Being With Dying:
The Upaya Contemplative End of Life Training Program

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I have worked in the area of contemplative care of the dying for forty years, beginning my professional work in 1970 at the University of Miami School of Medicine as a medical anthropologist. There, I realized that the most marginalized group of people in the hospital system were those who were dying. I was consulting as an anthropologist around issues related to culture-bound reactive syndromes. There was a significant amount of cultural diversity in the hospital, so it was important to have an anthropologist on hand to help be a bridge between cultural and medical perspectives.

My interest in the work with dying people, however, opened for me with the death of my grandmother, who took care of dying people. There were other factors that led me to this work, like becoming a Buddhist practitioner in the mid 1960s.

After I left medical school in 1972, I worked with psychiatrist Stanislav Grof, who was involved with a major project using LSD as an adjunct to psychotherapy with people dying of cancer. This work was profound, as most of our dying patients had the opportunity through the therapy to go through a contemporary rite of passage. This changed their experience of dying, benefited their quality of life and relationships, and transformed their view of death as they lived their final days.[1]

After this work with Grof, I received the Buddhist precepts in 1975, became a teacher in the Kwan Um Korean Zen School in 1980, and subsequently took Japanese Zen ordination from Rev. Bernie Tetsugen Glassman. This deeper step into the practice of Buddhism brought me in touch with the profound perspective that Buddhism offers to those who are dying, a perspective which normalizes death and sanctifies it as well.

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[1] Stanislav Grof and Joan Halifax, *The Human Encounter with Death* (New York: Dutton, 1977).

[2] Johan Galtung, *Peace by Peaceful Means: Peace and Conflict, Development and Civilization* (Thousand

These three forces opened me to the work with the dying: my grandmother, my experiences with Grof, and Buddhist practice.

Clinician Burnout and Trauma in the United States

The hallmark of compassionate and contemplative-based end-of-life care is relationship-centered care of people living and dying with life threatening conditions and their families. A number of curricula using different teaching methods have been developed to give health care professionals the knowledge and skills to care for dying people. Despite the development of these curricula, health care professionals report a lack of skills in psychosocial and spiritual care of dying people. They also report difficulties in caring for the dying, with high levels of moral distress, grief, and burnout.

There is increasing research on the deficit of the empathy and compassion among health care professionals. This compassion deficit often begins during the medical and nursing training experience. This suggests that health care professionals need more than technical skills to care compassionately for others and to sustain themselves in their care-giving roles. Clinicians are typically not given the tools to address their stress.

There are five "syndromes" that clinicians suffer from in terms of encountering the challenge of their vocation:

1) burnout - cumulative work demands and stress;
2) secondary trauma - dysfunction that arises from prolonged exposure to the suffering of others;
3) moral distress – moral conflicts when the clinician knows what is right to do but cannot do it;
4) horizontal hostility - disrespect among members of a peer group;
5) structural violence - violence in the system.

Burnout

There are specific symptoms and signs of burnout on the individual level. These are the kinds of things that we see often in clinicians here in the United States:

- complete emotional and physical exhaustion
- cynicism and being very detached from the job

- deep inadequacy about lack of effectiveness in being able to do the job
- over identification or involvement, and an almost addictive relationship to the job
- hyper vigilance and neurotic alertness that lead to a state of chronic irritability
- increasing social withdrawal from family and social relationships
- poor judgment and personal and professional boundary violations
- perfectionism and rigidity
- existential crisis in which the meaning of life and spiritual and religious beliefs are questioned
- increase in interpersonal conflicts
- avoidance of emotionally difficult situations
- issues with addiction, detachment, and an increasing sense of numbness
- difficulties in concentrating and various psycho-somatic illnesses like headaches and immune system impairments.

Secondary Trauma

This is very close to post-traumatic stress syndrome and involves hyper arousal, burnout, disturbed sleep patterns, irritability and anger outbursts, hyper vigilance, avoidance, and reliving disturbing encounters. On the team level, when there is a diminution of morale because of burnout, secondary trauma, moral distress, and horizontal hostility in the institution or structural violence, you see the morale of the institution drop. The result is impaired job performance, increased absenteeism, staff conflict, and high job turnover. It is a pretty dramatic situation that clinicians are facing in the United States. I am not saying that everyone is in this dilemma, but many clinicians are. A statistic that demonstrates this situation is the suicide rate among clinicians. A male clinician is 1.41 times more likely to commit suicide than the average American male, and the female clinician is 2.27 times more likely to commit suicide. The incidences of depression, addiction, and so forth because of stress are also very high among clinicians.

