, 1979), 42.

[145] John Mbiti, *Religions et Philosophie Africaine* (Younde: Editions Cle, 1972), 118-119.

[146] Masamba ma Mpolo, *Sorcellerie et Pastorale* (Kinshasa: Cedi, 1974), 8.

In the African view, illness, suffering, and death are interpreted as the visible expression of social tension in the community. Illness is caused by supernatural forces that attack the person's health by putting a curse on the individual that manifests pain, suffering and sometimes even death. This conception underlines a strong belief in spirits. The people believe that in the cosmos there are good spirits and bad spirits. These spirits have the power to influence circumstances that take place in human history.

It is also important to say that African people believe in their ancestors. They believe that they reside in the invisible world but also consider them as part of the living. As John S. Pobee noted, they see them, "as part of the clan who have completed their course here on earth and are gone ahead to the other world to be elder brothers of the living house of God."[147] This is why many families still have where they worship them with reverence and sacrifices.

The researcher cannot do justice to the truth if nothing is said about the belief in sorcery. African people believe in witchcraft. The witch is the person who has initiated the sorcery. This is the person who initiates the use of the force of nature and invokes spiritual forces to influence bad circumstances onto another person's life. In this conception, illness, suffering and death could be the consequence of some witchcraft activities. Therefore, it is not unusual to find African people who deny the medical diagnosis and believe that their cancer, stroke, or cardiac arrest was caused by an exterior agent.

Asa Dalman, a Swedish missionary, theologian, and anthropologist who studies the African conception of illness, suffering and death, found out that this concept is also alive in the Christian church. In other words, both Christians and non-Christians believe in the African view of illness, suffering, and death and that the spiritual world has some authority on the welfare on

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[147] John S. Pobee, *Toward and African Theology* (Nashville: Abingdon, 1979), 46.

the people in the community. The belief is that the invisible world influences life in the visible world. Therefore, Christians and non-Christians believe that illness, suffering, and death can have spiritual roots. Hence, in his *Introduction to African Religion*, John Mbiti clarifies that:

> Since African Religion belongs to the people, no individual member of the society concerned can stand apart and reject the whole of his people's religion. To do so would mean to cut himself off from the total life of his people. Even if the individual is converted to another religion, this should not mean abandoning his African culture together. Where there is no real conflict between African Religion and other religions, the convert retains much of his cultural and religious background as long as he remains within the traditional life.[148]

This does not mean that the church accepted these beliefs as is and claimed them to be orthodox. To the contrary, the church did not endorse them but recognized that this is how the people in the church and the community interpreted illness, suffering, and death.

It is crucial to point out that as of today many sub-Saharan immigrants who come to the United States hospital still strongly believe in the African traditional conception of illness, suffering, and death. They believe it when they are on the way to the hospital, during the registration process, the consultation with the physician after an MRI test, and even when they are bound to bed or actively dying.

There is no doubt that African people who live in Western countries, for example, are likely influenced to adopt the conception of illness, suffering, and death of the dominant culture of the country of their residence. Sociologically, this phenomenon is called acculturation. It is the process that operates the transference of culture from one person to another or one group of people to another group during the process of assimilation to a dominant culture. In other words, it could also be defined as the process through which a person or a group of people adopt a culture that is strange to their own culture and integrate it in their system of values and practice.

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[148] Mbiti, *Introduction to African Religion*, 14.

In fact, the process of acculturation can take place when a person or group of people have relocated to another country which is the case of sub-Saharan Africans who are the subject of this research. But the process can also take place from a distance. This through the influence of other means such as new technologies, art, and literature. This explains how some people who have never left their countries of origin can also be accultured and adopt beliefs and values from people from other parts of the globe.

However, even though in the present time many immigrant people of Africa who live in the United States, for example, have adopted the Western worldview on many things, it does not mean that they deny their own culture while they embrace the dominant culture. The acculturation process mostly allows them to conserve their own culture, specifically, the African traditional conception of illness, suffering and death described in the previous pages. Therefore, until today, many of them interpret illness, suffering and death in the context of that culture. How can this be possible? This is a great question to ask. Seth Nomenyo answered it by reminding us that African traditional cultures and ancestral customs have a way to maintain their viability and stability from generation to generation.[149]

Hospitals and the Utilization of Health Care Institutions in Sub-Saharan Africa

Health care delivery has always been a problem in sub-Saharan Africa. In fact, one would think that after the independence of African countries from their historical colonies in the sixties, African countries would continue to prosper and make life better for all, but history has proven it to be wrong. In his introduction to the book *Healthcare Services in Africa,* Chinua Akukwe states that:

[149] Seth Nomenyo, "Le Chretien Face aux Coutumes Traditionelles Africaines,'' *Flambeau* 32 (Yaounde: Editions Cle, 1971), 226.

> Today, according to annual statistics from leading international organizations such as the World Health Organization Regional Office of Africa, the World Health Organization (WHO) Secretariat in Geneva, the United Nations Development Program (UNDP), the World Bank and UNAIDS, Africa ranks poorly compared to Asia, Latin America, the Caribbean, North America and Europe in most all health indicators (2-5). In every known development index today, African countries dominate the laggards.[150]

If a comparison is to be made between the state of hospitals in sub-Saharan Africa from the missionary and colonization time to the present time, the literature indicates that the quality of hospitals and delivery of health care have significantly deteriorated in many sub-Saharan countries. Health care systems are exposed to serious challenges. Chinua Akukwe considers that the root causes of this situation are: the ineffectiveness of health care systems, dilapidation of health care infrastructures, problems associated with health care financing, health care workforce crisis, poverty, challenges with risk reduction and preventive health programs, governance issues in the health sector, poor involvement of the private sector, limited participation of the targeted population in the design and implementation of health programs, and heavy dependence of external development partners and donors.[151]

Friedeger et al. insist on the lack of strategies and policies able to sustain the quality in the delivery of health care.[152] Cathy A. Petti et al. argue that the state of laboratory medicine characterized by minimal-to-no laboratory support is a serious barrier to effective health care in

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[150] Chinua Akukwe, *Healthcare Services in Africa: Overcoming Challenges, Improving Outcomes* (London: Adonis & Abbey Publishers, Ltd., 2008), 2.

[151] Akukwe, 3-5.

[152] Friedeger Stierle, Miloud Kaddar, Anastasie Tchicaya, and Bergis Schmidt-Ehry, "Indigence and Access to Health Care in Sub-Saharan Africa," *International Journal of Health Planning and Management* 14, no. 2 (Chichester: John and Whiley Ltd, 1999): 81-105.

Africa, [153] while Omar B. Ahmad pinpoints the migration of health care professionals from poor countries to rich countries.[154]

This situation establishes that health care systems in sub-Saharan Africa do not provide conditions that would make a sick person want to go to the hospitals. Because of that, many people of Africa, including those who live in their non-native countries, are sometimes reluctant to report to health care institutions and take advantage of what western medicine has to offer. Many African people, in general, tend to utilize health care institutions as a last resort, meaning when other alternatives have failed to heal.

This attitude toward western medicine is also popular among sub-Saharan African who live in the United States. In many African countries, the deterioration of health care institutions has affected people's habit of reporting to hospitals when they are sick because this situation has distorted the image of western medicine. There are authors who believe that western medicine has, somehow, also contributed to this attitude. Gessler et al., for example, argue that health care workers trained in western medicine have failed to recognize that African people have their own well-establish medical systems that is part of their cultural heritage and religious beliefs.[155]

Many sub-Saharan African immigrants also have a hard time accepting western medicine because of attitudes which have existed since missionary time. History shows that the cohabitation of Western medicine and traditional African medicine had never been easy. The

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[153] Cathy A. Petti, Christopher R. Polage, Thomas C. Quinn, Allen R. Ronald, and Merle A. Sande, "Laboratory Medicine in Africa: Barrier to Effective Health Care," *Laboratory Medicine in Africa* 42, no. 6 (2006).

[154] Omar Ben Ahmed, "Managing Medical Migration from Poor Countries," *British Journal of Medicine* no. 331 (2005): 43-45.

[155] M. C. Gessler, D.E Msuya, M. H. Nkunya, A. Schar, M. Heinrich, and M. Tanner, "Traditional Healers in Tanzania: The Perception of Malaria and Its Causes," *Journal of Ethno-Pharmacology* 48, no. 3 (Nov 1995): 119-130.

success of the transference of Western medicine in Africa, is the result of active intellectual and cultural negotiations between missionary healers and African patients. Yet, Walima T. Kalusa provides an interesting discussion on this issue in the following quote:

> This article distances itself from scholarship informed by dominance-resistance debates. Driven by an awareness that the mission was a potent site of cultural negotiation, the article insists that conflicting ontologies of diseases and medicine between missionary healers and African patients scarcely prevented mutual healing interactions from taking place. Such healing interactions were the consequence of active intellectual and cultural negotiations in which both camps participated almost daily. In these negotiations, the article argues, each party wittingly and unwittingly incorporated into its medical system(s) the other idioms, images, and practices.[156]

From the very first day Western medicine was introduced to Africa there was the tendency to reject what Western medicine had to offer. Some African patients and their families were not ready to embrace the medical treatment provided in hospitals that were built by missionary organizations and colonial governments. For some reason, this mentality is still in full force to this day. There are many African people who prefer to be treated with the traditional African healing system rather than reporting to modern health-care institutions. According to Shanti Ghos:

> Traditional health workers are another assistant which we cannot afford to ignore because traditional medicine will remain the only source of care for many people in the developing countries where the organized health services provide only 10% of the medical care; another 10% is provided by qualified physicians, and the balance is split between home care and indigenous practitioners. There is no indication that traditional systems are losing their influence. Not only does traditional medicine make a significant contribution to the medical care of the people in rural areas, it is fairly prevalent in cities also, and one has noticed a resurgence of its popularity in recent years.[157]

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[156] Walima T. Kasula, "Missionary, African Patients, and Negotiating Missionary Medicine at Kalene Hospital, Zambia, 1906-1935," *Journal of Southern African Studies* 40, no. 2 (2014): 285.

[157] Shanti Ghosh, "Primary Health Care for Developing Countries," *Indian Pediatrics* 20, no. 3 (Apr 1983): 240.

Given this, it must be understood that for many sub-Saharan African immigrants who have experienced illness away from their countries of origin traditional medicine, this is constantly present in their minds. Thus, many of them believe in herbal medicine and still consider it to be the best source of healing. Many sub-Saharan African immigrants who come to the United States hospital do not come to a health care institution via personal conviction, but they feel forced to United States hospital because the traditional African medicine is not part of the health care orthopraxy in western countries. In fact, this argument is not simple speculation, it was well documented in one study published by Homes Venters and Francesca Gany expressed in the following words:

> Another aspect of life for African immigrants that bears on health is traditional medicine and healing. These practices involve the use of herbal medicine and may represent an overlap between traditional dietary and medical practices. A survey of over 500 Ghanaians living in Canada revealed that 75% retained a positive attitude about traditional medical practices. Although there have been no published surveys concerning traditional medicine practices among African immigrants in the U.S., our experience with several African advocacy organizations in the N.Y.C. area supports the idea that traditional medicine and traditional healers maintain a robust role in the lives of newly arrived Africans.[158]

One may wonder if this statement is not in contradiction with the fact that many rich African people travel to Western countries for treatment when they are sick, which raises the question if traveling to Western countries for medical treatment is not a clear indication that African people have fully embraced Western medicine as the only source of care? This is an interesting question. Honestly, it seems that way and could also be true to certain people, mostly those who are acculturated. However, even with that, coming to the United States hospital does not take away the fact that many African immigrant patients still believe in the traditional concept of pain, suffering and illness, and consequently believe in traditional medicine.

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[158] Venters and Ganey, 339.

Pastoral Care and Patient Satisfaction: A Literature Review

History of medicine in the United States suggests that measuring and reporting on the quality of health care services might have its founding moment in October 1965. As of today, the historical work of Avedis Donabenian, an immigrant physician and professor of medical care organization at the University of Michigan, is the most significant contribution that has helped the birth of the contemporary health care quality movement.[159] Ayanian and Markel stated that:

> His formative work was already known to readers of the Journal, including a 1963 article on administrative controls in medical care. When the conference paper was published in July 1966, Donabedian could not have anticipated that his article, "Evaluating the Quality of Medical Care," would become one of the most frequently cited public health articles of the next fifty years. More important, this article has become the nucleus of his influential body of work on the theory and practice of quality assurance and the merging field of health services research.[160]

It must be recognized that since the past few decades, research on patient satisfaction has become a very productive field. Research in this field evidence that:

> Measuring and reporting on patient satisfaction with health care has become major industry. The number of MEDLINE articles featuring "patient satisfaction" as a key word has increased more than 10-fold over the past two decades, from 761 in the period of 1975 *through* 1979 to 8,505 in 199.3 through 1997. Patient satisfaction measures have been incorporated into reports of hospitals and health plan quality, and armies of consultants make a good living selling software packages to health care providers to access their customers' reactions by telephone, fax, modem … reams of patient satisfaction reports sit on the desk of every health care administrator in America.[161]

Every year there is an incredible number of studies conducted in academic circles and health care institutions to investigate the quality of the delivery of health care. *The Journal of the American Medical Association, Journal of Palliative Care Medicine, International Journal for*

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[159] John Z. Ayanian and Howard Markel, "Donabedian's Lasting Framework for Health Care Quality," *New England Journal of Medicine* 375, no. 3 (July 21, 2016), 205-7.

[160] Ayanian and Markel.

[161] Richard L. Kravitz, "Patient Satisfaction : Critical Outcome or Trivial Pursuit?" *Journal of General Internal Medicine* 13, no. 4 (1998): 280-282.

Quality in Health Care and online resources such as MEDLINE are examples of sources that have published studies on patient satisfaction in health care settings. Patient satisfaction studies have become so important to health care institutions that currently there are institutions that even hire consultants to perform patient satisfaction studies for them.

Yet, the medical literature shows that even though limited research studies have focused on patient satisfaction in developing countries, there are institutions that are investing a lot of resources to demonstrate that they understand the importance of patient satisfaction studies in today's world. Articles such as "Patient Satisfaction in Developing Countries"[162] and "The Role of Quality Improvement in Strengthening Health Systems in Developing Countries," are perfect evidence of this.[163]

In several countries of Africa, research in patient satisfaction with the quality provided in health care institutions is still at the embryonic stage. While some countries in Africa have not even started to focus on patient satisfaction studies, there are countries where limited studies could be found. This should not surprise anyone because even in the Western world research on patient satisfaction has only reached its peak in the last few decades. Mostly since the emergence of professional institutions specialized in patient satisfaction studies in health care institutions such as Press Ganey.

In many African countries, such as Democratic Republic of Congo, Gabon, Central Africa Republic and many more, as of today, there are no existing professional institutions that are specialized in patient satisfaction studies. However, it must be recognized that there are a

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[162] Sheila Leatherman, Timothy G. Ferris, Donald Berwick, Francis Omaswa, and Nigel Crisp, "The Role of Quality Improvement in Strengthening Health Systems in Developing Countries," *International Journal for Quality in Health Care* 22, no. 4 (2010): 237-243.

[163] Michael H. Berhart, I. G. P. Wiadnyana, Haryoko Wihardjo, and Imbalos Pohan, "Patient Satisfaction in Developing Countries," *Social Science and Medicine* 48, no. 8 (1999), 989-996.

number of countries in the continent that have conducted patient satisfaction studies in health care institutions which indicate the interest of these countries to measure the quality of care provided to patients and families in health care institutions. This is the case of Tanzania,[164] South Africa,[165] and Ethiopia,[166] to name just a few.

Another perspective is that research on patient satisfaction is now a vast industry that has taken different directions. There are studies on patient satisfaction that focus on designing tools to be used to measure patient satisfaction in the health care setting, whether it means inpatient or outpatient care. There are studies which investigate the experience of the patient in the context of the treatment of a specific disease (cancer, heart failure, chronic illness…) while other studies research the experience of a patient in a specific unit of the hospital (Intensive Care, cardiac stepdown, radiology…) or sometimes a department such as nursing, the hospitalist, and clinical nutritionist in general. Given this, patient satisfaction could be performed in any specialty that operates in health care institutions.

Another preoccupation of the researcher, in this chapter, is exploring the contribution of healthcare chaplaincy to the literature on patient satisfaction. This provides evidence that chaplains are also actively involved in this endeavor. Specifically, in the effort of evaluating the satisfaction of patients with the delivery of spiritual care during hospitalization in the United States hospitals.

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[164] Kudhra Khamis and Bernard Njalu, "Patients' Level of Satisfaction on Quality of Health Care at Mwananyamala Hospital in Dar-es-Salam, Tanzania," *BMC Health Services Research* 14, no. 400 (2014).

[165] Wilfired N. Nunu and Pascalia O. Munyewende, "Patient Satisfaction with Nurse-Delivery Primary Health Care Services in Free State and Gaunteng Provinces, South Africa: A Comparative Study," *African Journal of Primary Health Care & Family Medicine* 9, no. 1 (April 2017): e1-e8.

[166] Taklu Marama, Hinsermu Bayu, Muluaalem Merga and Wakgari Binu, "Patient Satisfaction and Factors among Clients Admitted to Obstetrics and Gynecology Ward of Public Hospital in Mekelle Town, Ethiopia: An Institution-Based Cross-Sectional Study," *Obstetrics and Gynecology International* 18 (2018), 1-9.

The pastoral care literature establishes that even though health care chaplaincy is a relatively new discipline, the waves of the health care quality movement have also impacted the profession, since many years ago, sparking a special interest in this topic. Therefore, in the health care chaplaincy field, Larry VandeCreek has the merit to be known as one of the most influential people in this field. VandeCreek was the Assistant Director of the Department of Pastoral Care and Associate Professor in the Department of Family Medicine and Neurology at the Ohio State University for many years. VandeCreek has largely contributed to the patient satisfaction literature in health care chaplaincy.

Through his writings on hospital chaplaincy, VandeCreek has also helped raise the awareness of the importance of the measurement of quality in the delivery of pastoral care in hospitals among chaplains, which the researcher believes to be the second most powerful shift in the history of the profession after Anton Boisen founded the Clinical Pastoral Education (CPE) movement.

According to the pastoral care literature, in 1992 VandeCreek published the article entitled "Preliminary Results from a Patient Satisfaction Instrument for Pastoral Care." Before the publication of this article, the field of health care chaplaincy did not have any tools specifically designed to perform patient satisfaction studies with chaplaincy care services. VandeCreek stated this in the following words "We found no published patient satisfaction instrument (PPSI) especially developed for the evaluation of pastoral services." [167]

[167] Larry VandeCreek and Marjorie A. Lyon, "Preliminary Results from a Patient Satisfaction Instrument for Pastoral Care," *The Care Giver Journal* 9, no. 1 (1997): 42-43.

A few years later, VandeCreek and Lyons published the article "Ministry of Hospital Chaplains: Patient Satisfaction."[168] This article is the landmark work of VandeCreek that experts in the field of health care chaplaincy consider to be the first-rate case study on how to use statistics in pastoral care research.[169] Several professional chaplains responded to the content of the article through publications in the *Journal of Health Care Chaplaincy*, one of the leading journals in health care chaplaincy published by the Association of Professional Chaplains. Respondents included Michael Bostian,[170] George Handzo,[171] and Mary Westhone-Robinson.[172] This article gained a lot of attention so that, later, it was reprinted in a chapter-book format that the pastoral care literature recognizes as the first book on patient satisfaction with the delivery of pastoral care in health care institutions.[173]

The researcher believes that reactions to this article and the reprint of this article is the echo of the recognition by the professional chaplains' community of the importance of measuring the effectiveness of pastoral care in a health-care setting. After these contributions, a new interest in patient satisfaction with hospital spiritual care was observed in the field. Hence, discussions on patient satisfaction with spiritual care in hospitals gained more attention in the

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[168] Larry VandeCreek and Marjorie A. Lyon, "Ministry of Hospital Chaplains: Patient Satisfaction," *Journal of Health Care Chaplaincy* 6, no. 2 (1997), 1-61.

[169] George Handzo, "Response to: Ministry of Hospital Chaplains: Patient Satisfaction," *Journal of Health Care Chaplaincy* 8, no. 1-2 (1998): 127-130.

[170] Michael D. Bostian, "Response to: Ministry of Hospital Chaplains: Patient Satisfaction," *Journal of Health Care Chaplaincy* 8, no. 1-2 (1998): 123-126.

[171] Handzo, "Response," 127-130.

[172] Mary S. Whetstone-Robinson, "Response to: Ministry of Hospital Chaplains: Patient Satisfaction," *Journal of Health Care Chaplaincy* 8, no. 1-2 (1998): 131-136.

[173] Larry VandeCreek and Marjorie A. Lyon, *Ministry of Hospital Chaplains: Patient Satisfaction* (New York: The Haworth Press, 1997).

chaplaincy profession and became subject to active research. A few years later, for example, Kevin Flannely, Kathleen Galek and George Handzo published another instrument to measure the effectiveness of pastoral care with family members of the hospitalized patients.

Healthcare chaplaincy literature recognize that Dr. Larry VandeCreeck and his colleagues did extensive research on the spiritual care needs of hospitalized patients. Hence, they used various assessment tools to study patient satisfaction with spiritual care services provided to patients. However, they observed that Dr. Larry VandeCreeck and his colleagues did not try to develop a comprehensive scale to measure family satisfaction like they did for patients.[174]

The development of these instruments gave birth to a new perspective of the practice of hospital pastoral care; a perspective grounded on the idea that the utilization of research to evaluate the quality of ministry plays an important role in sustaining the efficacy of the pastoral ministry provided to people to entrust their care in those who care for them. That is the reason, nowadays, research on patient satisfaction with pastoral care has become a productive field. Given that, the researcher has no hesitation to say that these measurement instruments have become the catalyst for change in clinical pastoral care, forcing health care chaplaincy to get out of its comfort zone.

