

Impact of a contemplative end-of-life training program: Being with dying

CYNDA HYLTON RUSHTON, PH.D., R.N., F.A.A.N.,¹ DEBORAH E. SELLERS, PH.D.,²
KAREN S. HELLER, PH.D.,³ BEVERLY SPRING, B.A., M.D.,⁴
BARBARA M. DOSSEY, PH.D., R.N., F.A.A.N.,⁵ AND JOAN HALIFAX, PH.D.⁶

¹Johns Hopkins University School of Nursing, Baltimore, Maryland

²Education Development Center, Inc., Newton, Massachusetts

³Consultant, Framingham, Massachusetts

⁴Vancouver General Hospital, Vancouver, British Columbia, Canada

⁵Holistic Nursing Consultants, Santa Fe, New Mexico

⁶Abbott, Upaya Institute, Santa Fe, New Mexico

(RECEIVED March 11, 2009; ACCEPTED May 18, 2009)

ABSTRACT

Objective: Health care professionals report a lack of skills in the psychosocial and spiritual aspects of caring for dying people and high levels of moral distress, grief, and burnout. To address these concerns, the “Being with Dying: Professional Training Program in Contemplative End-of-Life Care” (BWD) was created. The premise of BWD, which is based on the development of mindfulness and receptive attention through contemplative practice, is that cultivating stability of mind and emotions enables clinicians to respond to others and themselves with compassion. This article describes the impact of BWD on the participants.

Methods: Ninety-five BWD participants completed an anonymous online survey; 40 completed a confidential open-ended telephone interview.

Results: Four main themes—the power of presence, cultivating balanced compassion, recognizing grief, and the importance of self-care—emerged in the interviews and were supported in the survey data. The interviewees considered BWD’s contemplative and reflective practices meaningful, useful, and valuable and reported that BWD provided skills, attitudes, behaviors, and tools to change how they worked with the dying and bereaved.

Significance of results: The quality of presence has the potential to transform the care of dying people and the caregivers themselves. Cultivating this quality within themselves and others allows clinicians to explore alternatives to exclusively intellectual, procedural, and task-oriented approaches when caring for dying people. BWD provides a rare opportunity to engage in practices and methods that cultivate the stability of mind and emotions that may facilitate compassionate care of dying patients, families, and caregivers.

KEYWORDS: End of life, Professional education, Contemplative, Interdisciplinary

INTRODUCTION

The hallmark of palliative end of life care is holistic, relationship-centered, and compassionate care of people living and dying with life-threatening conditions and their families. A number of curricula (Bednash & Ferrell, 2000; Emanuel et al.,

2002; Back et al., 2003; Liao et al., 2004; Browning & Solomon, 2005; Ferrell et al., 2005; Han et al., 2005; Ogle et al., 2005; Sullivan et al., 2005; Paice et al., 2006; Kelly et al., 2008) using different teaching methods (Williams et al., 2001; Browning & Solomon, 2005; Fryer-Edwards et al., 2006; Ferrell et al., 2007; Weissman et al., 2007; Meyer et al., 2009) have been developed to give health care professionals the knowledge and skills to care for dying people.

Address correspondence and reprint requests to: Cynda Hylton Rushton, 2312 Henslowe Dr., Potomac, MD 20854.
E-mail: crushton@son.jhmi.edu

Despite the development of these curricula, health care professionals report a lack of skills in psychosocial and spiritual care of dying people, high levels of moral distress, grief, and burnout (Institute of Medicine, 1997, 2003; Rashotte et al., 1997; Papadatou, 2000; Oberle & Hughes, 2001; Papadatou et al., 2001; Redinbaugh et al., 2003; American Association of Critical Care Nurses, 2004; Meltzer & Huckabay, 2004; Gutierrez, 2005; Gunther & Thomas, 2006; Hamric & Blackhall, 2007; Mobley et al., 2007; Rice et al., 2008), and loss of meaning and professional gratification (Barnard, 1995; Geller et al., 2008). These data suggest that palliative care professionals need more than technical skills and intellectual content acquisition to care compassionately for others and to sustain themselves in their caregiving roles (Wasner et al., 2005). To address some of these concerns, the “Being with Dying: Professional Training Program in Contemplative End-of-Life Care” (BWD) was created (Halifax et al., 2006).

BWD addresses the need for health care professionals to develop knowledge, skills, and practices in the psychosocial, ethical, and spiritual aspects of dying using a contemplative approach. Table 1 lists the core content of the program. The curriculum builds on contemplative practices that regulate attention and emotion, promote calm and resilience, reduce stress, and cultivate emotional balance. The premise of BWD is that cultivating stability of mind and emotions enables clinicians to respond to others and themselves with greater empathy and compassion.

BWD, delivered continuously since 1996, provides an opportunity for participants to discover wisdom and insight from their peers and an interdisciplinary team of facilitators that includes contemplative practitioners, clinicians, and educators. The 8-day residential program uses many learning modalities (e.g., didactic teaching, self-directed learning,

Table 1. Core content of the BWD program (Halifax et al., 2006)

-
-
- Integrative approaches to dying and death
 - Ethical, spiritual, psychological, and social aspects of care of the dying
 - Application of contemplative practices to the care of the dying, their families, and professional caregivers
 - Community-building around dying people and relationship-centered care
 - Cross-cultural issues related to dying
 - Exploration of pain, suffering, and peri-death phenomena
 - Care of the caregiver
 - Integration of psychosocial and spiritual content into conventional medical settings
-
-

inquiry, and creative processes) to enhance awareness of the importance of the inner life and professional responsibility. The nondenominational contemplative practices described in Table 2 are integral to the program.

This article reports the impact, both professional and personal, of the BWD program as retrospectively perceived by BWD participants.

METHODS

As an initial step in understanding the influence of BWD on those who participate, confidential open-ended telephone interviews and an anonymous online survey with previous BWD participants were conducted. The study design, methods, survey instrument, interview guide, and recruitment materials were reviewed by the Johns Hopkins University Institutional Review Board.