Moral Distress

These stresses are actions, dimensions, and experiences that we find common in many different clinical settings in the United States.

- Resources: There are many small hospitals that simply do not have the resources to have patients stay very long in specialized intensive care situations. In many places, there are not enough nurses to take care of the patients, and as a result, the few nurses are completely burned out. Thus, one main stress is inadequate access to resources.

- Informed Consent: Another stress is a lack of adequate informed consent. For example, a patient may arrive at a hospital who is comatose, but there is no paperwork indicating an agreement with regards to resuscitation or non-resuscitation, intubation, and so forth. In other words, the advance directives have not been articulated.
- Conflicts in Care: In other situations, the clinician, patient, and patient's family often have different goals in terms of care. The patient wants to live as long as possible; the family is running out of patience or economic resources and feels like nothing should be done or everything should be done; the hospital mandates that it can only keep the patient in the hospital for a certain amount of time.
- Causing Pain & Feeling Guilt: Clinicians often experience a tremendous amount of stress when engaging in interventions that cause pain and suffering. It is also not uncommon for a clinician to make a mistake, so clinical errors cause a feeling of guilt among clinicians.
- Futility: Clinicians also encounter a sense of futility with, for example, patients' demands, clinical errors they have committed, feelings of inadequacy of not being able to really help a patient adequately, seeing that many interventions do not really benefit the patient, and demands made by the institution.
- Death and Quality of Life: Often clinicians encounter deep disputes about life sustaining therapies related to hastening death. Questions arise such as: What is the merciful thing to do with someone who is in a persistent vegetative state? Is it to keep the body alive or is it to help death happen, what is called AND (Allow Natural Death)? What is it a patient needs to have quality of life? Is another intervention going to compromise the quality of life? Will it make them more miserable? Will it hurt them physically? What if the patient's family insists that the patient wants to be kept alive no matter what? This area includes very deep issues that clinicians have around prolonging dying through technology, physician assisted suicide, and last dosage use. When is the right time in these cases? If you increase the morphine dosage just a little bit, the patient will be more comfortable

and will die more easily and more quickly. However, is this legal or right? How does the family feel about it? How does the nurse feel carrying out the doctor's orders? Does she feel like she's engaging in homicide? There are quite a number of issues that come up.

- Denial of Death: These issues are compounded by western clinicians being trained to save lives at any cost. This leads them to a kind of denial of death. Clinicians may feel angst being in the presence of someone who is suffering from intractable pain, is in a state of extreme mental suffering, or is terribly afraid of death.
- Relational Inabilities: Another issue is that many clinicians simply do not have the ability to discuss interventions with patients and families around death and dying. They may also not have the capacity or interest to discuss stresses at work. In this way, they do not have the opportunity to work out issues, such as ones related to workaholism, perfectionism, or self-neglect.

Horizontal Hostility

This issue was brought to my attention by a nurse and student of mine, Jan Jahner, who has done a powerful presentation on this challenge in the medical setting. She has defined horizontal hostility as disrespectful behavior among peers, bullying between clinicians, and hazing that frequently occurs in medical training. Lateral violence or horizontal hostility is the consistent and often hidden patterns of behavior designed to control, diminish, or devalue another peer or group that creates a risk to health and/or safety. Horizontal hostility shares three elements common to racial and sexual harassments laws: 1) It is defined in terms of the effect on the recipient; 2) It must have a negative effect on the recipient; 3) The bullying behavior must be consistent. Signs include two domains: 1) overt: includes name-calling, sarcasm, bickering, fault-finding, back-stabbing, criticism, intimidation, gossip, shouting, blaming, put-downs, raising eyebrows, etc.; and 2) covert**:** includes unfair assignments, eye-rolling, ignoring, making faces (behind someone's back), refusal to help, sighing, whining, sarcasm, refusal to work with someone, sabotage, isolation, exclusion, fabrication, etc.