Several professionals in health care chaplaincy have desired to see health care chaplaincy embracing the contemporary quality movement. In one study that reviewed the literature on pastoral care in hospitals, Proserpio et al., for example, reported that there was a need for further studies in several areas of the discipline, including patient satisfaction:

> More than a third of the articles concerned the efficacy and the scientific nature of the service provided by hospital chaplains. These studies generally emphasized the need to publish research, reviews and quality analyses with a view to documenting the effectiveness of the chaplain's activities and to measuring the results, validating the

[174] Kevin J. Flannelly, Kathleen Galek, and George Handzo, "A Preliminary Proposal for a Scale to Measure the Effectiveness of Pastoral Care with Family Members of Hospitalized Patients," *The Journal of Pastoral Care & Counseling* 61, no. 1-2 (2007): 19-29.

> methods adopted, and assessing the quality of this service and the patient satisfaction with the chaplain's work, in order to avoid their role being considered only a marginal aspect of public health services.[175]

This quote underlines an important notion that is constantly being debated in health care chaplaincy today. It is the notion of research. The lack of research in health care chaplaincy has a damaging consequence on the future of the field. In other words, there is a lack or a shortage of research that chaplains could use to build the practice of spiritual care that could have a positive influence on the work of hospital chaplains. This is essential to understand because there is a correlation between research and clinical pastoral practice. Research allows professions to improve competence. As Proserpio et al. suggest, further studies on patient satisfaction could produce new knowledge and advance health care chaplaincy as it does to research-informed disciplines. This is a pivotal obstacle for the survival of the profession because it downsizes the authority of professional chaplains among other health care professionals.

Thus, the good news today is that, while organizations such the Association for Professional Chaplains is promoting the culture of research in the profession, there are studies that provide evidence that chaplains have embraced a more positive attitude toward research and have become more open to it.[176] This is contrary to the time that Larry VandeCreek wrote the book *A Research Primer for Pastoral Care and Counseling,*[177] where he devoted a whole section to explain the reasons chaplains do not like to do research. Given that, there are more research

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[175] Tillio Prosperio, Claudia Piccinelli, Carlo Alfredo Clerici, "Pastoral Care in Hospital: A Literature Review," *Tumori Journal* 97, no. 5 (September-October 20211), 667.

[176] George Fitchett, Jason A. Nieuwsma, Marc J. Bates, Jeffrey E. Rhodes, and Keith G. Meador, "Evidence-based Chaplaincy Care: Attitudes and Practices in Diverse Healthcare Chaplaincy Samples," *Journal of Health Care Chaplaincy* 20, no. 4 (2014).

[177] Larry VandeCreek, *A Research Primer for Pastoral Care and Counseling* (Chicago: Journal of Pastoral Care Publications, 1988), 7-17.

studies published in health care chaplaincy these days than there were at the end of the last century. Nowadays, patient satisfaction with the delivery of pastoral care in health care institutions is a topic that has gained an increase of interest in pastoral care literature.

As of today, several patient satisfaction studies with pastoral care in hospitals have been reported. Below are a few examples that make the case for health care chaplaincy:

- Studies indicate that about 70 percent of patients are aware of one or more spiritual needs related to their illness.
- Studies of patients in acute care hospitals establish that between one third and two thirds of all patients want to receive spiritual care.
- Studies indicate that patients are likely to choose that institution again for future hospitalization when chaplains help a family member of the patient during hospitalization.
- Another study reports that a large majority of patients were highly satisfied with spiritual care provided by professional chaplains. The same study shows that the satisfaction of family members of patients was higher than the satisfaction of patients. In addition, participants in this study reported that the chaplain's visit "made the hospitalization easier" because the visit brought them "comfort" and helped the patient to relax. This large study indicates that chaplains' visits helped patients "get better easier" and enhanced their "readiness to go back home" because of the impact of the visit on them.[178]

In addition, in the October 2016 publication of the Health Care Chaplaincy Network, entitled *Spiritual Care: What It Means, Why It Matters in Health Care,* the authors reported the following findings:

- A study of about 9,000 patients conducted at the Mount Sinai Hospital in New York, concluded that chaplains' visits increase patients' willingness to recommend the hospital. This conclusion is consistent with other studies on patient satisfaction released by both Press Ganey and Medicaid Services' Survey, Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS).
- One study of the Saint Vincent Comprehensive Cancer Center indicates that patients who have been unable to have their spiritual needs adequately met during hospitalization are more likely to have low satisfaction. In other words, their rating and satisfaction with their care and the quality of care received is significantly lower.

[178] VandeCreek and Burton, 14.

- Another study from the University of Chicago-Pritzer School of Medicine concluded that addressing spiritual needs of patients positively has a double impact. First, it influences patient satisfaction. Second, it increases trust in the medical team.[179]

These studies, for example, provide an overview of the contributions of health care chaplaincy to the debate on Quality Improvement (QI) in health care institutions. Given that, it is correct to affirm that health care chaplaincy has not remained absent in circles where QI in health care institutions is the center of discussion.

There are several studies available on patient satisfaction in the pastoral care literature, but it must be recognized that there is the need for more research. For instance, until this day, the literature shows that there is limited data that evidence that chaplain's visits are associated with meeting patient's spiritual needs and that chaplain's visits improve patient satisfaction scores.[180] Furthermore, there is no study available on patient satisfaction with African immigrants who are the consumers of health care in the United States regardless of the African immigrant's utilization of health care institutions.

The following research subscribes to the idea of filling the gap in this matter to contribute to the debate on QI in hospital pastoral care with African patients and families in the United States. This is an important task of health care chaplaincy in the era that the holistic approach to health care requires each field involved in health care delivery to best promote "excellence" in

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[179] Eric J. Hall, Brian P. Hughes, and George H. Handzo, "Spiritual Care: What It Means, Why It Matters in Health Care," *Healthcare Chaplaincy Network,* October 21, 2016, https://www.researchgate.net/publication/309346734_Spiritual_Care_What_It_Means_Why_It_Matters_in_Health_Care.

[180] Deborah B. Marin, Vanshdeep Sharma, Eugene Sosunov, Natalie Egorova, Rafael Golstein, and George F. Handzo, "Relationship Between Chaplain Visits and Patient Satisfaction," *Journal of Health Care Chaplaincy* 21, no. 1 (2015): 15.

the delivery of health care, a noble opportunity that gives meaning to the active role of chaplains in modern hospitals.

Summary

In this chapter the researcher has spent a significant amount of time discussing the emergence of patient satisfaction studies in health care chaplaincy. The chapter argues that the field of health care chaplaincy is not passively observing the consequence of the QI movement in the medical field. Professional chaplains have joined the "dance" and are fully aware of the importance of these studies for the development of professionalism in the field.

Professional chaplains are aware that joining the Quality Improvement movement benefits and ensures the growth of the profession, giving health care chaplaincy a stronger voice in public discussion about health and healing. The chapter began with a discussion on certain philosophical, and sociocultural factors that the researcher believes to have some degree of influence on sub-Saharan African patients and their families' experience in the United States hospital. The chapter ends with an overview of the state of research that has been done, as of this day, on patient satisfaction and pastoral care in the health care chaplaincy literature.

Researching the pastoral care literature on this issue was not only interesting but also very enlightening. First, the researcher found out that, as of today, there is no study, in the pastoral care literature, that evaluates the patient experience of sub-Saharan African immigrants with pastoral care services provided to them in the United States hospital. This is an important point because it establishes the originality of this research project. Second, the lack of studies available on this pertinent subject creates a need. It is the need to study this problem and create data that can provide a sense of directions to the need for an evidence-based approach.

Chapter Four

Research Methodology and Procedures

Background Information on This Study

It is essential to explain that the following research project was birthed by the researcher's desire to contribute to the evidence-based approach to pastoral care, which, nowadays, has become one of the driving forces in the delivery of pastoral care in health care institutions in the Western world, in general, and in North America in particular. There is currently a vast and very diversified number of studies in health care chaplaincy arguing that the profession of chaplaincy has reached a critical phase of its history in the last two decades. Hence, current health care dynamics affect how pastoral care should be delivered daily, which requires more research like this research study. New questions arising from the changes occurring in health care institutions oblige professional chaplaincy to reflect on best practices in health care delivery. Neglecting this task is a significant error that would strangle the profession because ignoring research in health care chaplaincy does not advance health care chaplaincy. Contrarily, it slowly and surely prevents it from developing at the same rhythm as other health care disciplines such as medicine, nursing, pharmacology, and allied health care professions that consider relying on research mandatory.

Publications of Larry VandeCreek, who was the director of the department of Pastoral Care at the Wexner Hospital of Ohio State University, suggest that he is one of the first professional chaplains who had developed an interest in patient satisfaction studies in health care chaplaincy.[181] As of this day, there is an increasing number of research articles and studies

[181] See Chapter Three pages 31-34.

published in the field. The researcher's focus of this study investigates the delivery of pastoral care to a specific category of patients who come to the United States Hospitals (USH): African immigrants from the sub-Saharan region of Africa. Yet, the researcher has found no evidence of previous studies on patient satisfaction of sub-Saharan people who utilize the United States hospital in the pastoral care literature.

In one article entitled "Recent Progress in Chaplaincy Care,"[182] George Fitchett provides an overview of studies available in chaplaincy-related research. This article ends with some perspectives on new areas that health care chaplaincy will need to explore in the future. Thus, this article establishes that there are six areas of research that have already gained the attention of researchers in this field: what the chaplain does, the importance of religion and the spiritual care to patients; the impact of the chaplain's spiritual care on the patient's experience, the impact of chaplain care on other patient outcomes, spiritual needs, patient care in palliative and end-of-life care, and chaplain care for staff colleagues.[183]

This article also suggests several new areas of study that will advance the field of health care chaplaincy. For example, research on spiritual care initiatives in outpatient services studies the effects of those initiatives in the delivery of pastoral care.[184] The underlying idea under this topic is that these studies will potentially allow health care chaplaincy to have a smooth transition to outpatient services since US health policy is currently shifting toward a new paradigm identified as prevention of illness and hospitalization.[185] Another article published in

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[182] George Fitchett, "Recent Progress in Chaplaincy," *Journal of Pastoral Care and Counseling* 71, no. 3 (2017), 163-167.

[183] Ibid.

[184] Fitchett.

[185] Ibid.

2018, discusses priorities in chaplaincy care-related research. The article is entitled, "Research Priorities for Health Care Chaplaincy: Views of the U.S. Chaplains."[186]

Authors of this article argue that chaplains in the United States and worldwide appear to support an evidence-based practice approach to chaplaincy care. The article reports on a study that investigated the opinions of healthcare chaplains who participated in a survey distributed at four chaplaincy conferences in 2016. According to this article, 193 chaplains participated in the survey resulting in 499 comments about research priorities for healthcare chaplaincy. This study indicates that research priorities in healthcare chaplaincy must be: research on outcomes of spiritual care, the development, and testing of the effectiveness of interventions, the development and evaluation of assessments and screening tools, and about subgroups of patients.[187]

There is another important article that is worth mentioning in this section. The article was recently published in the *Journal of Pastoral Care and Counseling*. The title of this article is "Mapping the Health Care Chaplaincy Literature: An Analytical Review of Publication authored by Chaplains and Theologians Between 2000 and 2018."[188] The authors investigated 199 publications written by chaplains and theologians in this article. The authors identify five key trends that have dominated health care chaplaincy literature. Those trends are the following:

> Chaplains' practice: what health care chaplains do or ought to do and how they are perceived in health care settings. (36% of publications)
> Spirituality: studies on spirituality, illness, and spirituality as an object of health care. (18% of publications.)
> Research: research promotion, methodological advice, spiritual assessments (25% of publications).

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[186]Annelieke Damen, Allison Delaney, and George Fitchett, "Research Priorities for Healthcare Chaplaincy," *Journal of Healthcare Chaplaincy* 24, no. 2 (Apr-Jun 2018). 57-66.

[187] Ibid.

[188] Emmanuelle Poncin, Pierre-Yves Brandt, Francois Rouiller, Mario Drouin, and Zhargalma Dandarova Robert, "Mapping the Healthcare Chaplaincy Literature: An Analytical Review of Publications Authored by Chaplains and Theologians Between 2000 and 2018," *Journal of Healthcare Chaplaincy* 26, no. 1 (2020): 16-44.

> Impact of spiritual care: outcomes of spiritual care on patients/families, chaplains, and other health care professionals. (13% of publications).
> Spiritual care practices of health care professionals: including training and referrals. (8% of publications).[189]

These studies appear to evaluate the outcome of health care chaplaincy in health care institutions as an essential endeavor. Investigating the satisfaction of sub-Saharan Africans with the delivery of pastoral care subscribes to this effort. This research project is original because the health care chaplaincy literature does not provide any proof that there are previous studies that research this issue. This explains the joy and dedication of the researcher in this project. Moreover, it must be noted that in this chapter, the researcher is referencing the following research questions stated in chapter one of this project:

1. When sub-Saharan African immigrants are hospitalized in the United States hospital, how satisfied are they with their knowledge of how to receive chaplaincy services?
2. What was the satisfaction level of sub-Saharan patients and families with chaplaincy services that were provided by the United States hospital?
3. What can the study on sub-Saharan African patients' and family's satisfaction with pastoral care in the United States hospital teach us about how pastoral care was delivered to them?

Before diving in-depth into the research, it must be clarified that the researcher's philosophy used familiar and established approaches, because, as noted in the book *Designing*

[189] Ibid, 19 and 21.

Clinical Research, the process of developing new methods and skills, can be time-consuming and uncertain.[190]

Design, Research Method, and Procedures

Type of Research

This research study investigated the satisfaction of a specific group of immigrants that lives in the United States of America and utilizes the United States health care systems when they are sick and need medical care: African immigrants originally from the sub-Saharan region of Africa.[191] This kind of research project is identified as an outcome research study. This is because the study aimed to evaluate the outcome of pastoral care that was delivered to a specific group of people. The article "Mapping the Health Care Chaplaincy Literature: An analytical Review of Publications Authored by Chaplains and Theologians Between 2000 and 2018,"[192] indicates that as of today, outcome health care research represents only 13% of publications in pastoral care literature.

This percentage shows that there is a need for further outcome research studies for health care chaplaincy. There is another study that surveyed a total of 193 chaplains that was compared with other research on the priorities for research in health care chaplaincy that agrees that outcome research is among the top priorities for health care chaplaincy today.[193] These studies

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[190] Stephen B. Hulley, Steven R. Cummings, Warren S. Browner, Deborah Grady, Norman Hearst and Thomas B. Newman, *Desining Clinical Research: An Epidiemologic Approach* (Philadelphia: Lippincott Williams & Wilkins, 2001), 19.

[191] See the map of participants' countries selected for this research in the page 13 of Chapter One.

[192] Poncin, Brandt, Rouiller, Drouin, and Robert, 19-21.

[193] Damen, Delaney, and Fitchett.

support the thesis that there is a need for more research in chaplaincy care to build chaplaincy as a profession.

One may ask why outcome research is vital for health care chaplaincy. Annelieke Damen et al. answered this question in one article arguing, "outcome research is essential for quality development within the profession because chaplains need to know if they care and deliver results in the outcome they hope to achieve."[194] Moreover, outcome research is also a critical factor in developing the evidence-based approach that is currently the driving force of health care chaplaincy in the third millennium.

Selected Research Methods

This research project utilized a mixed-method approach. This method has been used in several health care chaplaincy studies and other pastoral research focusing on the measurements of the experience of a particular group of people in a specific situation. Yet, nowadays, the mixed method has proven to be very efficient in evaluative research. The mixed method for this research includes both quantitative and qualitative measurements.

Participants were required to complete two screening questions before proceeding with the survey. The first question was: "Have you ever been admitted to US Hospitals for maternity or illness?" Ninety-Three participants responded to this question. Participants who were never admitted to a United States hospital were automatically exited from the survey. Those who had been admitted to a United States hospital were asked to respond to the second screening question.

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[194]Annelieke Damen, Carmen Schuhmann, Carlo Leget, and George Fitchett, "Can Outcome Research Respect the Integrity of Chaplaincy? A Review of Outcome Studies," *Journal of Healthcare Chaplaincy* 26, no. 4 (2020), 132.

The second question was: "Were you visited by a chaplain or other pastoral care provider during your recent hospital stay?" Sixty-four participants responded to this question. Those who responded negatively were also automatically exited from the survey. Only 22 participants were qualified to proceed with the electronic survey. This is a small sample that the researcher did not anticipate and recognized earlier in the first chapter as a weaknesses of this research project.

Quantitative Research Data

Characteristics

The article, "A Methodological Analysis of Chaplaincy Research: 2000-2009,"[195] identifies 49 quantitative studies in the field of health care chaplaincy from the year 2000 to 2009. This article discusses methods that are currently in use in chaplaincy research. The article also shows that there is a great deal of evidence available about the utilization of this method in chaplaincy research today.

One of the particularities of this research method is using statistics in the analysis of data. In William R. Myers words, the quantitative method, "attempts to measure available data through a sequence of increasingly sophisticated statistical programs."[196] The researcher for this project also utilized the statistical approach to analyzing data and elaborating conclusions. The researcher used a mathematical approach that was supported by graphics to ensure an accurate interpretation of the results.

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[195] Kathleen Galek, Kevin J. Flannelly, Katherine R. B. Jankowski, and George Handzo, "A Methodological Analysis of Healthcare Chaplaincy Research: 2000-2009," *Journal of Healthcare Chaplaincy* 17, no. 3-4 (2011), 127.

[196] William R. Myers, *Research in Ministry: A Primer for the Doctor of Ministry Program* (Eugene: Wipf and Stock Publishers, 2009), 21.

Data Collection Methodologies

While the project uses a mix method approach, the researcher applied a quantitative instrument for the initial portion of the research. This research was not based on any existing data from a previous study. The instrument used was a survey. It was not a blind survey. The researcher developed a Windows Excel Form that was used to log in information about the volunteers who agreed to participate in the data collection process. This form contained some basic demographic information of participants, such as email addresses to facilitate the process of sending the survey questions to them. The researcher sent the patient satisfaction survey questions to a total of 204 participants who voluntarily agreed to participate in this data collection process. Both the electronic survey and the interviews were conducted in the English language. A total of 22 completed and usable surveys were ultimately received. A further discussion of the results will be provided in a later chapter.

Measurement and Instruments

In the process of selecting the best instrument to use in this research, the researcher contacted two experts in this field to discuss their opinions: George Handzo [197] and George Fitchett.[198] Both of these gurus in health care chaplaincy research encouraged the researcher to use instruments that are already available in the discipline. Neither of them suggested or encouraged the use of a new instrument, which the researcher found interesting. In addition to

[197]George Handzo, email correspondence with the researcher, January 19, 2018. George Handzo is recognized as one of the experts in healthcare chaplaincy research. He is a board-certified chaplain with over 30 years of experience and has extensively published on topics related to healthcare chaplaincy. For more information, see http://www.handzoconsulting.com/.

[198] George Fitchett, email correspondence with the researcher, January 22, 2018. George Fitchett is a professor and Director of Research in the Department of Religion, Health, and Human Values at Rush University in Chicago, Illinois. He is also active in research at Transforming Chaplaincy. For more information, see https://www.transformchaplaincy.org/

them, Stephan B. Halley et al., also argues on behalf of the use of familiar and established approaches in clinical research.[199] The researcher agrees with their opinions because these instruments have proven to be efficient in previous studies as discussed previously.

Two reasons justify the validity of this opinion. First, it has been proven to be a straightforward strategy. Second, it is an opportunity to test the instrument and evaluate its strengths and weaknesses. George Handzo also observed that it will be fascinating to see what result the selected instrument produced after the study.

Their advise seemed a little confusing because of the rise in patient satisfaction studies in the health care setting today and the large variety of instruments available for such research. This made it a little difficult for the researcher to select which instrument to use. To date, some of the most popular instruments used for patient satisfaction studies in health care institutions are the Hospital Consumer Assessment of Healthcare Providers and Systems (HAHPS) and Press Ganey patient satisfaction surveys. For instance, many hospitals evaluate patient satisfaction with Press Ganey patient satisfaction surveys. These instruments are well known for their efficacy. They are proven to produce accurate and valuable feedback in health care patient satisfaction studies.

However, after examining them, the researcher struggled to select them for this research project because the questions they ask are not relevant to this research project. The main argument is that HCAHPC and Press Ganey surveys were not developed for the strict purpose of investigating patient experience with the delivery of pastoral care. Patient satisfaction with health care chaplaincy studies requires appropriate scales. These instruments use generic scales because they were not intentionally designed for health care chaplaincy research. Consequently, the

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[199] Hulley et al., 19.

researcher found them to be inappropriate for this project and decided not to use them in this research study.

The researcher explored other instruments. Pastoral care literature reports the existence of another instrument developed by George Fitchett that has been used in previous patient satisfaction research with health care chaplaincy. Flannelly et al. developed an instrument a few decades ago to evaluate the satisfaction of families of patients. Since this instrument did not measure the satisfaction of the hospital patient, but rather the satisfaction of the patient's family, the researcher chose not to use this medium.[200]

In the article "Patients' Satisfaction with Health Care Chaplaincy and Affecting Factors: An Exploratory Study in the German Part of Switzerland,"[201] the authors discuss the existence of more instruments, which is also the case in the article "A Methodological Analysis of Chaplaincy Research: 2000-2009."[202] These two articles are excellent materials for researchers seeking further information on instruments and methodologies for patient satisfaction with health care chaplaincy. At this point, the focus of the research is not to discuss these articles but to clarify that there are several instruments available to measure the efficacy of the work chaplains provide in health care institutions.

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[200] Kevin J. Flannelly, Kathleen Galek, Helen P. Tannenbaum, and George Handzo, "A Preliminary Proposal for a Scale to Measure the Effectiveness of Pastoral Care with Family of Members of Hospitalized Patients," Journal of Pastoral Care & Counseling 61, no. 1-2 (2007): 19-29.