The Sample

From 1996 to 2006, 447 people participated in 14 BWD retreats that include 23–53 participants per retreat. Approximately three fourths were female; 20% were physicians, 30% nurses, 25% therapists/social workers, 15% chaplains, and 10% other disciplines. No details are available regarding ethnicity or age. As part of the registration process,

Table 2. Definitions of contemplative practices (Halifax et al., 2006)

-
-
- **Mindfulness:** A practice that brings together concentration and insight by training the mind to bring attention to (1) the present moment, (2) responses to phenomena, (3) awareness of mental states, (4) experience of objects of mind.
 - **Council:** A process where people speak honestly and constructively, and listen with openness, nonjudgment, and concentration. Council is a bridge to greater mutual understanding, respect, and discovery of collective wisdom (Zimmerman & Coyle, 1996).
 - **Sand tray:** A process that enhances insight through self-exploration. It uses the imagination as a vehicle to bridge the unconscious and the conscious to discover new insights or meaning. The process uses a clear field such as sand as the ground for self-exploration by mindful selection of symbols that have meaning in response to a specific inquiry question. A partner witnesses the process and the story that is shared about their discovery.
 - **Yoga:** Yoga focuses on harmony between mind and body using movement, breath, posture, relaxation, and meditation in order to establish a healthy, lively, and balanced approach to living.
 - **Meditation:** A general term that is used to describe a practice or set of practices to engender mindfulness.
-
-

participants provided contact information, including e-mail addresses.

In 2006, the e-mail addresses of 191 participants were verified by e-mail or telephone contact. In January 2007, these 191 participants were asked by e-mail to (1) complete an anonymous online survey and (2) participate in a confidential telephone interview.

Data Collection and Analysis

The survey, developed by the research team, included closed-form questions about how the program influenced the respondent, what parts of the program the respondent incorporated into their lives, and what barriers impeded and what additional training would enhance their incorporation of the program content. Survey responses were 5-point Likert scales (1 = *strongly disagree* to 5 = *strongly agree* or 1 = *not at all* to 5 = *very much/a great deal*). Personal (gender, age, education, and religious affiliation) and professional (years of experience and number of patients who died in the past 12 months) characteristics of survey respondents were also obtained. Standard descriptive statistics were used to summarize the survey responses.

Confidential, open-ended, audiotaped telephone interviews were conducted using an interview guide that focused on the impact of BWD on the interviewees' professional and personal activities.

The qualitative interview data was analyzed using a standard analytic approach of an iterative process of open coding of the transcribed interview recordings (Marshall & Rossman, 1989; Miles & Huberman, 1994; Weiss, 1994; Kvale, 1996; Strauss & Corbin, 1999). The key objective was identifying, describing, and comparing themes in the data (Miles & Huberman, 1994). Codes were used to organize the data into categories that could be retrieved and linked to each other (Miles & Huberman, 1994). As coding proceeded, second-level pattern coding was applied to organize the data into relationships among emerging themes (Miles & Huberman, 1994).

RESULTS

Ninety-five individuals (49% of participants with verified e-mail addresses) completed the anonymous survey. Sixty-one individuals volunteered to complete a telephone interview. From this pool of 61, 40 individuals were selected to ensure representation from the four main health care disciplines that care for the dying (physician, nurse, social worker, and chaplain) as well as different practice settings and geographic locations. Table 3 describes the survey respondents and interviewees.

Four main themes emerged in the interviews: the power of presence, cultivating balanced compassion, recognizing grief, and the importance of self-care. These themes and relevant findings from the survey data supporting the concurrence of the themes among survey respondents are described below. The methods BWD participants reported learning and using personally and professionally and the ongoing impact of the BWD program on the participants are described.

The Power of Presence

Presence refers to the capacity to be fully there with a quality of attention and authenticity that informs relationships and actions. A prominent theme in the interviews was the recognition that the mandate in modern medicine "to do" and "to fix" and hopefully cure may no longer be appropriate when people are dying and, in fact, may require balancing with the quality of being present *with* those who are suffering. Interviewees said that BWD had helped them realize that being present with dying patients and their families and bearing witness to suffering are healing acts in themselves and are often "enough." This theme, illustrated by interview quotes in Table 4,

Table 3. Characteristics of interviewees and survey respondents

	Interviewees	Survey respondents
Number	40	95
Profession		
Nurse	10 (25%)	24 (25%)
Doctor	10 (25%)	14 (15%)
Social worker/ counselor	7 (17%)	31 (33%)
Spiritual care	7 (17%)	16 (17%)
Other	6 (15%)	10 (10%)
Women	33 (82%)	82 (85%)
Mean age (standard deviation)	—	53.4 (9.0)
Educates health care professionals	—	69 (73%)
Educates patients and families	—	73 (77%)
Provides clinical care	40 (100%)	50 (53%)
Conducts research	12 (30%)	23 (24%)
Religion		
Buddhist	10 (25%)	29 (31%)
Catholic	—	7 (7%)
Jewish	1 (3%)	6 (6%)
Protestant	—	5 (5%)
None	3 (7%)	15 (16%)
Other	—	32 (34%)
Christian	7 (18%)	—
Nondenominational	2 (5%)	—
Interfaith/eclectic	17 (43%)	—

was supported in the survey when 90% of respondents agreed or strongly agreed that “Compared to before I participated in BWD, the program helped me to cultivate my ability to be fully present with those I serve.” More respondents agreed with this item than with any of the other 38 items assessing the professional impact of the BWD program.

Survey respondents also reported that the qualities of presence, including skillful listening (76%), ability to stay centered (77%), and achieving balance in the face of change (65%), were enhanced by their participation in the BWD program. Compared to before BWD, 59% reported greater skills in listening deeply and approximately three quarters agreed or strongly agreed that the program helped to improve their listening skills with patients and families (78%) and with interdisciplinary colleagues (73%).