The prevalence of horizontal hostility in the United States has been documented: 33% of nurses leave their jobs due to horizontal hostility; 44% report "bullying;" 33% intend to leave because of verbal abuse; bullied staff have lower job satisfaction and higher stress, depression, and anxiety and higher intent to leave. In the United States, verbal abuse from physicians to nurses is 90-97%; newly registered nurses who leave their first position within six months because of some form of horizontal hostility is 60%; and verbal abuse is cited as the reason nurses leave their jobs.

Structural Violence

This is the discrimination against groups within an institutional setting causing suffering. The term “structural violence,” first used in the 1960s, has been attributed to Johan Galtung.[2] It is a type of violence that corresponds to the systematic ways in which a social structure or institution discriminates and causes suffering to others by preventing them from meeting their basic needs. Structural violence is attributed to the specific organizations of society that injure or harm individuals or masses of individuals. In medicine, structural violence occurs in relation to the uninsured, so-called ethnic minorities or people of color, women, people with AIDS, and so forth. It involves not only the denial of medical services to marginalized groups but the use of interventions that are suppressive or harmful. Structural violence is also meted out toward those employed by the medical system who are perceived to be lower in status.

Being With Dying:
Professional Training Program in Contemplative End of Life Care

To address the concerns explained in detail above, the “Being With Dying: Professional Training Program in Contemplative End of Life Care” (BWD) was created in 1996. The premise of BWD is that in order for clinicians to provide compassionate end of life care, it is necessary for them to: 1) become self aware and recognize their own suffering, 2) make a commitment to addressing their own suffering and 3) develop receptivity, compassion, and resilience through nurturing physical, emotional, mental, spiritual, and social dimensions in their own lives and in relationships with others.

We feel that cultivating stability of mind and emotions enables clinicians to respond to others and themselves with compassion. BWD 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.

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[2] Johan Galtung, *Peace by Peaceful Means: Peace and Conflict, Development and Civilization* (Thousand Oaks, CA: Sage Publications, 1996).

BWD is for clinicians who have been through extensive medical training. These include physicians, nurses, and the interdisciplinary team of social workers, psychologists, and chaplains.

We establish a fixed quota in the program of one-quarter doctors, one-quarter nurses, and the other half of individuals from the interdisciplinary team. The eight-day residential program uses many learning modalities (e.g. didactic teaching, self-directed learning, inquiry, and creative processes) to enhance awareness of the importance of the inner life and professional responsibility.

The training has four components that center respectively on the transformation of the clinician, the patient, the community, and the institution.

The Transformation of the Clinician

1) Worldview

Our first step in this work is to identify and clarify the worldviews, the values, the priorities, and the knowledge of the clinicians. This gives the clinician a functional base from which he or she can work. The worldview of the clinician actually influences how they deliver care. The worldview includes their values, which influences their priorities, which influences their knowledge—so we sequence it in that way.

2) Contemplative Interventions

The second area we work with in exploring how we can transform the clinician is related to contemplative interventions—in other words, we teach them meditation. We call them "contemplative interventions" as a skillful means, because when you say "meditation," it produces resistance in most medical settings. Our focus in these reflective practices or contemplative interventions is on the cultivation of insight, mental stability, and compassion. We work with a number of different contemplative interventions during the 8-day training program.

Let's look at what we mean by "contemplative" dimensions since we use that term to precede the term "end of life care." This work has come out of my relationship with the formation of the Mind and Life Institute, which sponsors neuroscience research and dialogues with His Holiness the Dalai Lama. For many years, we needed the neuro-scientific evidence to prove that these interventions were trackable and traceable and that the benefits could be clearly mapped. As mentioned in previous chapters in this volume, Jon Kabat-Zinn is one of the pioneers in this field and is also a board member of the Institute. The work in this area has increased exponentially over the past decade in large part due to the work that the Mind and Life Institute has done—much of which has been published.

When we say “contemplative,” we mean traditions that encompass moral and ethical virtues and values that also engage in reflective practices that cultivate the mind. We are now learning from contemporary neuroscience that these practices provide deep benefits in emotional regulation and improved skills of attention. Meditation, specifically, assists with creating greater resiliency for individuals, inducing greater calm, reducing stress, and enhancing coping skills. These practices also cultivate pro-social mental qualities, like empathy, compassion, and so forth. We have also learned that these practices have a profound effect on the well being of health care providers, as well as potentially on the patients, not only in terms of how the clinician interacts but also in terms of how the dying person perceives their own experience of dying.