[201] Urs Winter-Pfandler and Christoph Morgenthaler, "Patients' Satisfaction with Health Care Chaplaincy and Affecting Factors: An Exploratory Study in the German Part of Switzerland," *Journal of Healthcare Chaplaincy* 17, no. 4-5 (2011), 146-161.

[202] Galek, Flannelly, Jankowski, and Handzo.

For this research project, the researcher selected the instrument called Patient Satisfaction Instrument Chaplaincy developed by VandeCreek and Lyon.[203] Thus, the Patient Satisfaction Instrument Chaplaincy (PSI-CR) is the upgraded version of the Patient Satisfaction Instrument (PSI-C) developed by Larry VandeCreek. The Patient Satisfaction Instrument (PSI-CR) is composed of 23 Clinical items organized under four significant scales:

- Ministry that promotes coping
  - The chaplain helped me realize God cares for me.
  - The chaplain visit made my hospitalization easier.
  - The chaplain helped me use my faith/beliefs/values to cope.
  - The chaplain helped me feel more hopeful.
  - The chaplain's visit gave me the strength to go on.
  - The chaplain's visit aided my spiritual growth during illness.
  - The chaplain helped me face difficult issues.
  - The chaplain helped me overcome my fears.
  - The chaplain helped me adjust to my medical condition.
  - The chaplain's visit contributed to my readiness to return home.
  - The chaplain's visit contributed to a faster recovery.
  - The chaplain helped the clergy of my congregation understand my situation.
  - The chaplain helped me cooperate with the doctors and nurses.
- The supportive ministry of chaplains
  - The chaplain's prayer was a comfort to me.
  - The chaplain gave the impression s/he was really listening to me.
  - The chaplain seemed to know what s/he was doing during the visit.
  - The religious worship service met my needs.
  - My needs for the sacraments were fulfilled.
  - After talking with the chaplain, I felt better about my problems.
- Acceptance of the chaplain's ministry
  - The chaplain's visit scared me.
  - The chaplain talked too much.
  - The chaplain's visit made me too tired.
- Independent item
  - The chaplain seemed to be a person of spiritual sensitivity. [204]

[203]VandeCreeck and Lyon, "Preliminary Results."

[204] Christina Beardsley, "In Need of Further Tuning: Using a US Patient Satisfaction with Chaplaincy Instrument in a UK Multi-Faith Setting, Including the Bereaved," Clinical Medicine 9, no. 1 (February 2009): 53-58.

Furthermore, this Patient Satisfaction Instrument (PSI-CR) uses a Likert-type scale ranging from 1 to 5 (strongly disagree to strongly agree). The researcher proceeded with the same measurement technique to collect data. Hence, this instrument was developed in the United States and was tested in a study conducted at Chelsea and Westminster Hospitals in London by Christina Beardsley. In that study, Beardsley added one question that was not in the original Patient Satisfaction Instrument (PSI-CR): "What did you most like or dislike about the chaplaincy service?"[205] The researcher did not include this question in the survey. The survey and interview were in the English language.

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Description of Research Population

Participants in this project were African Immigrants from the sub-Saharan region of Africa who have utilized the hospital in the United States at any time of their stay in the country. The study focused on the satisfaction of participants who were once hospitalized in United States hospitals. Whoever had never been admitted in the United States hospitals for in-patient services was not allowed to participate in this study.

It is essential to clarify that the Cambridge Dictionary notes, an immigrant is "a person who has come to a different country to live there permanently."[206] This definition does not include people who have come to the United States for a temporary stay, for instance, a sub-Saharan African who has come to the US under a specific visa program with no intention to gain

[205] Ibid.

[206] "Immigrant," Cambridge English Dictionary, accessed March 1, 2020, https://dictionary.cambridge.org/us/dictionary/english/immigrant.

permanent resident status and make this country their second home. In this study, the word "immigrants" was used in a broader context. Be aware that it was also used in reference to sub-Saharan African people who have come to the United States for a temporary stay. Yet these are people who have encountered the delivery of pastoral care in the health care setting as an inpatient at least once during their stay in the United States. For example, international students, tourists, missionaries, and people who have come to the US for athletic competitions, artistic performances, professional gatherings, even those who have experienced some kind of discomfort during a layover at an international airport.

Sample and Sampling Instruments

Researching patient satisfaction in health care chaplaincy is an important task that requires the use of appropriate sampling instruments.[207] According to the scientific literature on sampling, several steps lead to a proper sample selection.[208] In simple terms, these steps could be described as follows: determining sample criteria, the sampling frame, and the sampling instruments.

First, the researcher developed a list of sample criteria. The role of this list was to determine the characteristics of qualified participants to be involved in the research project. This list provided demographic information such as age, gender, religion, country of origin, marital status, and illness. The research did not intend to involve subjects who lack decision-making capacity in this project, such as children, prisoners, or people who suffer from impaired decision-

[207] Jeovany Martínez-Mesa, David Alejandro González-Chica, Rodrigo Pereira Duquia, Renan Rangel Bonamigo, and João Luiz Bastos, "Sampling: How to Select Participants in Research Study?" *An Bras Dermatol* 91, no. 3 (May-Jun 2016): 326-330.

[208] Ibid.

making capacity or any behavioral health conditions. For instance, people who have been hospitalized for illnesses associated with memory deficiencies, such as Alzheimer's or mental health issues like schizophrenia or any other related illness. The consent form that participants signed had a question asking if the participant was hospitalized for any condition related to memory deficiency. The consent form also clarified that a person who has been hospitalized with such an illness could not be qualified to participate in this project.

Second, the sampling frame was identified. The term “sampling frame” is commonly used in social research and many other disciplines. It is defined as the database or the pool where qualified participants who compose the sample for the research are drawn. In this study, the researcher drew participants from different religious and social groups. For examples, from African immigrants’ churches, African immigrants’ cultural circles and associations, and international student organizations in colleges and universities.

The recruitment of participants in this research study was conducted in two ways. A letter of invitation was sent to potential participants. Those who agree to participate received a survey form and were allowed to opt-in for a follow-up interview. The researcher used the “word of mouth” approach. The researcher considered a random sampling approach to recruit participants, which was designed to make the survey accessible for every qualified sub-Saharan African immigrant who has experienced the United States hospital to participate in the study.

The researcher provided an orientation to each interview subject in which the researcher provided an informed consent form which included HIPAA consent and ensured that the subject met the requirements of good mental health. Subjects who were recently hospitalized were drawn from various physical health statuses but were screened during informed consent to ensure that their physical health would not impede their ability to participate. Participants in this project

were African Immigrants from the sub-Saharan region of Africa who have utilized the hospital in the United States at any time of their stay in the country. The researcher selected participants from African churches, organizations of African people, and African owned businesses. The research also used the word-of-mouth process, defined as an unpaid spread of information from one participant to another potential participant.

Qualitative Data

Characteristics

Raya Fidel notes that the qualitative method is different from the quantitative method, however, each method can use elements of the other.[209] The easiest way to establish the distinction between these two methods is to say that the qualitative method "… uses the data collection techniques of participant observation and intensive interviewing or data analysis techniques that are nonquantitative."[210] The qualitative method focuses on real-life situations as they unfold in one's experience, and aims to understand people from their own point of view, which introduces the use of case studies in the process. According to Fidel, this is the best method to study human behavior.

Techniques

A second instrument used as a component of the mixed method incorporated a qualitative tool. The researcher compared the results of the quantitative study to the results of the qualitative study to better analyze and interpret the data of the quantitative study. Thus, according to Fidel,

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[209] Raya Fidel, "Qualitative Methods in Information Retrieval Research," *Library & Information Science Research* 15 (1993), 265-272.

[210] Ibid.

who stated that the qualitative approach is the best method to study human behavior, justification was yielded for including the qualitative choice.[211] In this step, the researcher interviewed ten participants who agreed to the protocols and agreements articulated in the previous section. All interviews were conducted face-to-face. Participants were gracious enough to allow time for these interviews. Interviewees felt more comfortable to use the English language during these interviews. This allowed the collection of a large amount of qualitative data that was submitted to a systematic coding approach discussed in the book of Johnny Saldaña entitled: *The Coding Manual for Qualitative Researchers*.[212]

Protocols and Agreements

Yet academic research requires the respect of several ethical principles. This research considered the following principles: ethical integrity, respect for participants, the beneficence of the research project, justice, non-judgmental perspective, confidentiality, voluntary participation, and no harm to participants. Let the researcher explain.

Ethical integrity: the researcher committed himself to act with integrity during the whole research process. Pragmatically, this means that the researcher practiced fairness, decency, and honesty, as required in academic research, to promote the accuracy of the result of the study. The researcher communicated his commitment to ethical integrity to the prospective subjects early in the process to establish a sense of accountability in the research-participant relationship.

Respect for participants: the researcher agreed with Bernard Lo, who argues that "research participants are not a passive source of data, but individuals whose rights and welfare

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[211] Ibid.

[212] Saldaña, Johnny, *The Coding Manuel for Quantitative Researchers* (California: Sage Publications, 2016).

must be respected."[213] Therefore, the researcher demonstrated respect by obtaining informed consent to participates in the research. The main objective of the informed consent was to provide the participants with enough information about their rights associated with the research to allow them to make an informed decision regarding their participation in the research project.

The beneficence of the research project: the research was conducted for the benefit of others. As is the case in any health research, this study aimed to discover verifiable scientific new information that can enhance the delivery of pastoral care to sub-Saharan patients in the United States hospital and promote best practices in health care chaplaincy. Hence, the principle of beneficence, noted by Bernard Lo, requires that the research design be scientifically sound and that the research risks be acceptable with the likely benefit. Therefore, the researcher prevented anything that could cause harm, whether this meant physical harm or psychological harm, such as breaches of confidentiality, discrimination, and stigma. [214]

Justice: in any research, the principle of justice requires that the benefit and burden of research be distributed fairly. Therefore, the researcher treated every participant equally. In other terms, the researcher was committed to prevent any form of favoritism during the study and strove to provide the same conditions and experience to each participant.

Non-judgmental perspective: since the purpose of any research is to learn and produce new knowledge; the researcher was non-judgmental. This means that the researcher recognized personal biases concerning participant experiences and prevented them from making judgments. This is pivotal because, as a sub-Saharan immigrant who has also experienced the United States hospital as a patient, the researcher's experience somehow related to the participant's experience.

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[213] Hulley et al., 215.

[214] Hulley et al., 219.

Therefore, keeping a non-judgmental stance prevented the researcher from producing bias, which could poorly affect the objectivity of the results of the research study.

Confidentiality: the researcher pledged to keep participants' privacy because research with human subject does not authorize the researcher to divulge participants' personal information unless there are moral and legal obligations to prevent harm.[215] This research was not a group project. Therefore, the researcher was the only person who had access to information collected during the study. To protect the confidentiality of participants the researcher did not collect personal information such as name, date of birth, or address of the participant. When the participant agreed to participate in the project, he/she was required to sign a HIPPA Informed consent document. Data collected was stored in USB that was kept in a secured place that only the researcher could access. At the completion of the Doctor of Ministry program the researcher destroyed all information collected during the study and stored in a USB port. The materials destroyed included surveys, questionnaires, recorded audiotapes, consent forms and any electronic data. Materials were shredded, or erased from electronic files.

Voluntary participation: participation in this research project was based on a voluntary and an unpaid basis. The research clearly explained to participants that they had no obligation to participate in this research study. Participants were free to withdraw from this research whenever they liked without any obligations. However, the researcher encouraged participants to inform their desire to withdraw from the project as soon as possible.

Federal regulations: the researcher also considered the following three federal regulations that apply in research on human subjects:

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[215] Hulley et al., 219.

1. Informed consent: after a clear discussion with each participant, the researcher provided participants with a written consent form. A copy of the informed consent is available in the appendix. This form provides evidence that the participant gave his/her consent to participate in this research project. Since the researcher did not meet with participants in the electronic survey, the consent form had a box participants checked to confirm that they had reviewed the information and gave consent to partake in this research project. As Stephen Hulley et al. advised, the written informed consent form was written in a language the participants understand and exempted from any technical jargon.[216]
2. Authorization to use and disclose protected health/medical information for research purposes: participants also signed this document to provide evidence that the researcher had the legal authorization to disclose protected health/medical information collected during the study. This form determined what personal health/medical information the researcher wanted to use in the study, why the researcher needed the protected health/medical information, how that information was kept private, who could use this information and how to cancel this authorization in the event that the participant changed his/her mind.
3. IRB Review: every academic research is subject to IRB requirements. Therefore, the following research was submitted to Winebrenner Theological Seminary's IRB. The role of the IRB committee was to make sure that federal regulations and guidelines on research with human subjects were strictly implemented in every step of this research

[216] Hulley et al., 219.

study. Therefore, the researcher filled out the IRB application and submitted it to the IRB committee promptly as required.

Summary

To sum up, the main focus of this chapter was twofold. In the first part of this chapter, the researcher discussed the physiology of the research. In other terms, the researcher talked about the research methodology and procedures that were used to answer the three research questions that led to this study. Those questions are:

1. When sub-Saharan African immigrants are hospitalized in the United States hospital, how satisfied are they with their knowledge of how to receive chaplaincy services?
2. What was the satisfaction level of sub-Saharan patients and families with chaplaincy services that were provided by United States hospital?
3. What can the study on sub-Saharan African patients and families' satisfaction with pastoral care in the United States hospital teach us about how pastoral care is delivered to them?

The second section describes protocols and agreements that were in place to implement the project, as well as federal regulations that were used in the process, to make sure that the project has met all the criteria of academic research.

Chapter Five

The Results of the Research

This chapter aimed to provide the results of the research conducted using quantitative and qualitative instruments on the satisfaction of sub-Saharan patients in United States hospital with the delivery of spiritual care. The quantitative data is derived from the results from the survey that was sent electronically to participants. This report utilized the electronic statistical approach of Google forms. The numeric value of each item was automatically calculated and represented in pie charts.

The qualitative data was collected during interviews. The researcher discussed the codes recognized in the qualitative study. Furthermore, the report compared the results of the quantitative and qualitative data to determine the conclusions of the research. The purpose was to provide a meaningful analysis that interprets and explains the findings. It must be noted that the process of organizing and thinking about data is indispensable to understanding what the data does and does not contain. Furthermore, there are several ways to summarize data in its reporting; however, of greater vulnerability is the fact that raw data is notoriously easy to manipulate to purport certain conclusions or to substantiate the hypothesis. For this reason, the data was matter-of-factly reported, and the data summary was critically examined against the research hypothesis.

It is essential to point out that in this study, the researcher used a small data sampling. The main reason is that it was challenging to find participants since the subject of this research requires the participation of a population of immigrants who are initially from the sub-Saharan region of Africa. It was difficult to find people to volunteer for this project. Participants had to be people who have been admitted to the United States hospital. In addition, they had to be people

who had encountered a chaplain's visit during hospitalization in the United States hospital, which made it even more complicated.

Nature of the Project

This project is outcome-focused research. The research intended to contribute to the evidence-based approach to spiritual care for African patients with at least one experience with the United States hospital. The researcher hoped that the project would inform spiritual care practitioners regarding sub-Saharan Africans' experience with the delivery of spiritual care at the United States hospital.

The initial plan to find participants for this project was to select them from African churches and associations for African people, to use any helpful database that would be found credible during the process, and to use word-of-mouth (an unpaid spread of information from one participant to another potential participant). However, during the process, the researcher discovered another way. It consisted of directly reaching out to African people in public places such as the public library, grocery stores, shopping centers and malls, U.S. post offices, banks, African festivals, international markets, African stores, barbershops, and other business places owned by African entrepreneurs. The researcher came to find out that this option was preferred.

According to the Institutional Review Board agreement, every person who had ever been a patient in any of the Bon Secours Mercy Health Hospitals was disqualified from the study because this research project was not associated with Bon Secours Mercy Health in any way. Before participating in the project, the researcher asked each potential participant this question: "Are you now or have you ever been treated at any health care facility operated by Bon Secours Mercy Health System?" It was interesting to note, no one had ever been a patient at any Bon Secours Mercy Health System hospitals.

The researcher anticipated that many sub-Saharan Africans living in the USA might have language problems, so he proactively translated all survey materials into French to avoid language barriers during the data collection process. Participants were free to choose which language they wanted to use to complete the survey. A professional translator was used to certify the accuracy of the translations from English into French. Curiously, the French materials were not used since all participants chose to use English.

Despite the researcher's creativity in recruiting and efforts to accommodate language options it was difficult to find 204 individuals to complete the survey.

More surprising, is the very small percentage of the 204 individuals surveyed who had been admitted to a United States hospital and had encountered a chaplain during their hospitalization. Twenty-two of the 204 survey respondents could be used as a sample once the criteria was met.

Qualitative data was collected through a series of interviews. The researcher randomly selected twenty interviewees who had participated in the quantitative study. The twenty participants were divided into two groups. The first group was comprised of participants who had completed the entire survey. The second group was comprised of participants who exited after answering a question that a chaplain did not visit them during hospitalization.

The first group, those who completed the survey, was used to collect data that helped understand the results of the quantitative study. In this process, the researcher utilized the questionnaire designed for this purpose and approved by Institutional Review Board.[217] However, during the analysis, the researcher noticed that the original questionnaire needed to be supported by another series of open-ended questions enabling participants to discuss their

[217] See Appendix A, 180.

hospitalization experience in more depth. Therefore, the researcher reformulated questions from the electronic survey and injected them into the interview to help clarify the questions. The resulting questions are as follows:

1. How did the chaplain help you realize God cares for you?
2. How did the chaplain's visit make your hospitalization easier?
3. What did the chaplain use to help you use your faith/beliefs/values to cope?
4. How did the chaplain help you feel more hopeful?
5. Did the chaplain's visit give you the strength to go on?
6. How did the chaplain's visit aid your spiritual growth during your illness?
7. What did the chaplain use to help you face complex issues?
8. How did the chaplain help you?
9. In what ways did the chaplain visit help you adjust to my medical condition?
10. Explain how the chaplain visit contributed to your readiness to return home?
11. Did the chaplain's visit contribute to a faster recovery?
12. How did the chaplain help the clergy of your congregation to understand your situation better?
13. How did the chaplain help you cooperate with doctors and nurses?
14. Explain how the chaplain's prayer was a comfort to you?
15. Did the chaplain give you the impression that he/she was listening to you?
16. Explain what made you feel the chaplains seemed to know what they were doing?
17. How did the religious worship service meet your needs?
18. How were your needs for the sacraments fulfilled?
19. After talking to the chaplain, how did you feel better about your situation?

20. Did the chaplain's visit scare you?
21. Did the chaplain talk too much?
22. Did the chaplain's visit make you too tired?
23. Did the chaplain seem to be a person of spiritual sensitivity?

The second group was composed of participants who exited the survey because chaplains did not visit them during their hospitalization, either because they were not visited randomly or did not request a chaplain's visit. The researcher was curious to learn what they had to say from that experience of not seeing a chaplain and how that experience might promote best practices in delivering pastoral care to sub-Saharan patients in the United States hospital. With this group, the principal question used to collect data was, "Why did you not request the chaplain's visit during your hospitalization?"

Weakness and Strength of the Project

A significant weakness of the project was the small sample size of the survey. Despite the researcher's best efforts, it was difficult to locate a statistically significant sample of sub-Saharan African immigrants who had experienced pastoral care during hospitalization. This reality in and of itself suggests that this population may be underserved. The researcher sought to increase the survey numbers by visiting locations within the sub-Saharan African community such as barber shops and grocery stores, hoping that the relational qualities of the culture could increase the percentage of surveys returned. Even this additional tactic did not have an impact on the low return rate. A future research design would need to focus more intentionally on an advanced communication process with community partners such as churches and community groups to increase awareness of the projects' importance to increase participation.

Alternatively, the project could be supported by a hospital or healthcare system. This project did not benefit from such institutional support. It has not received any support from organizations such as the hospital where the researcher is employed because the study was not designed for that particular hospital. A study that benefits from institutional support would be mainly intended for specific hospitals. The spiritual care literature reports several studies that have benefited from institutional support in spiritual care research on the one hand and the contribution of institutional support to spiritual care research on the other hand. One example of this is the article "A National Study of Chaplaincy Services and End-of-Life Outcomes."[218]

Institutional support is essential and greatly emphasized in the spiritual care literature. It creates the conditions that allow the researcher to have the appropriate resources for the study. First, through institutional support, the research receives financial funding to help cover the cost of the study. Second, it allows the researcher sufficient time to research after regular clinical duties. Third, institutional support also allows other staff to participate in the study. Since this research did not benefit from institutional support, it was conducted in a general public setting. The researcher funded this research.

The strength of this research is the ethical research plan developed with Winebrenner Theological Seminary's Institutional Review Board that was in place and enforced. The researcher was obliged to complete the CITI certificate on research with human subjects before proceeding with the study.[219] Participants were required to sign a consent form which included a

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[218] Kevin J. Flannelly, Linda L. Emanuel, George F. Handzo, Kathleen Galek, Nava R. Salton, and Melissa Carlson, "A National Study of Chaplaincy Services and End-of-Life Outcomes," *BMC Palliative Care* 11, no. 10 (July 2012).

[219] See Appendix M.

HIPAA form before participating in the project.[220] No incentives were offered to participants, and everyone participated as a volunteer.