Cultivating Balanced Compassion

A core element of the BWD program is cultivating a stable internal foundation that supports

Table 4. *The power of presence*

A *physician* said: “[W]hat sticks with me most, and what has changed most in me since doing the training . . . is the comfort in witnessing. ‘I don’t have to fix anything here. I’m not expected to know the answers here. It’s enough just to witness.’”

Another *physician* noted: “I remember just completely breaking down . . . thinking . . . ‘there’s this whole other way to be with patients,’ rather than fixing things and testing them . . . and so it was like a . . . glimpse into possibly another way of doing things. . . . [T]hat moment stuck with me.”

A *counselor* said: “I think what has stayed with me the most, what was reinforced . . . because for me, this is one of the most important aspects of what I do, . . . was the concept of really being present. The art of being present, the art of listening, and bearing witness. And the sacredness of . . . doing this work.”

A *chaplain*, speaking of what had most helped her in her work, noted: “Basically, bearing witness to suffering and the relationship to pain and suffering, and mindfully being with someone. I mean it’s pretty simple, but if you can really be ‘present,’ which isn’t always an easy thing to do, . . . but to really hone in on the skill of deep listening and being present and bearing witness. . . . Just being with someone in the moment . . . that you don’t have to do anything really, you just have to be.”

A *nurse* observed: “I’m not going to be able to fix everything. I know that . . . sometimes just simply the presence of a person who can be there in the midst of all this chaos and pain and suffering . . . and just ‘be there,’ as a way to start. And . . . once you’ve . . . gotten yourself present in the situation, you can start looking around . . . and find what actually is important, which may not have been what you thought would be from your professional standpoint.”

compassion—the ability to be present to all levels of suffering, to experience it, and to aspire or to act to transform it without being overwhelmed by emotions or circumstances. As illustrated in Table 5, many interviewees described the attitudes and approach to patient and family care modeled in BWD as having an important impact on their work, including concepts such as “not knowing” (being open to inquiry and discovery), developing a “soft front” of compassion balanced with a “strong back” of stability and resilience, maintaining an attitude of “nonjudgment,” and “being with things just as they are.”

This theme was supported by survey respondents who agreed or strongly agreed that BWD helped them to have greater compassion toward self (83%) and others (81%). In addition, 88% reported having more balance as they face the suffering and pain of others; they reported that following BWD, they felt more balanced and caring in relationship to dying people (80%), patients and families (70%), and colleagues (72%).

Recognizing Grief

Grief, the intense emotional and spiritual suffering caused by loss, is part of the human condition and

Table 5. *Cultivating balanced compassion*

A *physician* attending BWD hoped to learn “how to take care of people who are this sick without hurting myself.”

A *social worker* who trains many staff wanted to learn strategies and techniques to help her colleagues “open up their hearts and minds to being with patients in a more compassionate way.”

Another *social worker* said: “[Y]ou’re not there to change anyone, you’re there to really walk with folks through their own process.”

A *physician* reflected on the notion of “soft front, strong back” as “the ability . . . to have the softness to receive whatever it is and to experience even the pain that may be associated with it, [with] a strong back and equanimity to try to be present.”

A *nurse* said, “The core of the training . . . is to me the whole notion of cultivating equanimity and compassion; . . . that’s the core practice. In the end, that’s the nugget of it all. It’s just the internal cultivation of that, so that I can be more present with myself and more present with other people no matter what the situation is. . . . [W]hat [BWD] drills in . . . to me, the most . . . [is] both the equanimity and the compassion, and it’s not either/or, it’s both.”

Another *nurse* said: “[W]hat I came away with and I think a lot of people came away with [is] taking that step back. . . . being present, but being in a really grounded place in one’s self . . . in order to be that middle ground for a family that’s in conflict, or for a medical team that’s in conflict. . . . [T]he whole Buddhist approach of the middle way.”

inherent in the roles of health care professionals. As illustrated in Table 6, two thirds of the interviewees talked about how BWD helped them recognize or deal with grief in themselves and others. Several interviewees remarked on the tremendous and often unacknowledged grief and loss that they and their colleagues experienced in caring daily for dying people. Some (27%) stated that the BWD training helped them express and deal with their own grief. The 79% of survey respondents who reported agreeing or strongly agreeing that BWD helped them to “be more aware of my own grief and grieving” also affirmed the role of BWD in helping them recognize or deal with grief.

Importance of Self-care

Self-care, an individual’s recognition and responsiveness to his or her unique needs for renewal, is an active process aimed at facilitating well-being and

Table 6. *Recognizing grief*

-
- A nurse said, “Nurses do not have the training on how to take care of themselves. And I definitely see that in our docs, too, but mostly what tugs at my heart is nurses. . . . I just notice that on a daily basis how each and every nurse carries the grief and the difficulty of the work in her own individual, yet very similar way.”
- Another nurse, who began to conduct staff retreats modeled on BWD, said she came to realize “how much actual grief work was necessary, . . . that what people are doing at the retreats is grief work, . . . a lot of it, . . . and I didn’t really put it together at first as much as I see now . . . because that has just emerged as something that is at the heart of it all.”
- A social worker said that at BWD, she became more aware of “the fear, and the effect of accumulated loss for the physicians and the nurses, . . . their need for support, and . . . once I was [back] at my hospital, I felt as strong a commitment to caring for my physician colleagues as I did to caring for the patient. Feeling that if they weren’t okay, then the patients wouldn’t be okay, as well as the nurses and social workers.”
- A chaplain dealing with a personal loss realized that “sooner or later” she needed to step out of work with dying people for awhile in order to do her own grieving.
- A physician said, “I think the most powerful [aspect] of that whole training . . . is recognizing that . . . we all have tremendous grief about many things, . . . we ourselves have tremendous grief. . . . And [the various facets of the BWD training] . . . break people’s hearts open . . . and get them in touch with their own grief . . . and now they go back . . . with the intention of . . . doing the work differently.”
- Another physician said that the core concepts of the training helped him deal with grief and burnout: “I think they give me a place to sort of see, . . . more truthfully, whatever I’m up against . . . I can be a little more direct with myself.”
-

personal integrity. Attention to self-care was an important component of BWD for many of the interviewees. Almost half (47.5%) of the interviewees considered it among the most valuable aspects of the training, and some wished that more time had been devoted to it. Table 7 provides illustrative quotes.