In this context, we feel it is very important to teach clinicians how to develop a meta-cognitive perspective, which is the capacity to be self-aware, to be resilient or pliant, to develop intentional balance, to be compassionate, and to discover meaning in their work. We endeavor to help clinicians understand that there are beneficial outcomes to these contemplative strategies. Outcomes include attentional and emotional balance, cognitive control, and resilience. Attentional balance, for example, means having an attention that is sustained, vivid, stable, effortless, and non-judgmental. We also explore emotional balance and the psycho-social impact and neural substrates of empathy, compassion, and altruism. We point out the benefits of cognitive control and how you can guide your thoughts and behavior according to your intention. We teach how to override habitual responses and down-regulate aroused emotional reactivity. Through these contemplative interventions, one can develop mental flexibility, insight, and meta-cognition, which means you are able to reframe experience in ways that are pro-social. There has also been important work in the area of resilience, which involves not only stress reduction and relaxation but also enhanced immune response and other health benefits.

- *Physiological practices:* We employ a number of different contemplative interventions to help people learn the very basic mental state, which is focused attention; that is learning how to have a narrow attention aimed at an object. For example, practices include mindfulness on the breath, body-scan meditation, and walking meditation. We also use yoga and chi-gong as a means for enhancing embodied concentration. Through these concentration practices, people begin to stabilize the mental continuum.

- *Compassion practices:* Connected to these basic physiological practices, I would like to also address the relationship between the clinician's ability to be aware of their visceral processes, which is called interoceptivity, and its relation to compassion. This interoceptivity could be everything from experiencing their digestive processes to their cardiovascular or respiratory ones. It is basically mindfulness of the body, which is one of the Four Foundations of Mindfulness taught by the Buddha in the *Satipattana Sutta* of the Pali Canon. What we have learned is that people who are numbed out or autistic do not have the ability to be interoceptive and to track their internal visceral processes. If you do not have this capacity, you will lack the capacity to actually sense into the feelings of another. Your capacity to be interoceptive is a building block in the experience of empathy. Without empathy, which is the ability to recognize and feel the suffering of another, there is no capacity for compassion.

  In this way, compassion is comprised of a number of different features. The first is its progression in stages from the ability to recognize suffering; then to feel suffering; to develop the aspiration to transform it (either directly or indirectly); and finally to not be attached to the outcome. There are also two basic forms of compassion: biased or referential compassion and unbiased or non-referential compassion. Referential compassion has an object, and non-referential compassion has no object; it is universal compassion. We ultimately train clinicians in non-referential compassion, but we begin by using referential compassion as a base. Finally, it is important that clinicians learn that compassion along with empathy and presence are not a one-way street. They are bi-directional; that is, experiences of mutuality. This means that in the moment, the individual is present, attuned, sincere, and well boundaried so that he/she does not go into a state of "empathic over-arousal." Authenticity is very important such a situation.

In this way, we teach the Four *Brahmaviharas* ("boundless abodes") of loving kindness, compassion, sympathetic joy, and equanimity, as well as a very long teaching on the Tibetan practice of *Tonglen* ("giving and receiving") in which one visualizes taking on the suffering of others and giving back to them well-being—a practice that we have seen the Rigpa Spiritual Care Program develop highly elsewhere in this volume.

- *Investigative practices:* The next domain in mental training that we feel is important to address is the investigative faculty. We have set practices that develop insight focus on values, altruism, pain, suffering, death, and violence. These are existential dimensions. We do this through the practice of classical Vipassana insight meditation from the Theravada Buddhist tradition, the Nine Contemplations of Atisha that come from the Tibetan Buddhist tradition, and the Contemplation of Priorities developed by Lama Yeshe. For the subjective familiarization of the experience of the moment of death, we teach the meditation on the dissolution of the body after death, as also explained in the *Satipattana Sutta*, and also the dissolution of the elements from the Tibetan tradition. We also do writing meditation exploring death and a process working with symbols called "sandtray" that is based in Jungian psychology. In addition, we address how to be present with pain and suffering without consoling or personalizing. One meditation we use is from the *Lotus Sutra*. We have done an adaptation called "Seeing Purely," which is to perceive an individual from their most unconditioned self. Then we do a complimentary practice called "Bearing Witness" in which people learn how to presence the truth of individual suffering without consoling or personalizing. Another practice that we teach is co-meditation practice. This is a breath and visualization practice done with a caregiver and a dying person. We also train people in Council Process in which people sit in a circle and speak of their experience while not seeking consensus. This process helps one to learn to bear witness to an individual's experience as it is.