Findings: Quantitative Study

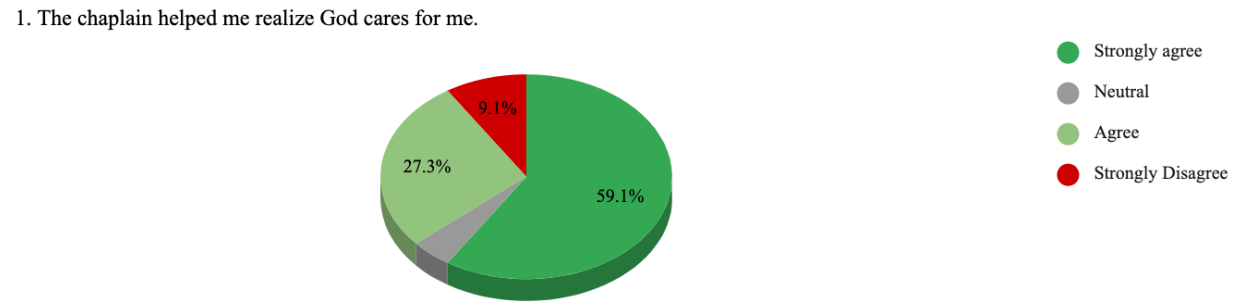


Figure 2. Ministry that promotes coping, question 1

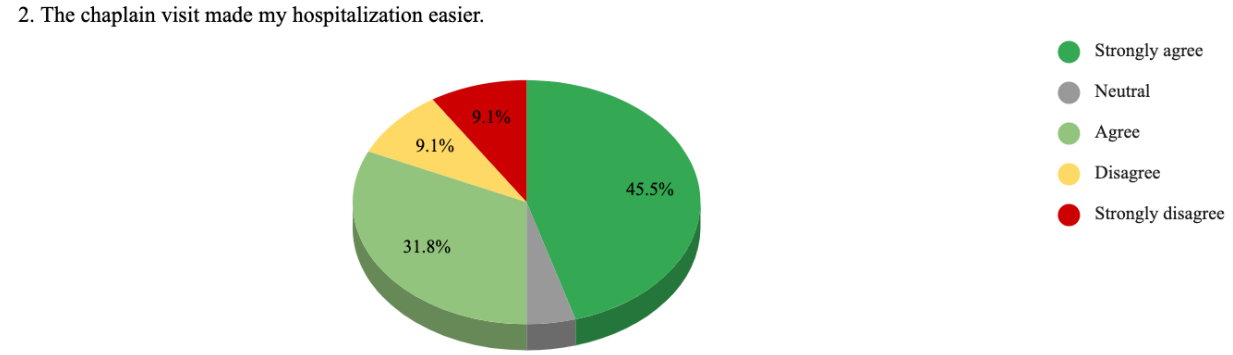


Figure 3. Ministry that promotes coping, question 2.

[220] See Appendix G.

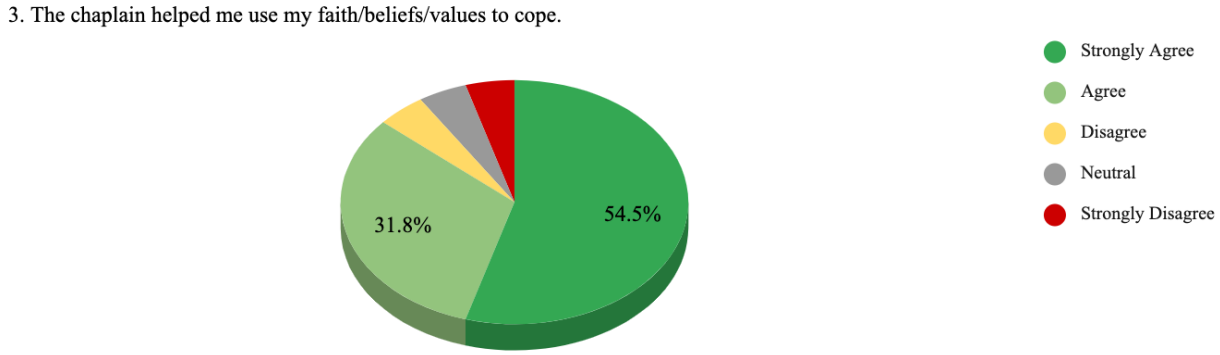


Figure 4. Ministry that promotes coping, question 3.

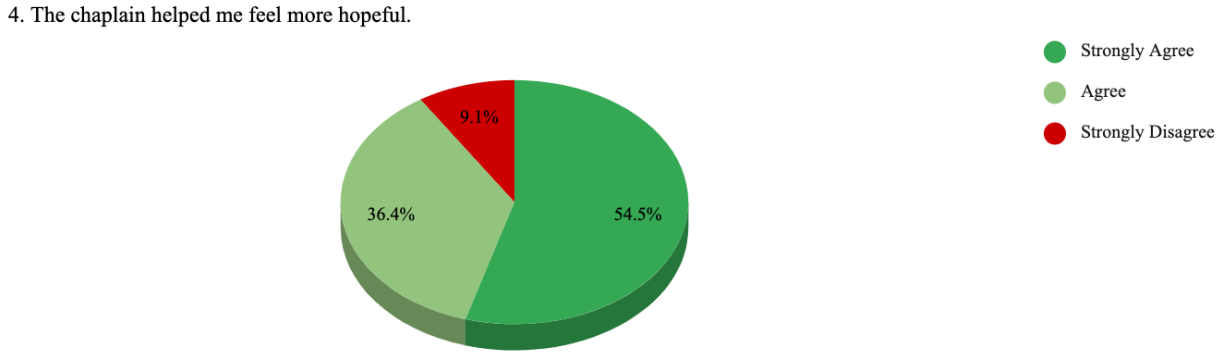


Figure 5. Ministry that promotes coping, question 4.

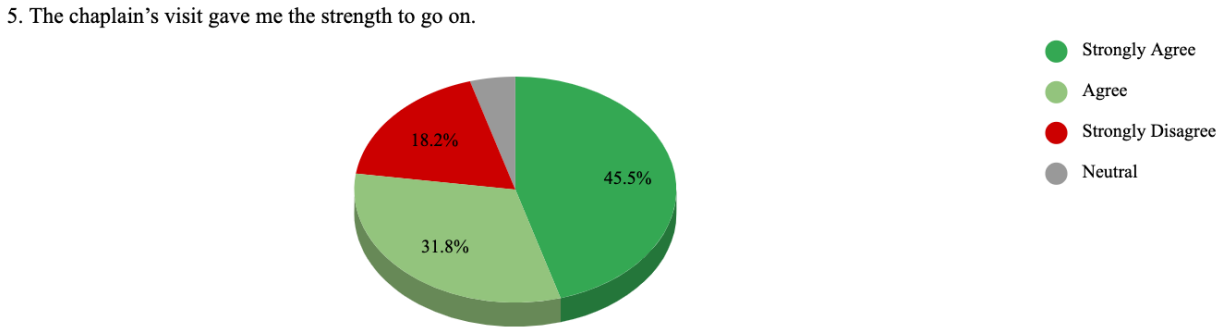


Figure 6. Ministry that promotes coping, question 5.

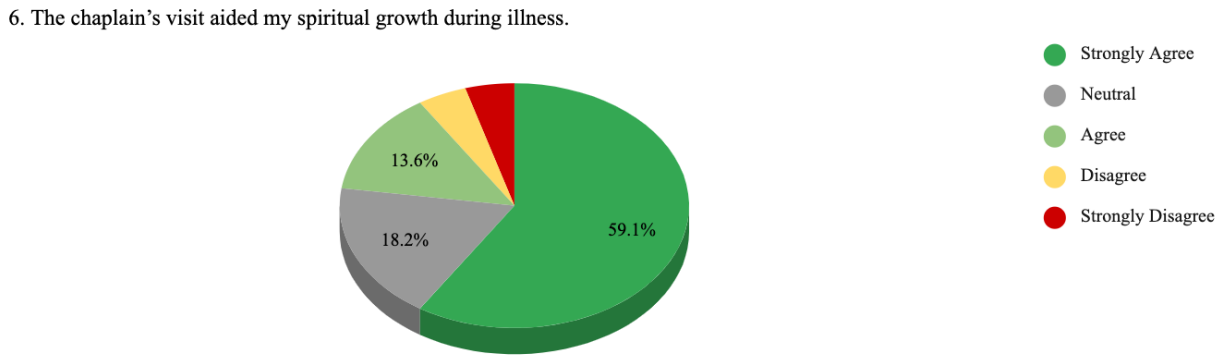
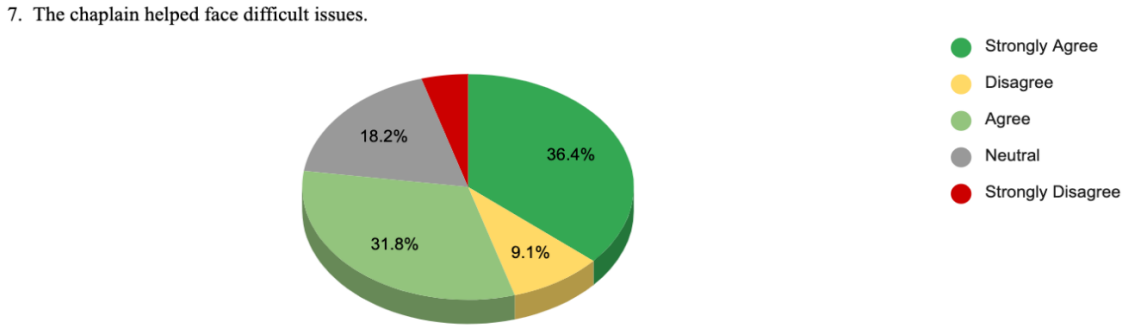


Figure 7. Ministry that promotes coping, question 6.



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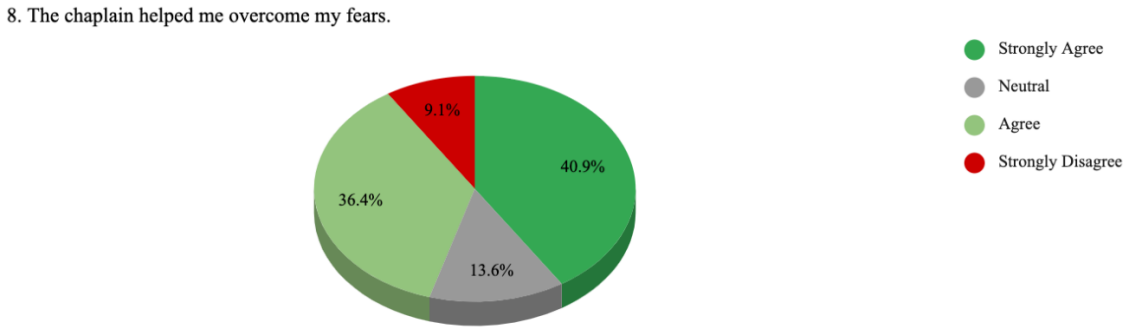


Figure 9. Ministry that promotes coping, question 8.

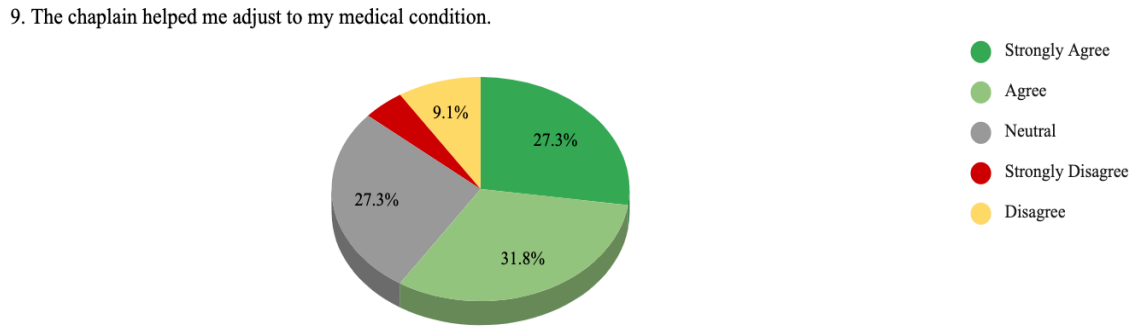
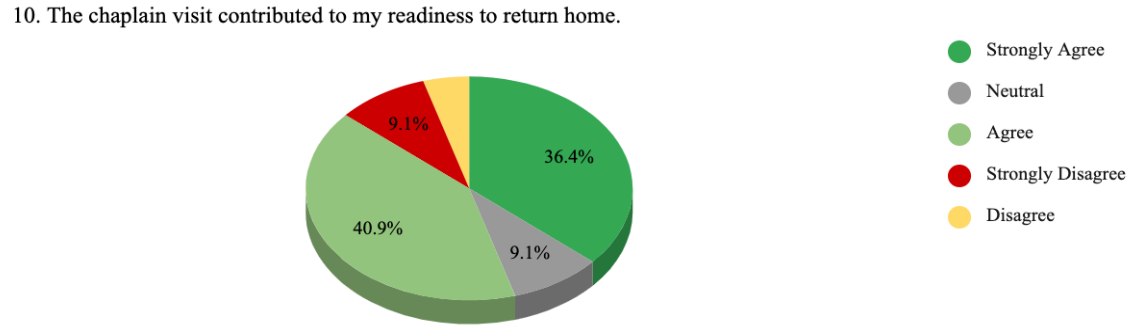


Figure 10. Ministry that promotes coping, question 9.



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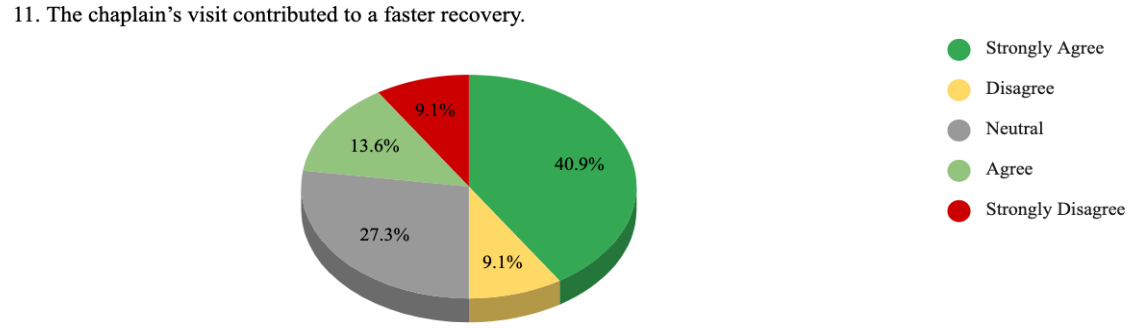

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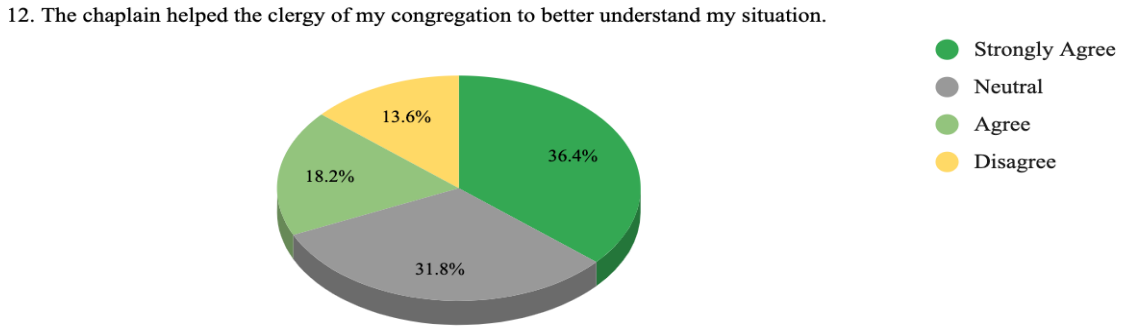

Figure 13. Ministry that promotes coping, question 12.

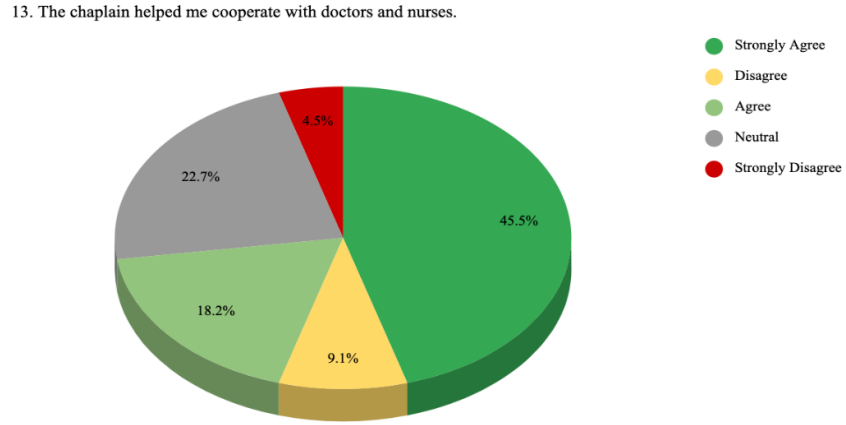

Figure 14. Ministry that promotes coping, question 13.

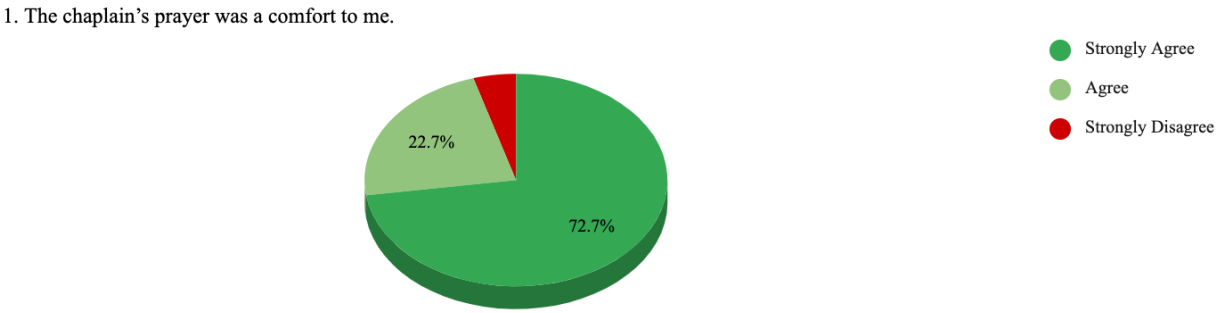

Figure 15. The supportive ministry of chaplains, question 1.

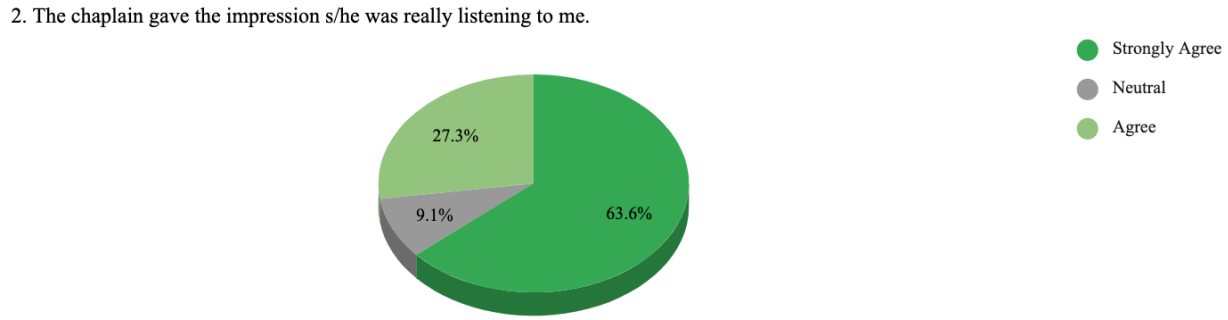

Figure 16. The supportive ministry of chaplains, question 2.

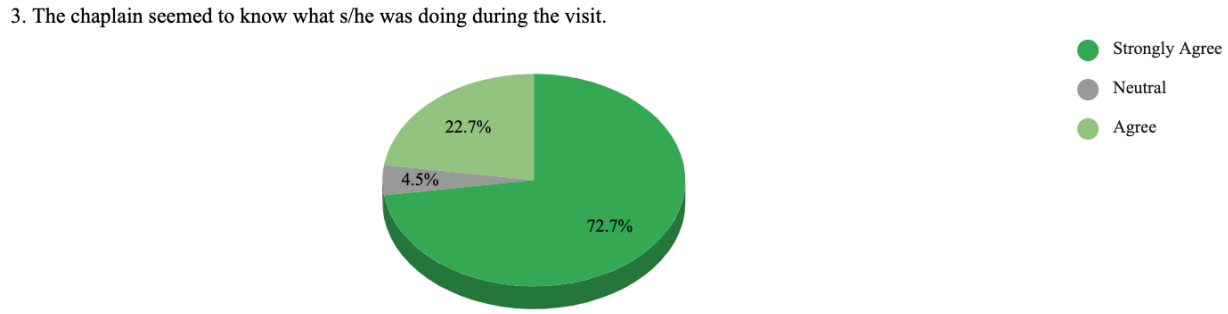

Figure 17. The supportive ministry of chaplains, question 3.

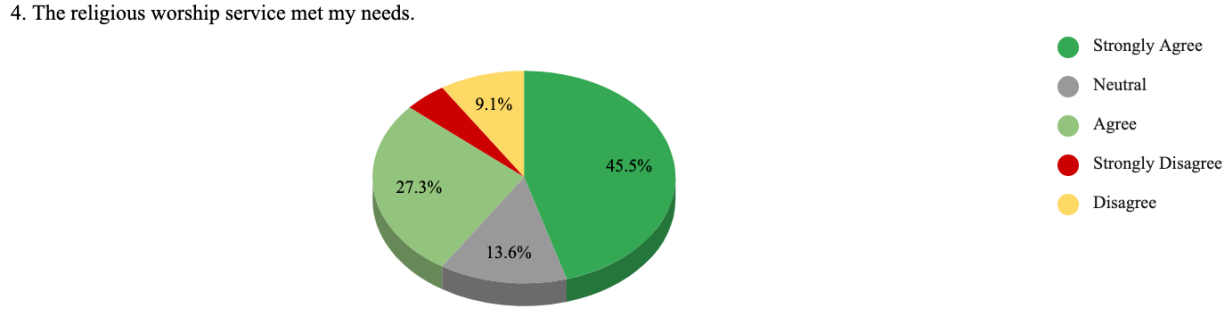

Figure 18. The supportive ministry of chaplains, question 4.