The interviewees mentioned a number of ways in which they take care of themselves (e.g., stopping throughout the day to breathe, being kinder to and more forgiving of themselves and others, taking more time off, getting massages, playing music, exercising, journaling). More than two thirds of the interviewees (67.5%) had enhanced or increased their self-care since the training.

Survey respondents also reported the importance of self-care: 87% agreed or strongly agreed that “compared to before I participated in BWD, the program helped me to be more compassionate toward myself in acknowledging my own limitations.” Two thirds of survey respondents also agreed or strongly agreed that the program helped them to have a greater commitment to self-care, and 57% reported that the

Table 7. *The importance of self-care*

-
- A nurse said: “I was kinder to myself. I have a lot of expectations of myself, and so I do that with other people. I’ve sort of backed off of that some, not that I’m not still critical of myself, and can be of other people, too, but I’m not as harsh about it as I was.”
- A health educator in a nonprofit said that about 6 months after she returned home from BWD, she made her will, as a process of “coming to terms with my own self,” not only death, but knowing “at a visceral level” that “I needed to take care of my own stuff first.”
- A physician said: “I just don’t see much self-care [among physicians], you know, particularly as sort of related to the job . . . [E]veryone has their hobbies and things, I do a lot of exercise, but . . . when it’s in relationship to the job, you know, there’s not much . . . sort of collegial introspection about just what the job is actually doing internally to people and how people actually cope with that and deal with it”
- A nurse said: “Nurses do not have the training on how to take care of themselves. And I definitely see that in our docs, too, but mostly what tugs at my heart is nurses. . . . I just notice that on a daily basis, how each and every nurse carries the grief and the difficulty of the work in her own individual yet very similar way. . . . [I]t’s amazing, because I feel like I’m steeped in lack of self-care by my peers each and every day.”
- A hospital-based nurse said she had “really insisted” that, every month, her staff meeting is devoted to “doing something that’s good for us. . . . So that’s one of the things that I absolutely put my flag in the ground and said, ‘We’re doing self-care work.’ And that self-care is part of the evaluation process; that everybody’s got to have a self-care plan.”
-

program helped them to adopt a new self-care practice. Half agreed or strongly agreed that following the training they experienced fewer moments of feeling “burned out”; 72% reported feeling more resilient in giving care. Compared to before BWD, 88% of survey respondents reported feeling more inspired by their work with dying people and 80% reported having a renewed sense of meaning in their work.

Methods to Facilitate Presence, Compassion, Grief Recognition and Self-care

As illustrated in Table 8, all of the interviewees said that the contemplative and reflective practices were among the most meaningful, useful, and valuable aspects of the BWD experience, though they acknowledged that maintaining an attitude of valuing self-care and the practices that sustain it is an ongoing, challenging process. When asked how much participation in the BWD program increased their use of contemplative or self-care practices, 35% of survey respondents reported that they had increased their use of mindfulness practice since participating in the BWD program. In addition, 72% of survey respondents circled 4 or 5 (on the 5-point scale from 1 = *not at all* to 5 = *very much*) for their use of mindfulness practice.

Table 8. *Methods for facilitating presence, compassion, grief, and self-care*

-
- A nurse said, “[T]he concept of having a contemplative practice for myself, and being able to have these tools in my pocket, to have no matter what situation that I’m in, has been and continues to be incredibly valuable.”
- Another nurse said: “The mindfulness practices are constantly with me everyday. It’s just a dropping down another level and getting to the core of what’s really going on with patients and family. . . . And moving to another level with the whole team. . . . And I think Being with Dying brought those skills to me to help teach the team how to do that. And they love it!”
- Commenting on a meditation in which participants were asked to imagine their own death, a chaplain said that after this meditation, she remembered “walking out of there . . . into the air out at Upaya, and looking up at the sky, and I was different. Something had changed.”
- A physician said that the training “actually really changed the way I am with people” by giving him “a depth of practice” and “a state of mind I could connect to.” He said that BWD helped him to understand that he needed to develop a “quality of mind” to be present with dying patients, and that this required practice to develop and maintain. He compared this to the place of practice in the life of someone who plays music.
- A social worker who lost a lot of family members and people close to her within a few years said: “I feel that my [contemplative] practice helped make it possible for me to get through all of that, quite honestly. And stay sane.”
-

Ongoing Impact

Overall, as illustrated in Table 9, the interviewees reported that BWD had “seeded” them with skills, attitudes, behaviors, and tools with which to change how they understand the death and the dying process (70%), how they work with the dying and bereaved (90%), and how they conduct themselves personally (72%) and with colleagues (62%). Many interviewees credited BWD with being an “opening” (30%) or “affirming” (50%) experience. More than one third (38%) said it had been transformative (a “watershed” experience, as one doctor put it) and had changed their lives. The changes stimulated or enhanced by the training affected the participants’ methods and style of caring for patients and families, their career focus, and their personal lives. Whether the changes they made were large or small, the interviewees acknowledged that what they had learned at the training continues to influence them and to reverberate years later in their personal and professional lives.