- *Non-dual Practices:* The final area that we teach is called Open Presence, which is developing panoramic, receptive, non-judgmental attention. This is basically a reflective practice of choiceless awareness.

3) Moral Character

The third area that we address has to do with the development of moral character. We explore the moral and ethical basis of what it is to not only cure but to care. We look at how one of the biggest challenges that clinicians encounter is moral distress. Thus, we teach people how to deal with moral dilemmas and moral conflicts.

We also have developed contemplative interventions to support relationship centered care. When one has emotional balance, for example, one can be in better relationship with people, have better interpersonal communication, be emotionally intelligent, have an easier time communicating difficult news, be more sensitive on the social and cultural level, and be a better facilitator of community. We find that having intentional and emotional balance and a metacognitive perspective assist with insight into ethical reasoning.

In this regard, we use the work of James Rest in terms of moral development. We think his ideas help develop increased moral sensitivity where you are better able to empathize with another person's distress. Because of intentional balance, you are better able to discern the most ethical action; to have a deeper moral motivation which means putting moral values ahead of other values; to develop moral character which is to become a person who manifests strength in their convictions; and finally to engage in moral actions.[3] To learn how to take action that is consistent with an ethical perspective is a big piece of training that we do. In all this, we see that the clinician's well-being is more and more valued, and this has a strong moral base.

As important as the development of compassion is, we feel becoming a wise clinician is equally important. We use the work of Thomas Meeks on the neurobiology of wisdom. Meeks looks at how wisdom is comprised of a number of different features including what we have already addressed in pro-social states of mind and behaviors. In other words, how do you actually value the promotion of the common good? We see that as a function of wisdom. How do you rise above self-interest and engage in empathy, compassion, social cooperation, and altruism?

When the mind is truly stable and deep, one's capacity to engage in wise decision-making is heightened. Such decision-making takes place on the social level

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[3] James Rest, *Development in Judging Moral Issues* (Minneapolis: University of Minnesota Press, 1979).

based on having lived a life in which you have been self-aware and not just operating out of an automatic perspective. This means one is able to call up from one's own life experience as a measure; "Well, I don't want to do that again. I learned from that experience." This capacity is very important in the domain of wisdom.

Meeks also talks about how emotional balance and stability is essential in terms of the cultivation of wisdom. It is also essential in the capacity to be self-reflective, to have self-understanding, and to not only be tolerant but to value altruism. From the point of view of tolerance, this means that one is able to see things from multiple perspectives and to be in a situation where there is an absence of projections. Meeks sees having a metacognitive perspective as essential in terms of the domain of wisdom, because it enables you to more easily deal with ambiguity. He talks about the capacity of the wise person to be open to new experiences and to act in the face of uncertainty.[4]

4) Self-care

The fourth and last area for the clinician that we feel is very important is to train them in strategies for self-care and how they can actually support their well being in a high stress profession. Many professional caregivers experience burnout because the system—particularly conventional medical institutions or hospices that are fiscally driven—pushes them so hard. It may even be that these institutions benefit little from caregivers' taking care of themselves. Often professional caregivers are financially rewarded for working overtime or taking on the night shift, and the overwork can produce stress that results in numbness. Numbness makes it difficult for a caregiver to feel what is really going on. It may make it difficult for her to perceive dysfunctional work patterns that the institution is perhaps encouraging. In the meantime, it is easy to become weary and gray with despair, sick from overwork and stress. We ask caregivers to assess nine areas of self-care: physical, emotional, intellectual, social, spiritual, cultural, relational, fun, and vocational.