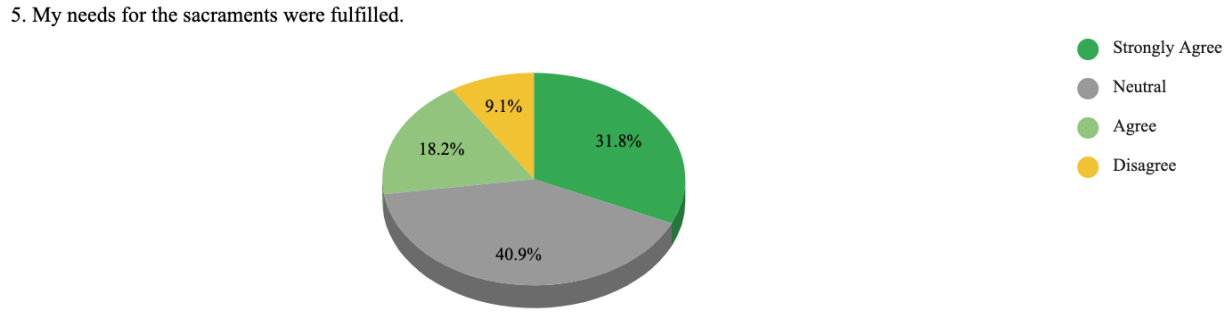

Figure 19. The supportive ministry of chaplains, question 5.

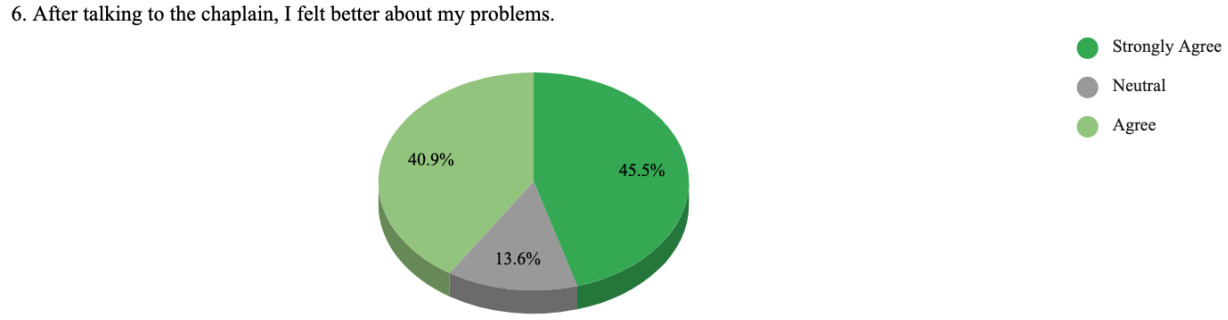

Figure 20. The supportive ministry of chaplains, question 6.

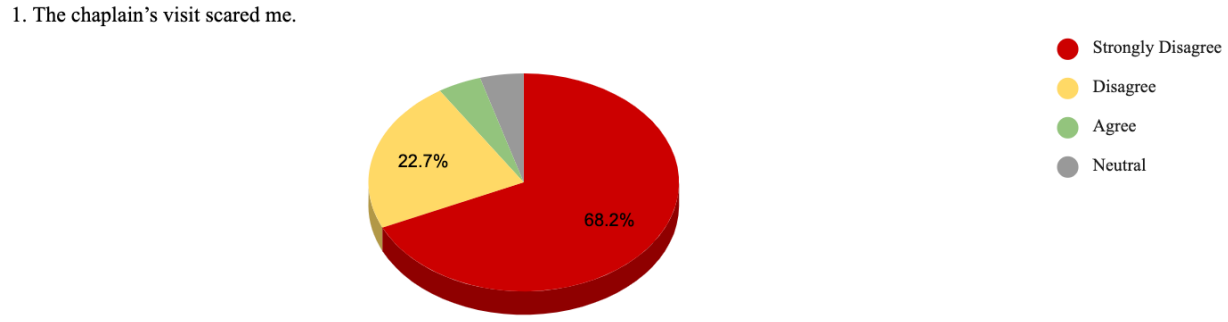

Figure 21. Acceptance of chaplain's ministry, question 1.

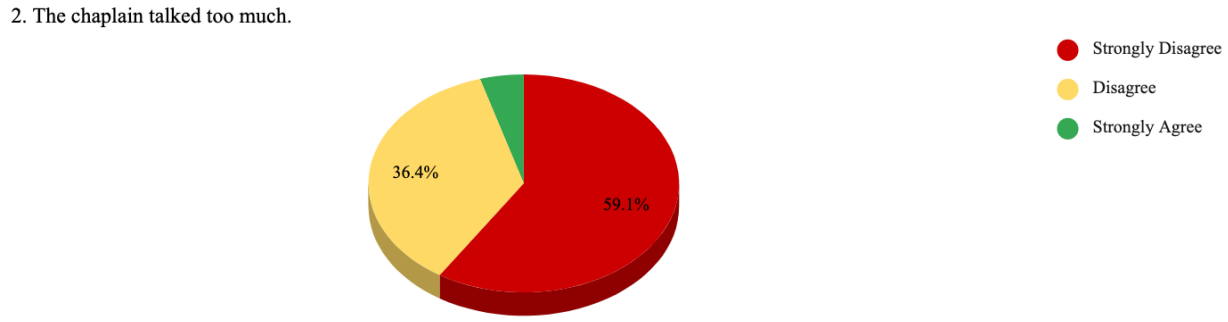

Figure 22. Acceptance of chaplain's ministry, question 2.

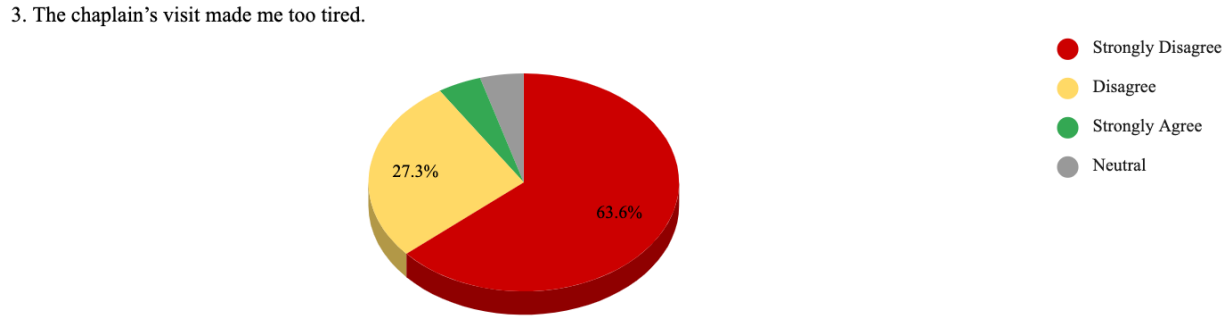

Figure 23. Acceptance of chaplain's ministry, question 3.

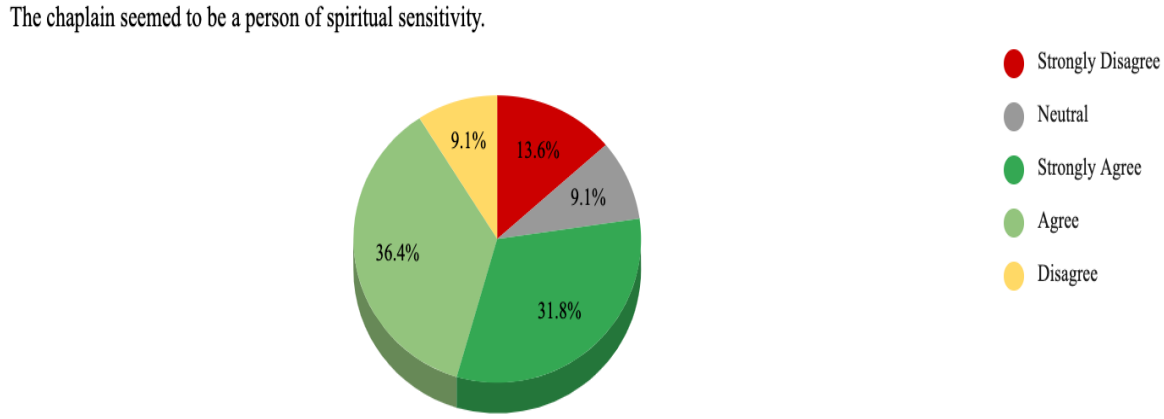

Figure 24. Independent question.

Findings: Qualitative Study

The qualitative data collection process took place through interviews. The researcher interviewed a total of twenty participants who voluntarily agreed to participate in the study. Specifically, ten people participated in each group. The first group was comprised of people hospitalized in the United States hospital whom the chaplain had visited during their stay. The second group was people admitted to the United States hospital at least once but never received a chaplain's visit. After collecting the data, the researcher submitted the results to a coding approach to identify the recognized codes that were analyzed to understand the findings of the qualitative study.

Recognized Codes – Group 1

The following section articulates recognized codes from the coding process. These codes were not presented with any order of importance. From this study, the researcher identified ten essential codes: compassion and empathy, African worldview, advance directives, advocacy, companionship, prayer, communication, distraction therapy, multi-faith approach, and testimonials. Each of these codes are discussed in greater depth below.

Compassion and Empathy

Most participants noticed that the chaplain demonstrated compassion and empathy in a very remarkable way. Some argued that in their countries of origin, they had never experienced the compassion they received during their hospitalization in the United States hospital. Participants discussed that in many sub-Saharan countries, primarily countries with reputations for high corruption, compassion and empathy are rare to experience. Participants denounced unethical practices such as upfront payment for registration, bribing with money to catch the best medical staff's attention, and confiscating a patient's goods until the patient's bill was paid in

full. One participant testified that the hospital in her country refused to discharge her and her baby until her husband sent payment three days later, including extra charges associated with the three days they stayed over for lack of money on discharge day.

Most of them believe that this behavior has something to do with poverty. Participant "A" stated, "It is the consequence of poverty… the hospital needs money to deliver health care, staff needs money to survive… people have no heart for others."[221] In many countries or specific areas in sub-Saharan countries, the medical staff is not well paid, the medical staff is overworked, and health care institutions do not provide conditions that encourage people to perform in the context of work as worship, such as decent salaries, employment benefits, bonuses, etc. Participants believe that these poor conditions negatively affect health workers' behaviors and impact the overall culture of hospitals. These conditions result in the health care workers' inability to practice compassion and empathy for patients and their families.

African Worldview

The African worldview is different from the western worldview. People have different customs, traditions, religious beliefs, languages, food, and different ideas about illness, suffering, death, and dying. Most participants thought these differences could become a source of friction between them and the staff or the chaplain during their stay at a U.S. hospital. Although the world has become so small with the influence of the internet, the customs, and traditions of many tribes in Africa are quickly changing. However, it is still utopic to declare that the African worldview has drastically changed.

[221] Participant "A," interview by the researcher, Columbus, Ohio, October 26, 2022.

One participant said he talked with a chaplain about the book *Why Do Bad Things Happen to Good People?*.[222] He said that he told this chaplain many stories about how witchcraft operates to cause pain, suffering, and death in many African families and that he believes in spiritual warfare. At the end of the visit, this participant said he was impressed with how the chaplain reacted to his points of view. He said that he anticipated a confrontation, but he experienced a learning attitude. Other participants said that they had also observed similar attitudes in their encounters with chaplains. This was another positive experience most participants reported during the qualitative study.

Advance Directives

Most participants said they disliked discussing the Healthcare Power of Attorney, Living Will, and organ donations with the chaplain during their hospitalizations. They argued that in their customs and traditions, people do not talk about death and dying until someone is on their deathbed. They believe that having a conversation about death can cause death in the family. They admitted that these three concepts were new to all of them, and they had difficulty understanding them because of cultural differences.

But some participants said that after clear explanations, they could see the value of the documents. One participant stated that during the education on advance directives, the chaplain remained calm and took his time to listen and explain why completing advance directives is a privilege to the patient rather than a threat. This participant stated that he experienced the chaplain like a teacher teaching him a chemistry class. Since that day, the participant understood the role of those documents. The participant also explained advance directives to his spouse, and

[222] Harold S. Kushner, *When Bad Things Happen to Good People* (New York: Anchor Books, 1981).

the same day they completed a Healthcare Power of Attorney and a Living Will before he was discharged. Participants recognized the chaplain's ability to engage in difficult conversations without losing their temper, which they considered very impressive.

Advocacy

Participants noted that chaplains played a crucial role in advocating for them, such as letting the staff know their needs and feelings, whether it meant their frustrations, anger, sadness, disappointment, or lack of understanding. They helped initiate family meetings with doctors and other care team members. One participant shared that he was scheduled for surgery. On the day before the surgery, as part of the medical procedure, he was not allowed to eat anything. While waiting for his time, he was never told that his surgery was postponed to another day. He was furious and complained to the chaplain during the visit. The chaplain invited the participant's nurse and the charge nurse into the conversation. They listened to his complaints, apologized for the miscommunication, and helped him to call nutrition services and place an order for his dinner.

Participants observed that in their countries of origin, it is unusual to see such behavior. It was their belief that people are self-centered because of the effect of poverty in their lives. The reality is that, for some people, such a dire situation like this could quickly become an exciting opportunity to make dirty money. The role of chaplains in advocating for participants during their hospitalization was an essential contribution to their satisfaction with spiritual care.

Companionship

One participant said the chaplain came to see him when he was very lonely, sad, and experiencing excruciating pain. When the chaplain walked into his room, he did not have the strength to engage in a conversation. He hoped that the chaplain would stay with him in the room

until he fell asleep. He said that he had been praying that in his heart because he was scared to be alone in the room. When the chaplain entered the room, he made eye contact and decided to sit on the couch and offer companionship. The chaplain stayed there until the participant fell asleep.

The participant confessed that he had never anticipated that, mainly because the chaplain was a young Caucasian male he had never met before in his life. The participant recognized that it takes some courage to offer companionship like this to a person you do not know, especially in a context where racial differences affect human relationships. Participants considered this a strength.

Prayer

Prayer was also one of the most repeated words during these interviews. For Christian participants, prayer is a common ground where the chaplain and the patient meet regardless of the divergence of their denominations. They asserted that prayer was part of their faith practice as Christians, and having a pastor pray for them during times of crisis, whether illness, death, or other life situations, was one of the attributions of their pastors when their church members are at the hospital.

Some participants recalled that while living in their countries of origin, their pastor would visit and pray for them even when someone was sick at home. Therefore, having the visit of the chaplain who prays for them was in line with what they believed to be the role of the pastor in their respective denominations. Non-Christian participants, specifically Muslims, were impressed that they were treated with respect by chaplains who were not Muslims. They were surprised that these chaplains would understand their needs to practice their religion during hospitalization, including prayer, and would respectfully help them to meet their spiritual needs. Chaplains would make sure that these participants knew where the interdenominational hospital

chapel was located and would also provide them with available useful religious resources such as the Koran, a prayer rug, and other materials to accommodate them.

Communication

Participants also greatly appreciated chaplains' listening skills, believing it significantly impacted their experience. Chaplains who had visited them were attentive and demonstrated that they were doing their best to understand them. Participants observed that chaplains practiced different listening skills including active, critical, informational, empathetic, and appreciative listening. In addition, participants stated that chaplains were instrumental in asking if it was necessary to call the language services. One participant appreciated the chaplain's availability. This participant observed that the chaplain was ready to sit down and offer a listening ear, whether the chaplain knew what to do or not in the situation. This participant observed that the chaplain was ready to provide pastoral presence and active listening, which are essential skills in the ministry of presence.

Other participants believed that this behavior indicates that chaplains wanted to prevent any miscommunication that could poorly affect the process of making informed decisions. Chaplains were open to talking about everything. Participants found this attitude very impressive. They positively noticed that chaplains were not afraid to be vulnerable during their visits, which many mentioned during their interviews.

Distraction Therapy

One participant said that since he came to the United States, he always wondered why hospitals put televisions in patients' rooms. He said that hospitals are places where people come when they are sick. People come to the hospital when they are in pain and suffering. This participant could not understand how a sick person would care about watching television under

such circumstances. In most African countries, the dream of hospital administrators is to have the proper medical technology, appropriate logistics and infrastructure, cutting-edge surgical and medical materials, and qualified health care workers to do the job. This dichotomy is enough to indicate a conflict in the perception of the philosophy of health care delivery between this participant and the Western world.

It was interesting to see that the same participant had an encounter that later taught him about the role of those televisions and how they could be used in patient care. When the participant came out of surgery, he was alone in his room, and the television was playing an action movie with lots of cursing, shooting, and killing. At that point, he wanted the television off, but he did not have the energy to find the remote control hanging off his bed to change the channel or turn it off. Then the chaplain who visited him on admission returned to his room for a follow-up visit. The chaplain noticed that the participant was in pain and that the movie playing was inappropriate. He changed the channel and turned it into an inspirational channel. This channel was playing Gospel music songs that the participant liked.

At that moment, the participant began to worship God in his heart until he felt asleep. He said this encounter connected him with the chaplain and transformed his hospitalization experience. Through the ministry of this chaplain, he learned that television could be used to bring distraction to the pain and suffering patients endure at the most vulnerable times of their lives. It can also help refocus the patient's attention on something that can empower someone emotionally and spiritually.

Multi-Faith Approach

Muslim participants admired the visiting hospital chaplains mainly because during the visits, they did not proselytize. They said that they did not feel discriminated against because of

their religion. Participants noted that even Christian chaplains who visited them treated them respectfully as if they were Christian patients, even though different religious groups can be mistreated and receive unequal care.

They recognized that this attitude was vital to their satisfaction with the hospitalization. Participants noted that this kind of attitude had an essential impact on the relationship-building process with chaplains. Participants declared that they felt respected and loved. Participants were astonished to be treated nicely because, they said, after 9-11, some rhetoric in the media was influencing behaviors that were not contributing to peace and good relationships with the Muslim population because of the bad image radical Islam had portrayed.[223] Participants stated that such an attitude towards them was very comforting. They noted that a patient has so much going on during hospitalization that accepting their faith "as is" and walking the journey with them regardless of their religious differences contributed to their emotional equilibrium, which they consider praiseworthy. This non-judgmental attitude of chaplains displays a strong sense of ecumenism. Participants stated that it contributed significatively to their satisfaction with spiritual care.

Testimonials

According to participants, some chaplains said they have African friends and find it very friendly to make that known during the conversation. Participants claimed that hearing a chaplain mention that in an initial pastoral care conversation says something about the chaplain's personality. Participants said some chaplains have even been to Africa for mission work with their churches. Participants noticed that talking about their experience in Africa during their

[223] This statement refers to the side of Islam that supports terrorism worldwide, causing massive amounts of death of innocent people around the globe.

mission trips was a great point of connection. When the chaplain brings some sense of humor to flavor the conversations, it helps them forget their obscure diagnosis and prognosis for a moment and creates an attitude of relaxation, joy, and gratitude. Participants said that testimonials like that would make them feel appreciated and valued. It reinforces the idea that testimonials significantly impacted their experience of hospitalization. It eased the process of relationship building, which is one of the most critical steps in delivering health care in general and spiritual care in particular. In addition, participants recognized that they felt more connected when the chaplain shared a personal story to which they could relate, specifically regarding their experience with hospitalization.

Recognized Codes – Group 2

This group did not participate in the survey. Participants were exited from the study after they had answered "no" to the question asking if the chaplain had visited them. Participants were also asked "Were you happy with your knowledge of how to receive chaplaincy care?" Most participants answered "No." The codes discussed in this section emerged from the question of why a chaplain did not visit them during their hospitalization. Participants replied that they did not ask for a chaplain visit for five principal reasons: ignorance, lack of experience with chaplaincy care, language barriers, cultural diversity issues, and "it never occurred to me." The following sections provide more explanation for these five reasons.

Ignorance of How Spirituality Is Integrated into a Health Care Setting

Participants argued they did not know that health care institutions in the United States hospital employ chaplains as part of the medical team. In the United States and many other countries in the Western world, the integration of spirituality in medicine is supported by hospital policies, protocols, and legislation regarding health care delivery in United States

hospital. For example, the Joint Commission supports spiritual care in hospitals in the United States.[224]

On the contrary, in most African countries, integrating spirituality in medicine through the work of health care chaplains is a new concept that needs more research. Some countries may have legislation that supports the delivery of chaplaincy care in hospitals but suffer from a lack of appropriate programs to support the implementation. On the other hand, some countries do not have such policies, which is the case of the health care system in the Democratic Republic of Congo.[225] Therefore, most participants did not know about the existence of Spiritual Care Departments in the United States hospital. Most participants argued that if they knew that in the first place, many would have no reservations in requesting a chaplain's visit to attend to their emotional and spiritual needs during their hospitalization.

Lack of Experience with Chaplaincy Care

Most participants did not know about board-certified chaplains and what they do in health care institutions. In other words, most of them had never experienced chaplaincy care in their lives. This is not a surprise because health care chaplaincy is a relatively new discipline quickly emerging to become the backbone of medicine in the third millennium, as discussed in previous chapters. Some participants argued that their lack of experience with a hospital chaplain justifies why they did not request a visit during their stay at the hospital. They said that in their countries of origin, visiting patients at the hospitals is the task of their local pastors.

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[224] John Ehman, "References to Spirituality/Religion in the Joint Commission's Comprehensive Accreditation Manual for Hospitals 2008 CAMH," *Penn Medicine: Pastoral Care & Education*, last updated 2008. https://www.uphs.upenn.edu/pastoral/resed/jcahorefs.html.

[225] Samuel Mampunza ma Miezi, phone interview by the researcher, July 7, 2022. Samuel Mampunza Mia Miezi is a well-known Democratic Republic of Congo psychiatrist. He is also a professor at the School of Medicine and General Secretary of Academic Affairs at the Congo Protestant University.