DISCUSSION

The BWD training integrates three primary foci: mindfulness, compassion, and self-care. First, the development of a foundation of mindfulness provides

Table 9. *Ongoing impact of BWD program*

-
- A social worker said: “I just think it really was, and I don’t exaggerate, one of the most impactful trainings I went to, . . . the educational component, the experiential component, the way that . . . the environment held the training, and the integrity of the training . . . you know, it’s still with me in some indefinable ways, but it’s with me.”
- A nurse said: “I can’t always come up with examples of where I’ve changed . . . but I know I have . . . and it goes back to Upaya. . . . I truly think that Upaya saved my sanity . . . and has allowed me to work in this job as long as I have . . . without a great deal of stress. . . . I think that there was a fundamental change that occurred inside of me because of Upaya.”
- Usefulness of principles of compassionate care**
- A nurse said: “I think going back to the principles of the Being with Dying work, it’s basically what keeps you from burning out. The work, you know, it’s just tough! But you’re working from another place if you’re using the things you learned in the course.”
- A physician, who said he had internalized the core concepts of the training as qualities or “habits of mind,” said that these helped him deal with grief and burnout.
- A social worker said that the training has helped her deal with feelings of burnout as they arise through greater self-awareness, by being “much more attuned to myself in order that I don’t become burned out.”
-

the stability of mind and emotions to support clinicians to engage more deeply in addressing the reality of living and dying (Wasner et al., 2005; Halifax, 2008). Second, the direct cultivation of compassion is integral to providing holistic end-of-life care. Compassion denotes the presence of an relationship appropriate to suffering and the capacity to respond to suffering without being overwhelmed by it and to transform it in beneficial ways. The third emphasizes self-care; in order for clinicians to provide compassionate end-of-life care, it is necessary for them to be self-aware, recognize their own difficulties, and to make a commitment to address their own suffering by nurturing physical, emotional, mental, spiritual, and social dimensions of their own lives and relationships to others (Institute of Medicine, 1997). These data suggest that the foundation of contemplative practice, compassion, and self-care offers clinicians a grounding for their work that allows them to cultivate ways of being that are congruent with their aspirations, moral sensibilities, and professional roles.

The findings from both the quantitative and qualitative studies highlight that bringing a present moment quality of presence to interactions has the potential to transform the care of dying people as well as the caregivers themselves. Cultivating this quality within themselves and others allows clinicians to explore alternatives to exclusively intellectual, procedural, and task-oriented approaches when caring for dying people. Although research has documented the positive impact of presence on patients and families and presence is suggested as an element of caring for dying people, there are few opportunities to engage in practices and methods that cultivate the stability of mind and emotions necessary to bring this quality to compassionate care of patients, families, and each other (Pettigrew, 1990; Pederson, 1993; Fredriksson, 1999; Stanley, 2002) Clinicians often lack competence in this vital aspect of clinical care (Koener, 2007).

Over the past two decades, there has been an increasing interest in how to apply contemplative practices to a diverse range of secular settings, including health care, education, business, and law (Duerr, 2004). One of the most widely used meditation techniques is Mindfulness-Based Stress Reduction (MBSR) (Kabat-Zinn, 2003). The qualities developed by mindfulness practice—self-reflection, deep listening, and moment-to-moment presence—are foundational to relationship-centered care, a core element of compassionate end-of-life care (Connelly, 1999, 2005; Epstein, 1999). Our findings infer that cognitive approaches alone are insufficient to create the possibility of shifting one's awareness and way of being with others; experiencing and using

contemplative practices can be instrumental in altering how clinicians care for dying people.

These data further support the premise that it is not possible for clinicians to care compassionately for others unless they are able to care compassionately for themselves (Reich, 1989; Rushton, 1992, 2004; Rushton et al., 2006; American Nurses Association, 2009). As caretakers of others, clinicians find that their needs are often set aside in order to fulfill their commitments to others, especially in situations where the needs are boundless and the systems are faulty. The personal costs that accompany abandoning their own needs and failing to care for themselves are often unaddressed. Data from both the survey and interviews in our study confirm that health care professionals need support and skills in compassionate care of themselves and others. The absence of compassion toward oneself may be a contributing factor in burnout, moral distress, secondary trauma, and compassion fatigue (Power & Sharp, 1988; Whippen & Canellos, 1991; Figley, 1995; Rushton, 1995; Sundin-Huard & Fahy, 1999; Jezuit, 2000; Chen & McMurray, 2001; Gundersen, 2001; Mealer et al., 2007). Lack of self-compassion may also contribute to the way clinicians resolve questions about care and take responsibility for decisions and outcomes for dying patients and may mute emotional responses (Meier et al., 2001; Redinbaugh et al., 2003; Ruopp et al., 2005). Our findings are consistent with related findings that (1) spiritual well-being (related to self-compassion and meaning) has a positive impact on job satisfaction and ultimately may decrease staff turnover (Clark et al., 2007) and (2) that significant increases in self-compassion occur among health care professionals who participated in MBSR courses (Shapiro et al., 2005).

Clinicians who care for dying people are themselves experiencing grief, although it is not routinely acknowledged or addressed (Behnke et al., 1987; Papadatou et al., 2002; Redinbaugh et al., 2003; Serwint et al., 2006). When grief is not acknowledged, processed, or supported, it can become "disenfranchised," leading to a variety of physical, emotional, and spiritual responses (Doka, 2002; Moss et al., 2003). Grief is addressed in the BWD training through guided meditations, experiential practices such as sand tray, small group councils exploring various dimensions of grief, and peer-to-peer learning. These data support efforts by palliative care and hospice programs to develop mechanisms for acknowledging and supporting clinicians in processing their own grief (Papadatou, 2000; Serwint et al., 2006).

Skills in self-care and renewal are essential for clinicians who care for dying people. These skills, coupled with strategies for cultivating authenticity through self-reflection and contemplation, offer

promising opportunities for creating personal and professional support systems. The skills offered in the BWD training can be used to cultivate inner stability and resilience that allow clinicians to be with suffering and death without being overcome by their own or others' emotions (Behnke et al., 1987; Scherwitz et al., 2006; Halifax, 2008). Alignment between individual values for self-care and a practice environment that supports clinicians to practice with integrity through self-care and renewal have the potential to enhance clinician satisfaction and ultimately improve patient care (Koener, 2007; Ulrich et al., 2007). Ways of sustaining one's commitment to his or her own well-being after the training is an area for further exploration.