These are four very large areas, but it basically comes down to the fundamentals of Buddhism[5]; that is, how can we assist clinicians to be wise and compassionate? The

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[4] Thomas W. Meeks and Dilip V. Jeste, "Neurobiology of Wisdom: A Literature Overview," *Archives of General Psychiatry* 66 (4) (2009): 355-65.

[5] In fact, the first three areas mirror the classic Buddhist pedagogy of *sila-samadhi-panna* (moral

training from many different perspectives opens up the values of wisdom and compassion, which are fundamental qualities to be developed for a sane and good person in the world today. We look at wisdom and compassion not only from the point of view of the individual but also in terms of helping institutions become wise and compassionate.

Transformation of the Patient

This focus on the clinician him/herself is not separate from the clinician's work in an area that we call transformation of the patient. Here we again have four major areas with a large curriculum behind each one.

1) Patient Issues

We train the clinician to use various interventions to ascertain the social, cultural, and psycho-spiritual issues from which a patient suffers. Cultural issues could be, for example, if they are from Japan or certain other Asian countries, where there is now more of a denial of death and speaking about death actually induces fear within the patient. This is the kind of thing—that it is actually not appropriate to speak about death in front of the patient—important for a clinician, especially a western doctor, to identify and understand.

2) Pain and Suffering

We address the distinction between pain and suffering by looking at physiological and psychological changes. Pain is acute physical stress, and suffering is the story around it, the perception of pain. This has a profound influence on patients in terms of asking them what they are more afraid of, pain or death. Many will say pain and issues around pain control that interfere with physiological or mental function. This is something that has to be worked with. In the program, we feel that humans have enough pain just being in their bodies and that it is fundamentally not redemptive. Thus, we feel it is important to relieve pain in the most skillful way possible and to try to make that something that is spiritually relevant.

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development-contemplative/meditative practice-wisdom/worldview), which are an encapsulation of the Buddha's Noble Eightfold Path, the way to realize the end of suffering.

3) The Moment of Death

We deal with peri-death phenomena, which are all the processes around the moment of death including what we call “active dying” (the final stage of the dying process), the actual moment of death, what happens for the patient and around the patient at the moment of death, and then care of the body after death.

4) Grief

We then focus on grief, in which we address issues related to anticipatory grief. This part also relates to clinicians and family members, because anticipating the death of a person effects people deeply and leads to grief. The anticipation of one’s own death and the loss of capacity is also often accompanied by feelings of deep grief. Finally, there is, of course, the grieving experience for the patient’s family and for the clinical team. One of the questions we ask our clinicians is, “How do you mark the death of a patient?” Many clinicians do not mark it, and, of course, there are consequences to doing this.

Transformation of the Community

We have a deep emphasis on the profound value of relationship, relationship centered care, and the development of the interdisciplinary team (IDT). The relational dimension could be clinician-patient, clinician-family, clinician-community, clinician-institution; patient-clinician, patient-family, patient-community, patient-institution; and so forth through all 16 dimensions. In these terms, we try to teach clinicians about presence, how to not personalize, and how to not devalue the relationships of other people who are offering care within the wider community system. We also have a deep emphasis on the development of respect. This leads us into techniques in community development and cultural sensitivity. This helps the clinician to ascertain the culture of the community and become sensitive to the cultural dimensions within the community in their care giving process. In terms of our training process, we frequently use role-playing, particularly for culturally complex situations. Another issue that we work with in terms of community development is inter-professional relationships, such as respecting other members on the interdisciplinary team and teaching doctors to listen to chaplains. Here we address issues related to horizontal hostility and the profound importance of respect.

Transformation of the Institution

This area addresses the ethical issues that arise in an end of life care situation. The way that these are mandated is the way the institution responds to them. This area deals with everything from having patient advocates to advanced directives to how patients are communicating with family members about DNRs (Do Not Resuscitate) and so forth. There is also increasing inquiry into the spirituality of clinicians, which asks, “Where does our sense of meaning come from?” The contemplative dimension looks at what practices actually open up our capacity. The challenge is how to input this content in clinician training and then how to actually apply it to clinical settings. In this way, we are strongly advocating increased research initiatives in the medical field, such as with the Fetzer Institute in Kalamazoo, Michigan. Due to the diminishment of empathy and compassion in the clinical setting, Fetzer is very interested in us developing compassion-based training for clinicians. For our training to be effective, it very much depends on the clinician learning how to value well being, insight, and compassion—and to basically have self-respect.