The pastor regularly visits parishioners at the hospital when their church members notify them. That means they had never experienced the delivery of pastoral care from a hospital chaplain. Some remembered that during the registration process, they were asked if they would like to have a chaplain visit. Thus, they declined the offer. They did not know what that meant because they had never encountered chaplaincy care in their countries of origin.

Language and Cultural Barriers

Language and cultural barriers were reasons for not requesting a chaplain's visit. Participants in this part of the study were from different countries in Africa. Some were from countries that used to be British colonies where English was the common language, while others were from former French-speaking and Portuguese colonies. Participants in this interview were knowledgeable in English and participated in conversations without the assistance of the language services of the hospital.

However, participants recognized that some conversations could still be challenging to engage with a person from a different social and cultural background. Language barriers could be overcome with the help of any robot machine specialized in language translation in a hospital setting. However, the cultural barrier may require more than words that allow the flow of communication.

For example, in some remote areas in Africa, the pastor is an authority figure who manages the missionary station, the denomination's conference, or the presbytery. The average person will not consider requesting his/her visit during hospitalization because, in this instance, a pastor is seen as someone highly elevated in dignity that only the most fortunate could have the opportunity to encounter. A person who grows up with such a mindset will likely not request the chaplain's visit during hospitalization.

The Culture of the Hospital

Participants also raised the hospital's culture as one of the reasons that prevented them from requesting a chaplain's visit during their hospitalization. They said they have always experienced the hospital as a strange place, which never motivated them to request a visit from the chaplain. Most participants agreed that health care is a serious problem in their countries of origin. Hospitals are not what they represent in the Western world. In many of these countries, government officials and wealthy people travel overseas for quality medical treatment. Hospitals in their countries are left to the poor and the less fortunate.

Participants argued that even during hospitalization, they had little hope and were still struggling to believe that the hospital would provide the best quality of care. Many recognized that they were driven by their assumptions instead of being realistic and engaging the staff to know their rights. One participant noted that too many people were on the medical team. He referred to the multidisciplinary team and said that it was confusing enough for him, much less to remember a chaplain.

Participants seemed lost in the health care system, which is not a surprise because hospitals are known for being weird places for people worldwide. According to their declarations, during their admission, participants wanted to understand the hospital system rather than taking advantage of what was available. Even when they needed spiritual support, they did not know what initiative to take to meet their emotional and spiritual needs.

"It Never Occurred to Me…"

Some participants said, "It just did not occur to me to request a chaplain to visit." As the researcher probed more on this subject, some interviewees believed that several other factors might cause a sub-Saharan African patient to not request a chaplain visit during hospitalization.

For instance, when things are going well, there is no need to call for the chaplain. Many participants believe that when a patient has the Bible and can pray alone, the patient can be fine whether there is a chaplain or not. In that case, they said the patient does not have to call a chaplain.

Another participant said that one day she could use the chaplain, but it never occurred to her to request a visit. She came out of major surgery and was too tired to think about something like that. The next day, her local pastor came to visit her at the hospital. At that moment, her need for a minister's visit was satisfied, and she did not have to call for a chaplain anymore.

Discussion

The overall result of this study contrasts with the assumption of the researcher that birthed this research project. Interestingly, the quantitative analysis shows that sub-Saharan immigrants who participated in this study had a positive experience with chaplains during their hospitalizations in the United States hospital. For the 13 items of the instrument measuring ministry that promotes coping in the survey, most participants selected "strongly agree" and "agree."[226] Thus, it is also the case for the six items measuring the supportive ministry of the chaplain,[227] the three items of the acceptance ministry of the chaplain,[228] and the independent question.[229] This clearly indicates participants' satisfaction with the ministry of the health care chaplain during their hospitalization.

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[226] See Figures 2 to 14.

[227] See Figures 15 through 20.

[228] See Figures 21 through 23.

[229] See Figure 24.

A comparison between the findings of the quantitative study and the qualitative data collected during the interviews indicates that the quantitative study results are consistent with the qualitative data. In other words, data collected during the interview process confirms that participants have recognized the positive impact of chaplaincy care during their hospitalization in the United States hospital as reported in the quantitative study. The researcher finds this very intriguing because this research project was built upon the premise that it will be difficult for sub-Saharan immigrants to experience patient satisfaction with the delivery of spiritual care because of several reasons, outlined as follows.

First, African life is different from Western culture. Therefore, the researcher believed strongly that those differences would heavily weigh and influence the quality of the experience of sub-Saharan African immigrants during hospitalization in the United States hospital. History shows that the African way of life and the Western culture has never cohabited without problems. At any given time, they have always unfolded in the context of culture shock. People have always found mechanisms to help them accommodate changes while developing new relationships.

Second, the Clinical Pastoral Education (CPE) program, which is the foundation of the health care chaplain's training program, was birthed and developed in the United States. This means thousands of miles from the countries of origin of participants to this research project. Yet this model was developed from a personal experience of Anton Boisen that did not have anything to do with the sub-Saharan way of life that is transmittable from one generation to another. The researcher anticipated that this factor could also have a negative impact on the satisfaction of sub-Saharan immigrants in the United States hospital because the CPE model of training was initially not designed with the experience of the African patient in mind.

Third, the integration of spiritual care in the delivery of health care in Africa is a new field. Thus, this discipline is more advanced in the Western world than in Africa. Significant contributions that have helped build this field are from the phenomenal work of several physicians who have devoted energy and time to research the intersection between spirituality, health, and medicine since the second half of the twentieth century. The fact that the integration of spirituality has not found its official place in African health care institutions yet leaves the chaplain's ministry in the shadow of medical practice. Most Africans ignore the health care chaplain even at the beginning of the third millennium.

This research project was developed on the premise that the three factors discussed in the previous paragraphs would poorly impact the satisfaction of sub-Saharan Africans in the United States hospitals. However, surprisingly, the study provides pieces of evidence that prove the opposite. Although the three factors discussed above may have some degree of influence on the overall experience of hospitalization of sub-Saharan patients in the United States hospital, it is irrational to think that they will automatically lead to a poor rating when it comes to poor patient satisfaction.

For instance, the coding results found relating to the ministry that promotes coping demonstrated that participants went through difficult times during their hospitalization. Participants experienced loneliness, fear, stress, conflicting worldviews, concerns with advance directives, relationship issues with staff, and emotional or spiritual concerns during admission, just to mention a few. However, both quantitative and qualitative results indicated that chaplains could still effectively provide emotional and spiritual needs with satisfaction.

The qualitative data collected on the supportive ministry of the chaplain shows a high percentage of satisfaction in Figures 15 through 20. Most participants selected "strongly agree"

and “agree” to these items. However, during the interviews, participants recognized struggling with some stressors associated with the culture of the hospital. Some of those stressors included personal faith issues and religious beliefs, the need for prayer support, ignorance of chaplaincy care, and the lack of understanding of the role the integration of spirituality plays in the United States hospital today. Things were not perfect, but the study’s results provided evidence that these factors did not have any poor effect on the overall outcome of chaplaincy care provided to participants. Chaplains could master their skills and offer excellent spiritual care to participants.

In addition, the quantitative and qualitative studies also indicated that chaplains who had visited participants during their admission to the United States hospital were well accepted, as shown in Figures 21 through 23. Most participants in the quantitative survey selected “strongly disagree” and “disagree” with these questions. Participants did not find chaplains annoying, talking too much, or making them too tired during the visit. These reports provide evidence that participants were comfortable with chaplains.

In other words, the qualitative data collected did not record any cases that prove the contrary. For example, there is no report of any incident with the chaplain that could lead to acts of violence, mistrust, or to make a patient angrily leave the hospital against medical advice during their admission. Participants did not report any escalated situations to the higher leadership that needed to be resolved to mend a conflict between the chaplain and the patient during hospitalization. Participants did not provide any evidence of a case where the chaplain was not well received during their pastoral visits.

The independent question measured the chaplains’ spiritual sensitivity. The pie chart in Figure 24 reveals that participants had different opinions on this question. However, 68% of participants believe in the chaplains’ spiritual sensitivity. This includes the 31.8% of participants

who selected “strongly agree” and the 36.4% who selected “agree.” The qualitative data revealed that many participants were reluctant to provide their opinion on this item. Some participants found it inappropriate and argued that, from their perspectives, it was similar to judging a person’s degree of spirituality.

Most participants who believed that the chaplain did not seem to be a person of spiritual sensitivity or those who responded “neutral” to this item were participants who usually utilize African traditional medicine more than Western medicine, even during the COVID-19 pandemic. Some of them admitted that when they are sick in their homeland countries, they would only go to the hospital after traditional medicine has failed to heal. This could explain why 9.1% of participants selected “disagree” on this item while another 9.1% remained neutral. However, this did not change the fact that most participants reported a positive experience with this.

Summary

This chapter aimed to provide the results and an analysis of the quantitative and qualitative study. In the first section, the researcher provided the compilation of the quantitative data in a pie chart format to best represent the numeric values associated with participants’ responses. The second section provided data collected during interviews. The researcher recognized codes that emerged out of the qualitative data collection process. This chapter also provided a comparative analysis of the results from the quantitative and the qualitative studies to confirm that the findings of the quantitative study are consistent with qualitative data.

In the next chapter, the researcher summarized the study and provided more reflections on the findings discussed in this chapter. The chapter also provides recommendations to contribute to evidence-based pastoral care to the sub-Saharan African patients who are consumers of health care in the United States to improve the delivery of chaplaincy care.

Chapter Six

Summary, Findings, Conclusions, and Applications Recommendations

This chapter unfolds in the following five sections: project Summary, Project Findings, Project Conclusions, Project Applications, and Recommendations.

Project Summary

This research project investigated the "accessibility" and "acceptability" of health care chaplaincy services to sub-Saharan African patients during hospitalization in United States hospitals. These two concepts, "accessibility" and "acceptability," were largely discussed in the first chapter of the research report. As a reminder, the researcher used these terms as defined by Roy Penchensky and J. M William Thomas.[230] In the context of this research project, "accessibility" refers to the opportunity to receive a visit from a hospital chaplain during hospitalization, while "acceptability" refers to the experience of the person who has benefited from the visit of the chaplain.

To investigate the relevance of these two concepts to the experience of sub-Saharan African patients in United States hospitals, the researcher used a mixed method: quantitative and qualitative. The quantitative method helped to measure sub-Saharan African patients' "accessibility" to chaplaincy care services. The qualitative study was used to evaluate participants "acceptability" of chaplaincy services during their hospitalization. The qualitative data played a pivotal role in the analysis and interpretation of the quantitative data.

The investigation revealed that participants indicated a positive experience. In other words, this research project demonstrates that sub-Saharan African patients who participated in it

[230] See Chapter One, 6.

were satisfied with the chaplaincy services to them during hospitalization. Yet, a comparative approach of the quantitative and qualitative instruments results in overall patient satisfaction of sub-Saharan African patients with chaplaincy services in the United States hospital.

In addition, this study verifies that providing spiritual care services to sub-Saharan African patients requires good knowledge of cultural diversity while the chaplain must also have cultural sensitivity and cultural competence. The study shows that it is easier for a chaplain with a good cultural diversity foundation to reach patient satisfaction with a sub-Saharan patient because of cultural factors that influence a patient's behavior during the visit. The coding process provided interesting information on how the religious and cultural background of the sub-Saharan African patient could influence the patient's experience with the delivery of spiritual care.

Project Findings

The findings of this research project verify that sub-Saharan African patients do not have good access to spiritual care services in United States hospitals. Their admission to the hospital indicates they should have the opportunity to encounter a chaplain during their stay, just like any other in the hospital. However, most of them did not have any visits with the chaplain during their hospital stay. The researcher observes that this situation is not a matter of eligibility-or lack of insurance because patients are entitled to chaplaincy care services like any other service. Spiritual care services are to be provided to them in the context of the holistic approach to health care that is guiding the practice of medicine today. Sub-Saharan African patients also have the right to a visit from a chaplain regardless of their race, gender, ethnicity, faith tradition, culture, or worldview. This service should be accessible to them upon their admission to United States hospitals.

As discussed in the first chapter of this research project, Derose, Escarce, and Lurie argued that in the United States, immigrants have a lower rate of health insurance, use less health care, and receive a lower quality of health care than U.S.-born populations.[231] The findings of this research project are congruent with this statement. This study revealed evidence that most sub-Saharan African patients who have participated in this research project denied receiving a visit from the hospital chaplain during an admission, which indicates a problem regarding their access to health care chaplaincy services.

Considering that health care is every person's right, sub-Saharan African patients should also benefit from chaplaincy care during hospitalization and are entitled to any service the hospital provides to patients during hospitalization. Therefore, they should also benefit from health care chaplaincy services like any other hospital service.

The findings of this research project also evidenced that health care chaplaincy services provided to a sub-Saharan African patient during hospitalization in United States hospitals produce patient satisfaction regardless of the color of the skin, communication barriers issues, religious beliefs, and cultural differences. The discussion on the results of the quantitative and qualitative study presented in chapter five of this research project provides significant evidence of that. These findings contradict the researcher's principal assumptions that gave birth to this research project. The initial assumption was that due to cultural diversity issues that play in spiritual care visits with sub-Saharan African immigrant patients during hospitalization in United States hospitals, the likelihood of a negative outcome is higher than an outcome that reaches patient satisfaction during a visit.

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[231] Kathryn Pitkin Derose, José J. Escarce, and Nicole Lurie, "Immigrants and Health Care: Source of Vulnerability," *Health Affairs* 26, no. 5 (2007): 1258.

However, the qualitative study demonstrated that cultural sensitivity and competence are essential to influencing positive outcomes. All the dominant codes that have emerged out of the coding process are congruent with this statement. Therefore, this establishes the importance of cultural sensitivity and cultural competence in spiritual care encounters with a sub-Saharan African patient. Participants in this patient satisfaction study argued that it is essential that chaplains who visit a sub-Saharan African patient have cultural sensitivity and cultural competence. They also believed that cultural sensitivity and cultural competence are the undeniable catalysts for success in a health care chaplaincy visit with patients from the sub-Saharan region of Africa.

Nowadays, there is a growing literature on cultural diversity in health care. Medicine and nursing, for instance, recognize the influence cultural sensitivity and cultural competence play in health care delivery. Information collected during the coding process of this study provides evidence that chaplaincy care faces the same problems as well. Health care chaplaincy is not spared from problems associated with cultural sensitivity and cultural competence in health care institutions.

This is because during spiritual care encounters with patients from other cultures, chaplains' sensitivity to issues that are related to patients' religious and cultural background matters.

When a sub-Saharan patient is hospitalized in United States hospitals, it is not only the physical body and other belongings, such as clothes, wallet, phone, etc., that the patient brings to the room. The patient also brings the complex reality of the human being: values, religious and cultural beliefs, and worldviews. These elements are in no way to be dissociated from the person because they are components of the human being as a whole. Mills writes, "What the patients

bring to illness and hospitalization, then, is themselves, their stories, relations, and understandings."[232]

Chaplains involved in spiritual care with sub-Saharan African immigrants must perceive their patients' stories, worldviews, and cultural backgrounds as working materials to attend to their emotional and spiritual needs during hospitalization. That means that their patients' stories, religious and cultural beliefs, and worldviews are not just abstract ideas but also the materials they bring to the hospital during admission. To provide excellent spiritual care to sub-Saharan African immigrant patients, the primary rule should be to have a working relationship that allows chaplains to listen to the real stories of the patients. It is in those stories and hidden materials that the chaplain needs to work. This primary rule is one of the most crucial truths for patient satisfaction when ministering to people from another culture in general and sub-Saharan African immigrant patients in particular.

In other words, this research project confirms that a sub-Saharan African patient's level of understanding of the illness and the experience of hospitalization, defined as the effects of hospitalization on the person, can often lead to a crisis, which is true for other populations as well.[233] This confirmation emerged from participants' interviews as they discussed their uncertainties during the healing process, pain, and the emotional and spiritual distress they experienced during the entire hospitalization. Therefore, chaplains working with sub-Saharan African immigrant patients must understand and take the crisis seriously. Overlooking the discomfort caused by the organization of the hospital, policies, and processes that seem strange

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[232] L. O. Mills, "Hospitalization, Experience of," in *Dictionary of Pastoral Care and Counseling*, Rodney J. Hunter, ed. (Nashville: Abingdon Press, 1990), 538.

[233] Mills, 538.

to the patient can poorly affect the outcome of the visit. Any negligence in this matter could help exacerbate the patient's crisis of self-understanding during hospitalization and cause dissatisfaction with the quality of the service the chaplains, and the hospital, are expected to provide.

The findings of this research project also indicated that chaplains' 'unconscious biases' have a negative effect on the delivery of quality spiritual care to patients from other cultures. A vast amount of literature is available on the impact of unconscious bias in the delivery of health care to patients from underrepresented groups in the United States. For instance, in one article written by Jasmine R. Marcelin et al., the authors noted: "In one systematic review on the impact of unconscious bias on health care delivery, there was strong evidence demonstrating the prevalence of unconscious bias (encompassing race/ethnicity, gender, socioeconomic status, age, weight, persons living with HIV, stability, and persons who inject drugs) affecting clinical judgment and the behavior of physicians and nurses toward patients."[234]

In fact, as of this day, no studies in the health care chaplaincy literature verify this statement to report how relevant it is to spiritual care. Such research would be beneficial in providing data that gives evidence of this since health care chaplaincy is developing as a stand-alone discipline. This could be a new field in which the researcher would encourage further studies. However, most participants in this research project who responded to the interviews suggested that there was a high probability that unconscious biases influenced chaplains who visited them.

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[234] Jasmine R. Marcelin, Dawd S. Siraj, Robert Victor, Shaila Kotadia, and Yvonne A. Maldonado, "The Impact of Unconscious Bias in Healthcare: How to Recognize Them and Mitigate It," *The Journal of Infectious Diseases* 220, Supplement 2 (August 2019), S64.

Chaplains who encounter sub-Saharan African immigrant patients must recognize that the presence of unconscious bias among health care professionals is a serious problem that can negatively affect the quality of the delivery of spiritual care. Several articles in the medical and nursing fields denounce cultural bias to make physicians and nurses aware of the negative consequences it may have on the delivery of health care. In one article, Chloe FitzGerald and Samia Hurst report a correlation between unconscious bias and poor health care quality. This knowledge could tremendously benefit the work of the health care chaplain.[235]

The researcher believes that health care chaplaincy must consider the seriousness of this problem better to advance patient satisfaction with spiritual care in health care institutions. Chaplains involved with spiritual care for sub-Saharan African immigrants must learn the appropriate skills and attitudes, considering the complexity of the task. Like physicians and nurses, chaplains must also be able to recognize their own biases during an encounter with sub-Saharan African immigrants and to use their stories to provide spiritual care rather than as a means to advance patient satisfaction during hospitalization in United States hospitals.

Project Conclusions

Following all that has been said in this study, the researcher believes that the findings of the research lead to three major conclusions.

Conclusion 1

During spiritual care encounters with sub-Saharan patients, the patient's cultural background influences patient satisfaction.

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[235] Chloe FitzGerald and Samia Hurst, "Implicit Bias in Healthcare Professionals: A Systematic Review," *BMC Medical Ethics* 18:19 (March 2017), 2-18.

The literature on cultural diversity in health care is unanimous that in spiritual care encounters, the patient's cultural background can influence the quality of the patient experience and affect patient satisfaction. Codes identified during the qualitative study are congruent with this. In other words, the patient's worldview, religious beliefs, and philosophy of life, death, pain, and suffering play an essential role in how a person responds to the chaplain's visit during hospitalization. This point of view is valid in medicine, nursing, and any helping professions. Geri-Ann Galanti, who has extensively published on this issue, provided numerous illustrations that support this statement.[236] For instance, in her book *Caring for Patients from Different Cultures,* she argues, "Although the physical experience of pain is universal, there is tremendous variation in how I expressed pain. Although there are individual differences, culture also influences whether or not people will act stoically or expressively in response to pain."[237]

Conclusion 2

During spiritual care encounters with sub-Saharan patients, the patient's cultural background may influence spiritual care outcomes.

During the interviews, all participants recognized that during a pastoral encounter with a sub-Saharan immigrant patient there are several cultural situations that interplay during a visit. Such as assumptions, culture shock, unconscious biases. All of the participants agreed that these three factors have the capacity to poorly influence the quality of the encounter. But they also articulate that chaplains who have cultural sensitivity and competence are likely to be more able to influence a positive outcome at the end of the visit. In other words, patient satisfaction is a

[236] Geri-Ann Galanti, *Caring for Patients from Different Cultures* (Philadelphia: University of Pennsylvania Press, 2008).

[237] Galanti, 50.

goal to achieve that could be reached when chaplains have cultural sensitivity and competence to manipulate cultural diversity issues that could have a negative influence on the quality of the visit. Participants' stories discussed above provide good illustrations of this. One of the assumptions that led to this study is that a sub-Saharan African patient could not experience satisfaction in chaplaincy care visits because of the effect of cultural factors that interplay during a visit. This study proves that a patient's cultural background could influence the encounter, but it does not determine whether the patient will have a good experience or a poor experience.

Conclusion 3

During chaplaincy care encounters with sub-Saharan patients, the chaplain's cultural sensitivity can influence behaviors that could affect the quality of the patient's visit.

In her book "*So You Want to Talk About Race"* Oluo Ijeoma noted that we do not live in a society that respects other cultures equally.[238] The researcher strongly agrees with this statement. However, the stories of participants demonstrate that a person who has cultural sensitivity could develop behaviors, such as tolerance and respect, that can enable people from different cultures to interact without paying attention to their differences or similarities with others.