To support the cultivation of authenticity and the quality of presence, it is necessary to create a safe learning environment where clinicians can reflect on their deepest motivations for choosing a career as health care professionals, can reflect on who they are as people and as professionals, and can explore their own suffering and the suffering of their patients and families. This requires an alternative learning approach that models interdisciplinary collaboration, discovery learning, and supportive facilitation. The data in our study suggest that engaging in contemplative practices that stabilize the mind and cultivate emotional well-being—key elements in BWD—are supportive to clinicians who want to deepen their work with dying people. These data also suggest that the design and content of a contemplative end-of-life professional training program is beneficial to clinicians as individuals and as professionals (Scherwitz et al., 2006). This has implications for educators and leaders in palliative care who are replicating or designing programs that continue to rely on didactic methods alone. These findings are consistent with other approaches that have called for experiential and relational teaching formats and greater attention to cultivating self awareness (Behnke et al., 1987; Fins et al., 2003; Wasner et al., 2005; Browning & Solomon, 2006; Scherwitz et al., 2006).

Limitations of This Study

The ability to generalize from the findings in this study is limited by the fact that the survey and interview samples may not be representative of all those who have participated in BWD and the lack of a comparison to a similar group of nonparticipants. The preponderance of women among the survey and interview participants reflects their preponderance in the sample and the greater number of women than men who have attended the BWD training over the years. In addition, the respondents' ethnicity was

not asked about. Self-report is a limitation because it relies on the participant's affective experiences and recall, for some, many years since attending the training. Finally, those who participated in the survey and/or interview may have been more likely to have experienced a positive impact from the program than those who did not complete the survey and/or an interview.

Conclusion

This study reports the perceived impact of a unique training program incorporating contemplative, experiential and creative practices on the interdisciplinary health care clinicians who participated. Our findings suggest that an alternative learning model has the potential for a positive effect on clinicians as individuals and as professionals in the care they give to themselves and others. The findings are consistent with empirical evidence that meditative and contemplative practices can aid in relieving the acute symptoms of compassion fatigue and burnout (Cohen-Katz et al., 2005; Galantino et al., 2005) including depression and anxiety (Shapiro et al., 1998) and physiological symptoms such as insomnia and a weakened immune system (Davidson et al., 2003). Additionally, these practices help to cultivate cognitive and physiological capacities that support overall well-being and strengthen the resiliency of care providers (Shapiro et al., 2005). Further studies of the long-term effects of this type of training on clinicians (and thereby on patients and families) are warranted in order to determine how best to ensure compassionate and sustainable end of life care.

ACKNOWLEDGMENTS

The authors express deep gratitude to all the former participants in the BWD programs, those who participated in the study, and the past and current faculty and facilitators. We are deeply grateful to Kelly Wilson-Fowler and Jean Wilkins for their technical support. This study and ongoing CEOLC programs are made possible by the generosity of Ann Down, John and Tussi Kluge, Hershey Family Foundation, Grant Couch, Louise Pearson, and the Hunt Foundation. The BWD program has been generously supported by The Nathan Cummings Foundation, the Soros Foundation's Project on Death in America, and Laurance Rockefeller.

REFERENCES

- American Association of Critical Care Nurses. (2004). *Moral Distress Position Statement*. Aliso Viejo: Author.
- American Nurses Association. (2001). *ANA Code of Ethics for Nurses*. Silver Spring, MD: American Nurses Association.