The narratives of participants discussed in the qualitative study show that the chaplains remained considerate of patients' values because of their cultural sensitivity. From this perspective, cultural sensitivity allowed these chaplains to establish the emotional connections needed to develop a professional relationship with their patients. Every participant recognized that their experience with their chaplains was improving each time they were attentive to

[238] Ijeoma Oluo, *So You Want to Talk About Race* (New York: Seal Press, 2019), 151.

emerging religious and cultural factors that were interplaying during the visit. They also argued that cultural sensitivity and competence are foundational in chaplaincy care to sub-Saharan African immigrants patients to achieve patient satisfaction. In other words, cultural sensitivity and cultural competence are the game changers that caused the contradiction between the initial assumption of this research and the results of the study.

Conclusion 4

During a chaplaincy encounter with a sub-Saharan African immigrant patient, compassion compels the chaplain to do the cultural diversity work expected to promote patient satisfaction.

This conclusion was built upon the premise that compassion releases positive energy that could motivate chaplains to go the extra mile while working with a sub-Saharan African immigrant patient. The researcher strongly believes that this is because compassion is a spiritual resource. As a spiritual resource compassion has the propensity to increase a person's desire to care for others. In addition, compassion is also a spiritual practice. As a spiritual practice, compassion allows persons to listen to the pain and suffering of others and moves toward it with a caring heart.

In other words, compassion opens chaplains to the pain and suffering of others while it also increases the desire to meet the patient's needs. Based on the participants stories, the researcher observed that it was because participants' chaplains were driven by compassion, that they were more open to the idea of doing the cultural sensitivity work required to meet their patients spiritual needs and achieve patient satisfaction. Every story of participants reported earlier in the "recognized codes" section provides enough indications of that. All participants in this research project testified that they had noticed a great deal of compassion in their interaction

with their chaplains and believe that their compassion contributed to their experience of satisfaction during their hospitalization in the United States hospitals.

Project Applications

Since the Doctor of Ministry program was designed to lead to more effectiveness in ministry while improving professional competence, this research has birthed two continuing education applications for healthcare chaplains and those who work with people from other cultures, in general, and sub-Saharan African immigrant patients, in particular.

The first application is an audiovisual program. The researcher plans to develop audio video materials to promote awareness and evidence-based approaches for chaplaincy care to sub-Saharan African immigrant patients in the United States hospital. A few materials are already available, such as an introductory video and an initial training video that discusses practical issues in chaplaincy care encounters with sub-Saharan immigrant patients in United States hospitals.[239]

Future plans include educational opportunities on cultural diversity and sensitivity through conferences, workshops, seminars, and training that strive to address cultural diversity issues in the delivery of chaplaincy care services to this specific segment of the United States population. These materials will support best practices in the delivery of spiritual care to sub-Saharan immigrant patients in healthcare institutions. However, the researcher strongly believes that the findings of this research study could also benefit other professionals in healthcare institutions and would be open to provide continuing education sessions on this subject.

[239] For more information see Appendix K and Appendix L.

This program will encourage the use of case studies. As Steve Nolan noted in his introduction to the book entitled *Case Studies in Spiritual Care,* the researcher believes that "Possibly the greatest value of case studies is their ability to take us into the intimacy of the bedside and allow fellow chaplains, health care colleagues and those who commission chaplaincy care, as well as the general public, to see what actually goes on in the private space of the chaplaincy/spiritual care relationship."[240]

Recommendations

The researcher believes that the experience of sub-Saharan African immigrant patients in United States hospitals has many things to teach chaplains and health care professionals. Therefore, in this section, the researcher provided practical recommendations to advance spiritual care praxis toward sub-Saharan African patients in United States hospitals. These recommendations were intended to promote best practices for health care chaplains and promote evidence-based spiritual care. The recommendations unfold in three different groups:

1. Clinical Pastoral Education (CPE) programs
2. Professional chaplaincy
3. Clinical Pastoral Education (CPE) students

Finally, the researcher provided some suggestions for future topics on cultural diversity issues with spiritual care with sub-Saharan African patients in United States hospitals.

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[240] George Fitchett and Steve Nolan, eds., *Cases Studies in Spiritual Care: Healthcare Chaplaincy Assessments, Interventions & Outcomes* (Philadelphia: Jessica Kingsley Publishers, 2018), 11.

Clinical Pastoral Education Programs

These past three decades, the health care profession has been flooded with literature on cultural diversity in health care. However, Randy Grieser et al. made an intriguing remark about cultural diversity within organizations that could inspire CPE. They said, "Although some organizations continuously prioritize workplace culture, many only give it occasional attention, if any at all."[241] The researcher believes this statement is true for CPE in America.

Every CPE program in the United States recognizes the importance of cultural diversity in health care institutions. For example, it is written in the Clinical Pastoral Education (CPE) program of Saint Joseph Hospital that the center teaches CPE students didactics on "grief and loss, developmental and behavioral theories, group and systems theory, cultural and pastoral identity formation, level I/II consultations, Native American and Latino Cultures, boundaries, wellness and preparation for Chaplaincy Board Certification."[242] However, the researcher believes that several CPE centers still need a more solid program to promote cultural competence in health care chaplaincy. From this perspective, the researcher made two recommendations.

CPE training on cultural diversity needs to become more intentional and transformational. Currently, many CPE educational programs on cultural diversity still unconsciously focus on cultural awareness. These programs are more theoretical or cognitive than pragmatic. They maintain a gap between the "knowing" and the "doing" that requires immediate attention to better contribute to holistic health. By being intentional and transformational CPE may be able to close that gap and transform cultural diversity to a way of

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[241] Randy Grieser, Eric Stutzmam, Wendy Loewen, and Michael Labun, *The Culture Question: How to Create a Workplace Where People Like to Work* (Canada: Achieve Publishing, 2019), 8.

[242] "Clinical Pastoral Education Program: A Satellite of Bay Area Center for CPE," Dignity Healthcare, accessed April 16, 2023, www.dignityhealth.org/content/dam/dignity-health/pdfs/arizona/sjhmc-pastoral-clinical-education-program.pdf.

living among people who are from other cultures which will best support the role of chaplains in healthcare institutions.

Professional Chaplaincy

Over these past two decades, several fields of specialization have been developed in health care chaplaincy. For example, the Association of Professional Chaplains has developed a certification program on palliative care.[243] Since the establishment of this program, several hospitals in the United States have been utilizing chaplains in the hospital Palliative Care Team. This is a tremendous achievement for health care chaplaincy. This kind of specialization in health care chaplaincy care is advancing this new profession.

Considering the role health care chaplains could play in assisting physicians, nurses, and other hospital multidisciplinary team members in detecting cultural diversity issues that interfere with patient satisfaction during hospitalization, the researcher recommends organizations that commission chaplaincy care to develop a specialization track in cultural diversity. This recommendation makes perfect sense since chaplaincy care is also an advocacy profession.

The chaplain could play a key role in helping the multicultural team of the hospital detect cultural diversity issues often overlooked by the medical staff. For example, such a program could include teaching to identify cultural diversity issues that interplay during the rounds of the hospital's multidisciplinary and how to address them to create a positive experience for the patient.

[243] See Association of Professional Chaplains.

CPE students

The researcher recommends that students in CPE develop a better theological understanding of cultural diversity, including unconscious bias, whether it means Christian theology or theologies from other religious traditions. This is because theology and theological reflections can help CPE students better understand how to engage the *imago Dei* in each person, including people from other cultures, in the delivery of spiritual care. The researcher strongly believes that pastoral praxis can handle certain limitations caused by the lack of cultural sensitivity and cultural competence with a solid theological foundation.

Learning from the contrasting Biblical stories of the Tower of Babel (representing the disunification of the human race) and the day of Pentecost (representing reunification) could set the stage for a good understanding of the actual value of cultural diversity and increase motivation for cultural sensitivity and cultural competence in health care chaplaincy.

The researcher also recommends CPE student to consider other ways of learning about cultural diversity. For example, participation in mission trips with their churches or any other organization is also a good way to learn about other cultures. These experiences allow the student to emerge in one culture and learn from experience. This could also be done oversea or by attending an African immigrant church in the United States, participating in their festivals and develop relationships or partake in a rescue mission after natural disasters in an area mostly occupied per people from other cultures. Mission trips provide great opportunities to learn how to integrate their learning in their relationships.

Future Research on Cultural Diversity Issues with Spiritual Care with Sub-Saharan African Patients in United States

As discussed earlier, the researcher recommends future studies on this topic. First, the researcher believes that further research is needed to understand why most participants to the electronic surveys did not receive a visit from the chaplain during their hospitalization in United States hospitals. Such a study could help evidence-based spiritual care understand the reason and determine new directions for the work of the chaplain with this category of the U.S. population.

Second, the researcher also believes it would be exciting to verify the conclusions of this research project with a larger sample. This suggests expanding both quantitative and qualitative studies. Such projects will need institutional support because it is difficult to gather the financial, material, and human resources required to strive for excellence. That was the case for this research project.

Third, it would also be fascinating to investigate this subject from the perspectives of non-African chaplains. Such a study would highlight new perspectives for chaplains who provide chaplaincy care to immigrant patients. Exploring this subject could enlighten the challenges non-African chaplains face in providing care to sub-Saharan patients and suggest new directions for evidence-based chaplaincy care to this category of American health care consumers.

Conclusion

We live in the metrics age; patient satisfaction research has become a central approach to measuring how people react to services received. Patient satisfaction studies have become crucial for most health care institutions, corporations, and for-profit businesses in the United States.

Some hospitals even hire specialized firms such as Press Ganey to perform those studies for them and report their findings to engage in process improvement.[244]

In recent years research on patient satisfaction has also caught the interest of health care chaplaincy. The health care chaplaincy has also embarked on this journey and is currently actively engaged in the measurement of patients' satisfaction with spiritual care in hospitals. From this perspective, the researcher encourages patient satisfaction studies in health care chaplaincy among sub-Saharan African patients. This is because sub-Saharan African immigrant patients are consumers of American health care and should also access chaplaincy care services when they are hospitalized in United States hospitals. Besides, there is a lack of material published on this subject to inspire evidence-based spiritual care. More research on this category of the US population will contribute to increasing the literature and development of resources that could be used to improve the quality of spiritual care to be provided to them.

This research project has focused on the experience of sub-Saharan African immigrant patients in United States hospitals with the delivery of spiritual care. The project studied the accessibility of sub-Saharan Africans to health care chaplaincy in United States hospitals. In addition, the project studied what sub-Saharan African patients said about their experience with a chaplain's visit during hospitalization, knowing that culture influences how people live and behave under specific circumstances. Completing this research has been a long journey, but it has also been an exciting one. The researcher has learned that cultural sensitivity and diversity are crucial to patient satisfaction of sub-Saharan Africans in United States hospitals.

This study revealed that patient satisfaction might suffer when the cultural sensitivity and competency of the chaplains fall short during a spiritual care visit with a sub-Saharan African

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[244] For more information on Press Ganey Associates, see www.pressganey.com.

immigrant patient. There are times when the lack of cultural sensitivity and competence during a spiritual care encounter with sub-Saharan African Immigrant patients creates misunderstandings and situations that escalate into more serious conflicts affecting the patient-chaplain's working relationship.

However, chaplains from other cultures should not be intimidated by cultural diversity issues that may surface during an encounter when working with sub-Saharan African immigrant patients. Instead, they must keep a positive attitude and be emotionally present during the visit. That way, chaplains may become aware of their unconscious biases and negative emotions that affect the quality of spiritual care service. That attitude allows chaplains to discover the learning curves that require cultural work to improve their future visits. Patient satisfaction with sub-Saharan immigrant patients requires great courage, love, compassion, and attention to detail as discussed in chapter two of this project. Chaplains who can integrate love, compassion, and the ability to pay attention to details in their encounters with sub-Saharan African immigrants have more chances to provide excellent chaplaincy care and achieve patient satisfaction. This is because love, compassion, and the ability to pay attention to details are three ingredients for success in spiritual care.

It is essential that chaplains to spend a great deal of time mastering competencies of the Association of Professional Chaplains because these competencies were developed to allow excellence in any spiritual care encounters in professional chaplaincy care. In any spiritual care encounters, chaplains who use them as tools are likely to be more successful in their endeavors. The study showed that sub-Saharan African patient satisfaction is closely linked to the chaplain's cultural sensitivity and competence. The research project argues that only chaplains who have developed cultural sensitivity and competence in their practice of spiritual care could effectively

navigate waves of cultural diversity issues during an encounter with sub-Saharan African patients. Cultural sensitivity and competence are imperative for best-practice in the delivery of spiritual care to sub-Saharan African immigrant patients.

Appendix A

PSR Instrument (English version)

Select below the box that best represents your satisfaction with the ministry of the chaplain during your hospitalization:

	Ministry that promotes coping	Strongly agree	Disagree	Neutral	Agree	Strongly disagree
1	The chaplain helped me realize God cares for me					
2	The chaplain visit made my hospitalization easier					
3	The chaplain helped me use my faith/beliefs/values to cope					
4	The chaplain helped me feel more hopeful					
5	The chaplain's visit gave me the strength to go on					
6	The chaplain's visit aided my spiritual growth during illness					
7	The chaplain helped face difficult issues					
8	The chaplain helped me overcome my fears					
9	The chaplain helped me adjust to my medical condition					
10	The chaplain visit contributed to my readiness to return home					
11	The chaplain's visit contributed to a faster recovery					
12	The chaplain helped the clergy of my congregation to better understand my situation					
13	The chaplain helped me cooperate with doctors and nurses					

	The supportive ministry of chaplains	Strongly agree	Disagree	Neutral	Agree	Strongly disagree
1	The chaplain's prayer was a comfort to me					
2	The chaplain gave the impression s/he was really listening to me					
3	The chaplain seemed to know what s/he was doing during the visit					
4	The religious worship service met my needs					
5	My needs for the sacraments were fulfilled					
6	After talking to the chaplain, I felt better about my problems					

	Acceptance of the chaplain's ministry	Strongly agree	Disagree	Neutral	Agree	Strongly disagree
1	The chaplain's visit scared me					
2	The chaplain talked too much					
3	The chaplain's visit made me too tired					

	Independent item	Strongly agree	Disagree	Neutral	Agree	Strongly disagree
1	The chaplain seemed to be a person of spiritual sensitivity					

Appendix B

PSR Instrument (French version)

Sélectionnez ci-dessous la case qui représente le mieux votre satisfaction à l'égard du ministère de l'aumônier pendant votre hospitalisation:

	Ministere favorisant l'adaptation	Tout a fait d'accord	Pas d'accord	Neutre	D'accord	Pas d'accord du tout
1	L'aumonier m'a aide a realiser que Dieu prends soin de moi					
2	La visite de l'aumonier a rendu facile mon hospitalization					
3	L'aumonier m'a aide a utilize ma foi/croyances/valeurs pour faire face a la maladie					
4	L'aumonier m'a aider a me sentir plus optimiste					
5	L'aumonier ma donné la force de continuer					
6	La visite de l'aumonier a aide ma croissance spirituell pendant la maladie					
7	L'aumoier m'a aide a faire face a des problemes diffciles					
8	L'aumonier m'a aidé a surmonte ma peur					
9	L'aumonier m'a aide é m'adapter amon ett de sante					
10	La visite de l'aumonier a contribuée a ma preparation au retour a la maison					
11	La visite de l'aumonier a contribute a un retablissement plus rapide					
12	L'aumonier a aide le clergé de ma congregation a comprendre ma situation					
13	L'aumonier m/a aide a cooperer avec les medecins et infirmieres					

	L'aumonier et le ministère de soutien	Tout a fait d'accord	Pas d'accord	Neutre	D'accord	Pas d'accord du tout
1	La priere de l'aumonier a ete un reconfort pour moi					
2	L'aumonier a donne l'im pression qu'il m'ecoutait					
3	L'aumonier semblait savir ce qu'il faisit pendant la visit					
4	Le culte a repondu a mes besoins					
5	Mes besoins enc e qui conerne les sacrements on ete satisfait					
6	Apres avoir parle avec l'aumonier, je me sentais mieux par rapport a mes problemes					

	Acceptation du ministère de l'aumonier	Tout a fait d'accord	Pas d'accord	Neutre	D'accord	Pas d'accord du tout
1	La visite de l'aumonier m'a fait peur					
2	L'aumonier parlait trop					
3	La visite de l'aumonier m'a rendue trop fatigue(e)					
	Question Indépendante	Tout a fait d'accord	Pas d'accord	Neutre	D'accord	Pas d'accord du tout
1	L'aumonier semblait etre une personne spirituelle					

Appendix C

Letter of Recruitment (English Version)

Date:

RE:

Dear _____

You are invited to participate in a web-based online survey on Patient Satisfaction study of African Immigrants with the delivery of Pastoral Care in the United States Hospitals'. The research will be conducted by Dido A. Ntontolo, a doctorate student at Winebrenner Theological Seminary, Ohio.

The survey should take approximately 10 (ten) minutes to complete. The conditions of participation, agreements and procedures are explicitly described in the *Informed Consent Form* attached to this letter.

I would appreciate it if you choose to participate in this study. If you decide to participate, please, read the *Informed Consent Form* attached to this letter, sign it, and send it back to me as soon as you can.

Sincerely,

Dido Augustin Ntontolo

Appendix D

Letter of Recruitment (French Version)

Date:

Objet:

Cher _____

Vous êtes invités à participer à un sondage en ligne sur l'étude sur la satisfaction des patients des immigrants africains avec la prestation de soins pastoraux dans les hôpitaux des États-Unis. La recherche sera menée par Dido A. Ntontolo, doctorant à Winebrenner Theological Seminary, en Ohio.

Le sondage devrait prendre environ 10 (dix) minutes à remplir. Les conditions de participation, les ententes et les procédures sont explicitement décrites dans le *formulaire de consentement éclairé* joint à la présente lettre.

J'apprécierai que vous choisissiez de participer à cette étude. Si vous avez décidé de participer, veuillez lire le *formulaire de consentement éclairé* joint à cette lettre, le signer et me le renvoyer dès que possible.

Sincèrement

Dido Augustin Ntontolo

Appendix E

Interview Questions for the Qualitative Method (English Version)

1. Have you ever been hospitalized in the United States? If yes, please tell me a little bit about your condition and the length of your stay.

2. When you were hospitalized did you feel like the visit of a chaplain would be helpful to you? If yes, please explain.

3. During your hospitalization did you receive the visit of the hospital chaplain? If yes, under what circumstances.

4. Can you tell me about some emotional/spiritual needs that you had during the hospitalization?

5. What did you expect from the chaplain's visit?

6. How do you describe your interaction with the chaplain during the visit? Explain.

7. At the end of the visit, did the chaplain meet your emotional/spiritual need? Explain.

8. Were you satisfied with the visit of the chaplain?

9. What could the chaplain have done differently to meet your emotional/spiritual needs?

10. Do you have anything else that you want to say?

Appendix F

Interview Questions for the Qualitative Method (French Version)

1. Avez-vous déjà été hospitalisé aux États-Unis? Si oui, parlez-moi un peu de votre état et de la durée de votre séjour.

2. Lorsque vous avez été hospitalisé, avez-vous eu l'impression que la visite d'un aumônier vous serait utile? Dans l'affirmative, veuillez expliquer.

3. Pendant votre hospitalisation, avez-vous reçu la visite de l'aumônier de l'hôpital? Si oui, dans quelles circonstances ?

4. Pouvez-vous me parler de certains besoins émotionnels et spirituels que vous avez eu pendant l'hospitalisation?

5. Qu'attendiez-vous de la visite de l'aumônier?

6. Comment décrivez-vous votre interaction avec l'aumônier pendant la visite? Veuillez expliquer.

7. A la fin de la visite, l'aumônier a-t-il répondu à vos besoins émotionnels et spirituels? Expliquez.

8. Avez-vous été satisfait de la visite de l'aumônier? Veuillez expliquer

9. Qu'est-ce que l'aumônier aurait pu faire différemment pour répondre à vos besoins émotionnels et spirituels?

10. Avez-vous autre chose à dire?

Appendix G

Informed Consent Form (English Version)

Institutional Review Board Informed Consent form

Contact persons: For more information concerning this research, please contact [name of principal researcher] at [phone].

If you believe that you may have suffered a research-related injury, contact [name of IRB chair] at [phone].

If you have further questions about your rights as a research subject, you may contact [name of principal researcher] at [phone].

VOLUNTARY PARTICIPATION: Participation in this research is voluntary. You are free to participate or to withdraw at any time, for whatever reason. In the event that you do withdraw from this study, the information you have already provided will be kept in a confidential manner. (Note *to researchers: please include if applicable* – For studies utilizing students, state that the subject does not jeopardize grades nor risk loss of present or future faculty or institution relationships.)

CONSENT: Federal regulations require precautionary measures to be taken to insure the protection of human subjects on physical, psychological, social, and other issues. This includes the use of "informed consent" procedures.

I, _____ , (PRINTED NAME OF SUBJECT) have been adequately informed regarding the risks and benefits of participating in this research. My signature also indicates that I can change my mind and withdraw my consent to participate at any time without penalty. Any and all questions I had about my participation in this research have been fully answered. I understand I will receive a copy of this consent form for my records.

SUBJECT SIGNATURE:

_____

DATE

I have witnessed the consent process and believe the subject has been fully informed, understands the research study, and has agreed to participate in the research.

WITNESS PRINTED NAME:

_____

WITNESS SIGNATURE:

_____

DATE:

Appendix H

Informed Consent Form (French Version)

Formulaire de consentement éclairé de la Commission
d'examen institutionnelle

Personnes-ressources : Pour de plus amples renseignements concernant cette recherche, veuillez communiquer avec [nom du chercheur principal] à [téléphone].

Si vous croyez avoir subi une blessure liée à la recherche, communiquez avec [nom du président de la CISR] au [téléphone].

Si vous avez d'autres questions sur vos droits en tant que sujet de recherche, vous pouvez communiquer avec [nom du chercheur principal] au [téléphone].

PARTICIPATION VOLONTAIRE : La participation à cette recherche est volontaire. Vous êtes libre de participer ou de vous retirer à tout moment, pour quelque raison que ce soit. Dans le cas où vous vous retirez de cette étude, les informations que vous avez déjà fournies seront conservées de manière confidentielle.