- Back, A.L., Arnold, R.M., Tulsy, J.A., et al. (2003). Teaching communication skills to medical oncology fellows. *Journal of Clinical Oncology*, *21*, 2433–2436.
- Barnard, D. (1995). The promise of intimacy and the fear of our own undoing. *Journal of Palliative Care*, *11*, 22–26.
- Bednash, G. & Ferrell, B. (2000). *End-of-life Nursing Education Consortium (ELNEC)*. Washington, DC: American Association of Colleges of Nursing.
- Behnke, M., Reiss, J., Neimeyer, G., et al. (1987). Grief responses of pediatric house officers to a patient's death. *Death Studies*, *11*, 169–176.
- Browning, D.M. & Solomon, M.Z. (2005). The initiative for pediatric palliative care: An interdisciplinary educational approach for healthcare professionals. *Journal of Pediatric Nursing*, *20*, 326–334.
- Browning, D.M. & Solomon, M.Z. (2006). Relational learning in pediatric palliative care: Transformative education and the culture of medicine. *Child and Adolescent Psychiatric Clinics of North America*, *15*, 795–815.
- Chen, S.M. & McMurray, A. (2001). "Burnout" in intensive care nurses. *Journal of Nursing Research*, *9*, 152–164.
- Clark, L., Leedy, S., McDonald, L., et al. (2007). Spirituality and job satisfaction among hospice interdisciplinary team members. *Journal of Palliative Medicine*, *10*, 1321–1328.
- Cohen-Katz, J., Wiley, S.D., Capuano, T., et al. (2005). The effects of mindfulness-based stress reduction on nurse stress and burnout, Part II: A quantitative and qualitative study. *Holistic Nursing Practice*, *19*, 26–35.
- Connelly, J. (1999). Being in the present moment: Developing the capacity for mindfulness in medicine. *Academic Medicine*, *74*, 420–424.
- Connelly, J.E. (2005). Narrative possibilities: Using mindfulness in clinical practice. *Perspectives in Biology and Medicine*, *48*, 84–94.
- Davidson, R.J., Kabat-Zinn, J., Schumacher, J., et al. (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine*, *65*, 564–570.
- Doka, K. (2002). *Disenfranchised Grief: New Directions Challenges and Strategies for Practice*. Champaign, IL: Research Press.
- Duerr, M. (2004). *A Powerful Silence: The Role of Meditation and Other Contemplative Practices in American Life and Work*. Northampton, MA: Center for Contemplative Mind in Society.
- Emanuel, L.L., Ferris, F.D. & von Gunten, C.F. (2002). EPEC: Education for Physicians on End-of-Life Care. *American Journal of Hospice and Palliative Care*, *19*, 17–18.
- Epstein, R.M. (1999). Mindful practice. *JAMA*, *282*, 833–839.
- Ferrell, B.R., Dahlin, C., Campbell, M.L., et al. (2007). End-of-life Nursing Education Consortium (ELNEC) Training Program: Improving palliative care in critical care. *Critical Care Nursing Quarterly*, *30*, 206–212.
- Ferrell, B.R., Virani, R., Grant, M., et al. (2005). Evaluation of the End-of-Life Nursing Education Consortium undergraduate faculty training program. *Journal of Palliative Medicine*, *8*, 107–114.
- Figley, C.R. (1995). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner/Mazel.
- Fins, J.J., Gentlesco, B.J., Carver, A., et al. (2003). Reflective practice and palliative care education: A clerkship responds to the informal and hidden curricula. *Academic Medicine*, *78*, 307–312.
- Fredriksson, L. (1999). Modes of relating in a caring conversation: A research synthesis on presence, touch and listening. *Journal of Advanced Nursing*, *30*, 1167–1176.
- Fryer-Edwards, K., Arnold, R.M., Baile, W., et al. (2006). Reflective teaching practices: An approach to teaching communication skills in a small-group setting. *Academic Medicine*, *81*, 638–644.
- Galantino, M.L., Baime, M., Maguire, M., et al. (2005). Association of psychological and physiological measures of stress in health-care professionals during an 8-week mindfulness meditation program: Mindfulness in practice. *Stress and Health*, *21*, 255–261.
- Geller, G., Bernhardt, B.A., Carrese, J., et al. (2008). What do clinicians derive from partnering with their patients? A reliable and valid measure of "personal meaning in patient care." *Patient Education & Counseling*, *72*, 293–300.
- Gundersen, L. (2001). Physician burnout. *Annals of Internal Medicine*, *135*, 145–148.
- Gunther, M. & Thomas, S.P. (2006). Nurses' narratives of unforgettable patient care events. *Journal of Nursing Scholarship*, *38*, 370–376.
- Gutierrez, K.M. (2005). Critical care nurses' perceptions of and responses to moral distress. *Dimensions of Critical Care Nursing*, *24*, 229–241.
- Halifax, J. (2008). *Being with Dying: Cultivating Compassion and Fearlessness in the Presence of Death*. Boston: Shambhala.
- Halifax, J., Dossey, B. & Rushton, C. (2006). *Compassionate Care of the Dying: An Integral Approach*. Santa Fe, NM: Prajna Mountain Publishers.
- Hamric, A.B. & Blackhall, L.J. (2007). Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. *Critical Care Medicine*, *35*, 422–429.
- Han, P.K., Keranen, L.B., Lescisin, D.A., et al. (2005). The palliative care clinical evaluation exercise (CEX): An experience-based intervention for teaching end-of-life communication skills. *Academic Medicine*, *80*, 669–676.
- Institute of Medicine. (1997). *Approaching Death*. Washington, DC: National Academy Press.
- Institute of Medicine. (2003). *When Children Die: Improving Palliative and End-of-Life Care for Children and Their Families*. Washington, DC: National Academy Press.
- Jezuit, D.L. (2000). Suffering of critical care nurses with end-of-life decisions. *Medsurg Nursing*, *9*, 145–152.
- Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present and future. *Clinical Psychology: Science and Practice*, *10*, 144–156.
- Kelly, K., Ersek, M., Virani, R., et al. (2008). End-of-Life Nursing Education Consortium. Geriatric Training Program: Improving palliative care in community geriatric care settings. *Journal of Gerontological Nursing*, *34*, 28–35.
- Koener, J.G. (2007). *Healing Presence: The Essence of Nursing*. New York: Springer.
- Kvale, S. (1996). *Interviews: An Introduction to Qualitative Research Interviewing*. London: Sage Publications.
- Liao, S., Amin, A. & Rucker, L. (2004). An innovative, longitudinal program to teach residents about end-of-life care. *Academic Medicine*, *79*, 752–757.
- Marshall, C. & Rossman, G.B. (1989). *Designing Qualitative Research*. Newbury Park, CA: Sage.
- Mealer, M.L., Shelton, A., Berg, B., et al. (2007). Increased prevalence of post-traumatic stress disorder symptoms in critical care nurses. *American Journal of Respiratory Critical Care Medicine*, *175*, 693–697.
- Meier, D.E., Back, A.L. & Morrison, R.S. (2001). The inner life of physicians and care of the seriously ill. *JAMA*, *286*, 3007–3014.

- Meltzer, L.S. & Huckabay, L.M. (2004). Critical care nurses' perceptions of futile care and its effect on burnout. *American Journal of Critical Care, 13*, 202–208.
- Meyer, E.C., Sellers, D.E., Browning, D.M., et al. (2009). Difficult conversations: Improving communication skills and relational abilities in healthcare. *Pediatric Critical Care Medicine, 10*, 352–359.
- Miles, M.B. & Huberman, A.M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook* (2nd ed.). London: Sage Publications.
- Mobley, M.J., Rady, M.Y., Verheijde, J.L., et al. (2007). The relationship between moral distress and perception of futile care in the critical care unit. *Intensive Critical Care Nursing, 23*, 256–263.
- Moss, M.S., Moss, S.Z., Rubinstein, R.L., et al. (2003). The metaphor of “family” in staff communication about dying and death. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 58*, S290–S296.
- Oberle, K. & Hughes, D. (2001). Doctors' and nurses' perceptions of ethical problems in end-of-life decisions. *Journal of Advanced Nursing, 33*, 707–715.
- Ogle, K.S., Mavis, B. & Thomason, C. (2005). Learning to provide end-of-life care: Postgraduate medical training programs in Michigan. *Journal of Palliative Medicine, 8*, 987–997.
- Paice, J.A., Ferrell, B.R., Virani, R., et al. (2006). Appraisal of the Graduate End-of-Life Nursing Education Consortium Training Program. *Journal of Palliative Medicine, 9*, 353–360.
- Papadatou, D. (2000). A proposed model of health care professionals' grieving process. *Omega, 31*, 59–77.
- Papadatou, D., Bellali, T., Papazoglou, I., et al. (2002). Greek nurse and physician grief as a result of caring for children dying of cancer. *Pediatric Nursing, 28*, 345–353.
- Papadatou, D., Martinson, I.M. & Chung, P.M. (2001). Caring for dying children: A comparative study of nurses' experiences in Greece and Hong Kong. *Cancer Nursing, 24*, 402–412.
- Pederson, C. (1993). Presence as a nursing intervention with hospitalized children. *Maternal-Child Nursing Journal, 21*, 75–81.
- Pettigrew, J. (1990). Intensive nursing care. The ministry of presence. *Critical Care Nursing Clinics North American, 2*, 503–508.
- Power, K.G. & Sharp, G.R. (1988). A comparison of sources of nursing stress and job satisfaction among mental handicap and hospice nursing staff. *Journal of Advanced Nursing, 13*, 726–732.
- Rashotte, J., Fothergill-Bourbonnais, F. & Chamberlain, M. (1997). Pediatric intensive care nurses and their grief experiences: A phenomenological study. *Heart and Lung, 26*, 372–386.
- Redinbaugh, E.M., Sullivan, A.M., Block, S.D., et al. (2003). Doctors' emotional reactions to recent death of a patient: Cross sectional study of hospital doctors. *British Medical Journal, 327*, 185.
- Reich, W.T. (1989). Speaking of suffering: A moral account of compassion. *Soundings, 72*, 83–108.
- Rice, E.M., Rady, M.Y., Hamrick, A., et al. (2008). Determinants of moral distress in medical and surgical nurses at an adult acute tertiary care hospital. *Journal of Nursing Management, 16*, 360–373.
- Ruopp, P., Good, M.J., Lakoma, M., et al. (2005). Questioning care at the end of life. *Journal of Palliative Medicine, 8*, 510–520.
- Rushton, C.H. (1992). Care-giver suffering in critical care nursing. *Heart and Lung, 21*, 303–306.
- Rushton, C.H. (1995). The baby K case: Ethical challenges of preserving professional integrity. *Pediatric Nursing, 21*, 367–372.
- Rushton, C.H. (2004). The other side of caring: Caregiver suffering. In *Palliative care for infants, children, and adolescents. A practical handbook*, Carter B.S. & Levettown M. (eds.), pp. 220–243. Baltimore: Johns Hopkins University Press.
- Rushton, C.H., Reder, E., Hall, B., et al. (2006). Interdisciplinary interventions to improve pediatric palliative care and reduce health care professional suffering. *Journal of Palliative Medicine, 9*, 922–933.
- Scherwitz, L., Pullman, M., McHenry, P., et al. (2006). A contemplative care approach to training and supporting hospice volunteers: A prospective study of spiritual practice, well-being, and fear of death. *Explore, 2*, 304–313.
- Serwint, J.R., Rutherford, L.E. & Hutton, N. (2006). Personal and professional experiences of pediatric residents concerning death. *Journal of Palliative Medicine, 9*, 70–81.
- Shapiro, S.L., Astin, J.A., Bishop, S.R., et al. (2005). Mindfulness-based stress reduction for health care professionals. Results from a randomized trial. *International Journal of Stress Management, 12*, 164–176.
- Shapiro, S.L., Schwartz, G.E., & Bonner, G. (1998). Effects of mindfulness-based stress reduction on medical and premedical students. *Journal of Behavioral Medicine, 21*, 581–599.
- Stanley, K.J. (2002). The healing power of presence: Respite from the fear of abandonment. *Oncology Nursing Forum, 29*, 935–940.
- Strauss, A. & Corbin, J. (1999). *Basics of Qualitative Research* (2nd ed.). Newbury Park, CA: Sage.
- Sullivan, A.M., Lakoma, M.D., Billings, J.A., et al. (2005). Teaching and learning end-of-life care: Evaluation of a faculty development program in palliative care. *Academic Medicine, 80*, 657–668.
- Sundin-Huard, D. & Fahy, K. (1999). Moral distress, advocacy and burnout: Theorizing the relationships. *International Journal of Nursing Practice, 5*, 8–13.
- Ulrich, C., O'Donnell, P., Taylor, C., et al. (2007). Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States. *Social Science and Medicine, 65*, 1708–1719.
- Wasner, M., Longaker, C., Fegg, M.J., et al. (2005). Effects of spiritual care training for palliative care professionals. *Palliative Medicine, 19*, 99–104.
- Weiss, R.S. (1994). *Learning from Strangers: The Art and Method of Qualitative Interview Studies*. New York: Free Press.
- Weissman, D.E., Ambuel, B., von Gunten, C.F., et al. (2007). Outcomes from a national multispecialty palliative care curriculum development project. *Journal of Palliative Medicine, 10*, 408–419.
- Whippen, D.A. & Canellos, G.P. (1991). Burnout syndrome in the practice of oncology: Results of a random survey of 1,000 oncologists. *Journal of Clinical Oncology, 9*, 1916–1920.
- Williams, M.A., Lipsett, P.A., Shatzer, J.H., et al. (2001). Experiential, interdisciplinary training in end-of-life care and organ donation. *Critical Care Medicine, 28*(Suppl): A204.
- Zimmerman, J. & Coyle, V. (1996). *The Way of Council*. Las Vegas: Bramble Books.