(Note *aux chercheurs : veuillez inclure, le cas échéant* – Pour les études utilisant des étudiants, indiquez que le sujet ne compromet pas les notes ni ne risque de perdre les relations actuelles ou futures avec le corps professoral ou l'établissement.)

CONSENTEMENT : La réglementation fédérale exige que des mesures de précaution soient prises pour assurer la protection des sujets humains sur des questions physiques, psychologiques, sociales et autres. Cela comprend l'utilisation de procédures de « consentement éclairé ».

Moi,_____
_____ Ma signature indique également que je peux changer d'avis et retirer mon consentement à participer à tout moment sans pénalité. Toutes les questions que j'avais au sujet de ma participation à cette recherche ont reçu une réponse complète. Je crois savoir que je recevrai une copie de ce formulaire de consentement pour mes dossiers.

SIGNATURE DE L'OBJET : _____

DATE : _____

J'ai été témoin du processus de consentement et je crois que le sujet a été pleinement informé, qu'il comprend l'étude de recherche et qu'il a accepté de participer à la recherche.

NOM IMPRIMÉ DU TÉMOIN : _____

SIGNATURE DU TÉMOIN :

_____

DATE :_____

Appendix I

Authorization to Use and Disclose Protected Health/Medical Information for Research Purposes (English Version)

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH/MEDICAL INFORMATION FOR RESEARCH PURPOSES

Participant Name: _____
Principal Investigator: Dido A. Ntontolo
Principal Investigator's Contact Information:
Phone: 614-971-1933.
Email: ntontolok@findlay.edu
Home address: 5116 Sand Court, Groveport, OH43125
Title of Study: Healthcare Chaplaincy: A Study of Patient Satisfaction of African Immigrants in the Unites States of America Hospitals.

What is the purpose of this form?
The health-related information that we gather about you in this study is personal. In this form, we describe who will be working with this information and ask for your permission to use the information in the research study.

Please read this form carefully. If you have any questions, please ask the Principal Investigator listed above before signing this form. By signing this form, you agree that the researcher may use your personal health (medical) information.

Why does the researcher want my personal health/medical information?
Dido A. Ntontolo will collect your health and/or medical information and share it with Dr. Kathryn Helleman, Dr. Joel Cocklin and Dr. Kristina Gutierrez to use in the research study that is described in the *Informed Consent* document.

What personal health and/or medical information does the researcher want to use?
The researcher wants to use portions of your health/medical information that they will need for their research. Some of the information that will be used and/or shared may include the following:
• The diagnosis and history of your disease or condition;
• Information about other medical conditions you may have;
• Information about your level of satisfaction with Spiritual Care services.

Who will be able to use my personal health information?
The investigator involved in this study will use your health/medical information for research. As part of this research, they may share your information with their research advisor and/or instructor, as listed at the top of this form. Additionally, your information will be included in the final research paper and report of research findings.

How will information about me be kept private?
The investigator will keep all participant information private to the extent possible by *de-identifying* participant information. In turn, your de-identified information may be used in the final research paper and report written by the investigator. However, any information that shows clear and eminent danger to the research participant and/or identified others cannot be kept private. In cases of foreseeable harm to self or others, necessary information will be reported to proper authorities.

What happens if I do not sign this form?
You have a right to refuse to sign this form. If you do not sign this form, you will not be able to participate in this research study.

What happens if I want to withdraw my permission?
You may change your mind and revoke (take back) this Authorization at any time, except to the extent that Dido A. Ntontolo has already acted based on this Authorization.

> ***To withdraw your permission***, please contact the person below. He/she/they will make sure your written request to withdraw is processed correctly.

Dido A. Ntontolo, Principal Investigator
Phone: 614-971-1933.
Email: ntontolok@findlay.edu
Home address: 5116 Sand Court, Groveport, OH43125

May I have a copy of this form?
Yes, you have a right to receive a copy of this form after you have signed it. If after you have signed this form you have any questions about your rights, please contact
Dr. Kathryn Helleman, Research Advisor.
950 N. Main Street, Findlay, OH45840
Phone:419-434-4200
Email: Katheryn.Helleman@winebrenner.edu

This Authorization will expire upon completion of the research study (including written and reported findings).
Authorization Statement: I have read this form and all questions about this form have been answered. By signing below, I give permission for the described uses and sharing of information.*

_____ _____
Signature of Participant or Personal Representative Date

_____
Print Name of Participant or Personal Representative

_____
If applicable, a description of the personal representative's authority to sign for the participant
Participant or Personal Representative Contact Information:
Address: _____
Home Phone: _____ Cell Phone _____
Email Address: _____

THE PARTICIPANT OR HIS/HER/THEIR PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.
**If you sign this form, you may change your mind at any time. If this happens, you must withdraw your permission in writing. If you sign this form and participate in the research study, but later change your mind and withdraw your permission, you will be removed from the research study at that time.*

Appendix J

Authorization to Use and Disclose Protected Health/Medical Information for Research Purposes (French Version)

AUTORISATION D'UTILISER ET DE DIVULGUER DES RENSEIGNEMENTS MÉDICAUX OU DE SANTÉ PROTÉGÉS À DES FINS DE RECHERCHE

Nom du participant : ____
Chercheur principal : Dido A. Ntontolo
Coordonnées du chercheur principal : Téléphone : 614-971-1933.
Courriel : ntontolok@findlay.edu Adresse du domicile : 5116 Sand Court, Groveport, OH43125
Titre de l'étude: Healthcare Chaplaincy: A Study of Patient Satisfaction of African Immigrants in the Unites States of America Hospitals.

Quel est le but de ce formulaire?
Les informations relatives à la santé que nous recueillons à votre sujet dans cette étude sont personnelles. Dans ce formulaire,
Nous décrivons qui travaillera avec ces informations et vous demandons la permission d'utiliser le
dans l'étude de recherche.

Veuillez lire attentivement ce formulaire. Si vous avez des questions, veuillez les poser au chercheur principal.
énumérés ci-dessus avant de signer ce formulaire. En signant ce formulaire, vous acceptez que le chercheur puisse utiliser vos renseignements personnels sur la santé (médicale).

Pourquoi le chercheur veut-il obtenir mes renseignements personnels sur la santé ou les renseignements médicaux?
Dido A. Ntontolo recueillera vos informations médicales et / ou de santé et les partagera avec le Dr Kathryn Helleman, le Dr Joel Cocklin et le Dr Kristina Gutierrez pour les utiliser dans l'étude de recherche décrite dans le document *de consentement éclairé*.

Quels renseignements personnels sur la santé et/ou les renseignements médicaux le chercheur souhaite-t-il utiliser?
Le chercheur veut utiliser des parties de vos renseignements médicaux ou de santé dont il aura besoin pour sa recherche. Certaines des informations qui seront utilisées et / ou partagées peuvent inclure les éléments suivants:
• Le diagnostic et les antécédents de votre maladie ou affection;
• Informations sur d'autres conditions médicales que vous pourriez avoir;
• Les informations sur votre niveau de satisfaction avec Spiritual Csont des services.

Qui pourra utiliser mes renseignements personnels sur la santé?

L'investigateur impliqué dans cette étude utilisera vos informations médicales / de santé pour la recherche. Dans le cadre de cette recherche, ils peuvent partager vos informations avec leur conseiller en recherche et / ou instructeur, comme indiqué au haut de ce formulaire. De plus, vos informations seront incluses dans le document de recherche final et le rapport des résultats de recherche.

Comment les informations me concernant seront-elles gardées privées?
L'enquêteur gardera toutes les informations personnelles privées dans la mesure du possible en dépersonnalisant les informations sur les participants. À leur tour, vos renseignements anonymisés peuvent être utilisés dans le document de recherche final et le rapport rédigé par l'enquêteur. Toutefois, toute information qui démontre un danger clair et éminent pour le participant à la recherche et/ou d'autres personnes identifiées ne peut être gardée privée. En cas de préjudice prévisible à soi-même ou à autrui, les informations nécessaires seront signalées aux autorités compétentes.

Que se passe-t-il si je ne signe pas ce formulaire?
Vous avez le droit de refuser de signer ce formulaire. Si vous ne signez pas ce formulaire, vous ne pourrez pas participer à cette étude de recherche.

Que se passe-t-il si je souhaite retirer mon autorisation ?
Vous pouvez changer d'avis et révoquer (reprendre) cette autorisation à tout moment, sauf dans la mesure où Dido A. Ntontolo a déjà agi sur la base de cette autorisation.

Pour retirer votre autorisation, veuillez contacter la personne ci-dessous. Il s'assurera que votre demande écrite de rétractation est traitée correctement.
Dido A. Ntontolo, chercheur principal
Téléphone : 614-971-1933
Courriel: ntontolok@findlay.edu
Adresse du domicile : 5116 Sand Court, Groveport, OH43125

Puis-je avoir une copie de ce formulaire?
Oui, vous avez le droit de recevoir une copie de ce formulaire après l'avoir signé. Si, après avoir signé ce formulaire, vous avez des questions sur vos droits, veuillez communiquer avec la Dre Kathryn Helleman, conseillère en recherche.
950 N. Main Street, Findlay, OH45840 Téléphone :419-434-4200 Courriel : Katheryn.Helleman@winebrenner.edu

Cette autorisation expirera à la fin de l'étude de recherche (y compris les résultats écrits et rapportés).
Déclaration d'autorisation : J'ai lu ce formulaire et j'ai répondu à toutes les questions à ce sujet. En signant ci-dessous, je donne la permission pour les utilisations décrites et le partage d'informations. *

_____ _____

Signature de la date du participant ou du représentant personnel

_____

Nom du participant ou du représentant personnel en lettres moulées

_____

S'il y a lieu, une description de l'autorité du représentant personnel à signer pour le participant

Coordonnées du participant ou du représentant personnel :

Adresse: _____

Téléphone résidentiel: _____ Téléphone cellulaire _____

Adresse courriel: _____

LE PARTICIPANT OU SON REPRÉSENTANT PERSONNEL DOIT RECEVOIR UNE COPIE DE CE FORMULAIRE APRÈS SA SIGNATURE.

**Si vous signez ce formulaire, vous pouvez changer d'avis à tout moment. Si cela se produit, vous devez retirer votre autorisation par écrit. Si vous signez ce formulaire et participez à l'étude de recherche, mais changez d'avis par la suite et retirez votre autorisation, vous serez retiré de l'étude de recherche à ce moment-là.*

Appendix K

Audio-visual Materials for Chaplain's Sensitivity and Engagement on Cultural Diversity Issues in Hospital Settings

Video 1:

Introduction video to the researcher's work on cultural diversity in healthcare institutions.

Content:

Hello, I am Dido Ntontolo. I have been a professional healthcare chaplain with over 20 years of service in the healthcare ministry. In this video, I would like to introduce a research project I conducted for Winebrenner Theological Seminary in Findlay, Ohio. This research project focuses on the satisfaction of sub-Saharan African immigrant patients with spiritual care in hospitals in the United States.

I have worked as a professional healthcare chaplain in several hospitals in the United States, having received my certification in 2004. My experience in healthcare chaplaincy is from Duke University Medical Center in Durham, North Carolina; Cabell Huntington Hospital in Huntington, West Virginia; St. Mary's Medical Center in Huntington, West Virginia; and the OhioHealth System located in Columbus, Ohio. I am currently at Springfield Regional Medical Center as a staff chaplain in Springfield, Ohio.

Over the years, I have had the privilege of having pastoral encounters with people from many different walks of life. My experience as a healthcare chaplain extends from working in the Emergency Room, Intensive Care Units, and other units of hospitals, meaning that I have participated in several traumatic crises, deaths, code blues, and different acute situations at the patient's bedside.

During most of my ministry in the hospital setting, I thought it could be difficult for most sub-Saharan patients in United States Hospitals to have a satisfactory experience with the hospital chaplain during hospitalization due to the potential influence of cultural differences may have on the experience. This assumption emerged from the following two situations.

My first experience was in 1995, a few days after I came to the United States. I had gotten a cold, and I was not feeling well. At the time, I was taking English as a Second Language classes (commonly referred to as ESL) and was not fluent in English yet. I knew that I needed to go to the hospital, but I was afraid. I was fearful of the embarrassment that language barriers tend to cause in public places. I knew it would be difficult to describe my symptoms and pain to the medical staff, and I wanted to save myself from that embarrassment and humiliation. At the time, I did not know that hospitals utilize language services to circumvent the language barriers of people from other countries, allowing them to be adequately accommodated. I resisted the idea of going to the hospital for a couple of hours, but ultimately, I drove myself to the closest ER when the pain became unbearable. A chaplain came to see me, but I did not have a good experience with him.

My second experience with U.S. Hospitals is with my wife, Emilie. She was hospitalized and was recovering from total hysterectomy surgery. Several hours after her surgery, a chaplain assigned to her unit visited her. After the chaplain left, I felt the air in the room was slightly uneasy. I asked her how her experience with the chaplain was, to which she responded, “I am in excruciating pain… I felt like [the chaplain] just came to wake me up for no reason… He brought me flowers … and I do not need flowers.” Her disheartening reply revealed to me that she was not satisfied with the visit by the chaplain assigned to her.

In the years since my arrival, I have also listened to the stories of my peers who have had pastoral encounters with sub-Saharan African patients. Many individuals have come to the same conclusions. At the same time, many sub-Saharan African patients have reported great satisfaction with the visit of the healthcare chaplain during a hospital stay in the United States. I have observed that healthcare chaplaincy is becoming more and more of an evidence-based field, similar to other professions such as nursing, medicine, pharmacy science, and other paramedical fields. This factor in particular influenced my decision to research this topic, to verify the accuracy of my observations and contribute to improving the quality and overall delivery of spiritual care for sub-Saharan patients in Hospitals in the United States.

I have chosen to research the satisfaction of sub-Saharan patients with the delivery of spiritual care in hospitals in the United States. This is an original study, meaning that this subject has no pre-existing research that can be used to analyze or compare with my findings. It is an essential subject to research as a substantial population of sub-Saharan African immigrants live in the United States, especially those utilizing its hospitals when sick or have otherwise fallen ill. Therefore, it is quintessential to investigate what those individuals have said regarding the spiritual care delivered to them by the incumbent healthcare chaplains during hospitalization.

This research was birthed by the desire to contribute to the evidence-based approach that is slowly and surely becoming the norm in the work of the healthcare chaplain. Most professional organizations for healthcare chaplains (such as the Association of Professional Chaplains, Chaplaincy Lab, Transforming Chaplaincy, Spiritual Care, and National Association for Catholic Chaplains, to name just a few), have decided that in the 21st century, healthcare chaplaincy must follow the steps of other professions that are involved in clinical practice and become an evidence-based profession. Since every evidence-based profession uses research to

establish best practices, I wanted to evaluate the experience of sub-Saharan patients with chaplaincy care provided in the United States hospitals.

This research is identified as outcome research. The study aims to evaluate the outcome of spiritual care delivered to a specific group of individuals who, in this instance, are consumers of American healthcare. I consider this a crucial step towards improving the quality of the work done by healthcare chaplains among this specific population. In this research, I utilized a mixed-methods approach. I have used quantitative and qualitative instruments. Two hundred fifty participants volunteered to partake in the data collection process. I had email exchanges with George Hando and George Fitchett, well-known experts in this field, who encouraged me to use instruments already available, leading to the choice of PSI-CR, developed by Larry VandeCreek and Marjorie Lyon.

Some limitations of this research include that it did not benefit from institutional support, as is the case with much research published in the Journal of Spiritual Care and Counseling. I funded this study with minimal resources. Hence, institutional support is essential and greatly emphasized in spiritual care literature. This is because it creates conditions that allow the researcher to have the appropriate resources for the study. this topic is still recommended for further studies, as there is much to learn about cultural diversity and how it impacts the delivery of spiritual care to patients, especially patients from the sub-Saharan region of Africa who seek out hospitals in the U.S. for healthcare support.

It is aberrant to think that this research covers everything that needs to be learned under such limitations. I consider this study as an introduction to research on patient satisfaction with spiritual care, especially for patients from the sub-Saharan region of Africa. It is an area that is

not yet fully explored and that ultimately deserves attention to ensure best practices in the spiritual care of this population, a healthcare consumer in the United States hospitals.

This research provides exciting conclusions for best practices in spiritual care to sub-Saharan African immigrants. At the beginning of this study, I assumed that a sub-Saharan patient's satisfaction with spiritual care within American hospitals would be low due to the numerous cultural factors that affect the patient-chaplain working relationship. However, the study shows that this assumption is not correct. The study provides evidence that suggests it may be a challenging experience, but when a chaplain has the knowledge and the skills to apply the professional competencies of the Association of Professional Chaplains, they are better able to navigate through the culture-satisfying experience with chaplaincy care to sub-Saharan immigrant patients.

In addition, the study establishes that a chaplain with cultural competence (or, in other words, has training in cultural diversity serving sub-Saharan African patients) is likely to reach patient satisfaction with healthcare chaplaincy easier than a chaplain who is a stranger to cultural differences. This confirms the importance of administering training that focuses on cultural diversity for chaplains who may work with sub-Saharan patients in American hospitals.

Appendix L

Audio-visual Materials for Chaplain's Sensitivity and Engagement on Cultural Diversity Issues in Hospital Settings

Video 2:

A case study of an encounter with a sub-Saharan African immigrant patient.

Contents:

This is the case of a patient from the Democratic Republic of Congo, briefly coming to the United States to attend his son's college graduation at The Ohio State University in Columbus, Ohio. During his stay, he started to feel ill. He was in much pain but refused to come to the hospital until his pain became unbearable. His spouse and children encouraged him to go to the closest Emergency Department, but he refused and said, "I will be fine." On the third night, he began to wail loudly in excruciating pain. His son immediately called the ambulance against his wishes out of concern for his father.

After arriving at the hospital, several tests were conducted. The ultimate diagnosis determined that this patient had suffered a mini stroke, likely caused by untreated hypertension. During the admission process, the nurse asked the patient, "On a scale from one to ten, with one being mild and ten being egregious, how do you describe your pain?" His answer was seven.

When the physician consulted the patient after the nurse, he also complained about having a severe headache. The physician asked the patient to describe his pain, to which the patient replied that the pain was a seven out of ten, with ten being the worst. After this, the patient was in his room most of the day. Since he was not fluent in English, the staff utilized the Language Services tablet to communicate with him. Everyone thought everything was going

well and that the patient was getting the best care. A Caucasian chaplain had visited him twice before I asked to see him for emotional support.

During my visit, the patient reported that he was highly thankful to the previous chaplain because he came to pray for him. He also expressed frustration, saying the physician asked him too many questions. “I am the patient. I came here for [the physician] to tell *me* what was wrong and to determine the treatment plan. *Not* for him to ask me questions.” The nurse also admitted to being mildly frustrated, as whenever she asked the patient about his pain, he would rate it a seven while asking for more pain medication.

Analysis

Several cultural issues in this encounter should be considered to improve the quality of care, whether it means spiritual care or nursing care.

His spouse and children encouraged him to go to the closest Emergency Department, but he always refused, saying, “I will be fine.”

In most developing countries, people tend to have a high level of pain tolerance, especially in the case of those living in rural areas where the healthcare system is nearly inaccessible due to factors such as lack of resources, funding, distance from metropolitan areas, or a combination of the three. In these areas, people rarely report to a hospital or medical center for healthcare while dealing with an illness, and it is when things take a turn for the worse that they do. From this perspective, coming to the hospital means the person is seriously hurting or dying, which is not always the case in the United States since pain medicine has become a specialty in Western medicine.

“On a scale from one to ten, with one being the least and ten the highest, how do you describe your pain?” The patient’s answer was seven.

French-speaking countries have a different grading system from those in United States schools. For instance, in the Democratic Republic of Congo, grading seven (7) or 70% in any exam is a great achievement. That grade is a distinction. It is a very high score that every student strives to achieve. From this perspective, when a person describes their pain as seven on a scale of one to ten, that means that the patient's pain is very high. This is not the same reality in the United States.

In the American grading system, a person earning seven (7) or seventy percent (70%) in any exam or test is a C or mediocre. Medically, it means that the person is in pain, but the pain is not excruciating. Ignoring these kinds of cultural details during a spiritual care encounter influences the accuracy of the assessment of the chaplain. This is also true of the work of the multidisciplinary team and the efficacy of the treatment plan given to the patient.

"I am the patient… I came here for [the physician] to tell *me* what is wrong and to determine the treatment plan. *Not* for him to ask me questions…"

This statement reveals that the patient is unaware that the patient or the Healthcare Power of Attorney play the principal role in the decision-making process in American medicine rather than the physician. In most African cultures, the physician is the person who knows the best solutions to the patient's problem and subsequently determines the plan of treatment for them to follow with very little to no input from the patient. People believe that every physician has the training to determine the diagnosis and the competence to determine the treatment needed to fight an illness.

Learning

These findings indicate that if a chaplain is adequately equipped with knowledge of these cultural differences, that the chaplain could be a key resource to the medical staff that may

encounter a sub-Saharan patient. The chaplain's knowledge could potentially aid the medical staff in obtaining an accurate assessment of the patient's pain, which will undeniably impact patient satisfaction. In addition, a chaplain who understands the difficulties likely to arise in such circumstances could also educate the patient about how the healthcare system varies from home countries to hospitals in the United States. This will allow the patient to adjust to the complexity of healthcare in the United States.

Appendix M

Certification of Completion on Research of Human Subject

CITI PROGRAM

Completion Date 15-Sep-2021
Expiration Date 14-Sep-2024
Record ID 44819726

This is to certify that:

Dido Ntontolo

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Social & Behavioral Research - Basic/Refresher
(Curriculum Group)
Social & Behavioral Research
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

The University of Findlay

Collaborative institutional training initiative

Verify at www.citiprogram.org/verify/?weaa9f8a7-1fc2-4911-91e0-c681fb0f6ec-44819726

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