There is more and more interest today in spiritual care that is being mandated in very important ways in conventional medicine. For example, the Mayo Clinic in Rochester, New York says spirituality is an integral dimension of compassionate care and an important aid to healing for patients, their families, and their caregivers. For one of our most renowned medical institutions in the United States, spirituality is considered to be an essential dimension in the healing process. At the University of Virginia Medical School, where an academic chair in contemplative end of life care is now funded, they say the good practice of medicine depends upon a physician’s awareness of both their patient’s and their own spirituality.

This major shift by many medical institutions in the United States to embrace the complete care of patients, their families, clinicians, and their communities has come about from the increasing suffering on the part of patients and clinicians. It has also come about because some very influential people, like Christina Puchalski, have begun to influence medical policy in this country. Her commitment to introducing spiritual inquiry into medicine by taking spiritual histories has changed medical policy in this country; for example, policy now mandates that during the intake of the patient, there must be a spiritual interview.[6]

The Buddhist Chaplaincy Program and Total System Change

In our Buddhist Chaplaincy Program, not only do we address suffering on a person-to-person level but, like the BWD program, we look at whole systems that are suffering. Many clinicians have gone into medicine because of a calling. What is fascinating is that many clinicians are coming into our Buddhist Chaplaincy Program, because their calling is not being fulfilled in medicine. What they want to do is what a chaplain does, which is to address the spiritual dimensions in health care. We also have lawyers in our chaplaincy program, who in a similar way, changed fields because their desire for justice was not being realized in a dysfunctional legal system. We have people who are doing specializations in environmental chaplaincy, sacred diplomacy as chaplaincy, and youth chaplaincy in addition to prison and hospital chaplaincy. We have people now who are engaged in projects related to gender minorities, because chaplaincy relates to people who have gender identities that are not the two most common ones. We have people in human rights organizations and legal organizations that have become chaplains, because they are trying to understand justice in terms of compassion.

Our training program does not provide certification from the Association of Professional Chaplains (APC), but you do not need this to sit with dying people or work in a legal institution. As a religious person, I think the kind of certification that is required in this country is useful. However, I do not think it is necessary at all. If you are a minister, then you go and minister; but let's step back even further—if you are a good person, then you step in and you care. We have a chaplaincy program that is very powerful. However, I really think this is about the human heart and about compassion, not certification. In those environments and countries where there is resistance to compassion, you have to be skillful. Certification is not going to get you into a system that is not interested in caring for people but just curing them—which is something we have seen in the chapters on the Japanese medical system. As seen in the following chapter on Buddhist hospice care in San Francisco, hospice volunteers do tremendous

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[6] Christina Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Patient Care.* (West Conshohocken, PA: Templeton Press, 2010).

work in this country, and they do not have psychological credentials. They do a brief hospice training, have good supervision, and serve dying people. Ultimately, I think the idea of certification makes it harder for people to do the thing that is only human. We would not even need a system of certification per se if our communities were inspired to take care of the dying.

I feel that there is not much that separates the trained from the untrained. It really has to with aspiration. If you truly care, you can do the work. If this is not your work to do, then you won't do the work. You won't do the service. You won't be engaged in compassionate care. It is not everybody's job. I think it is fine that people want to create systems and standards, but I think it can prevent more good from happening and does not stop so much of the bad. For example, I know many people who are certified at the highest level as religious personages, professional psychologists, and psychiatrists but who are unsympathetic and unable to do this work. They have spent so much time getting certification that their own hearts have not awakened. You can try to train people in presence, but this is not how it works. Meditation is helpful in this regard. There are all kinds of games and techniques, but it is in a way a natural gift. Moreover, one's aspiration really matters in this kind of vocation.

Our vision of chaplaincy operates on many different levels. Because you cannot separate the patient from the clinician, the clinician from the community, or beings from the institutions themselves, we have used a systems theory approach for both our Buddhist Chaplaincy Training and BWD training programs. Joanna Macy, the well-known Buddhism and Systems Theorist, is a teacher for us. Merle Lefkoff, who worked with Jimmy Carter in his White House administration as a diplomat and is a Systems Theorist, is on our faculty. We feel that a systems perspective is the only viable one. An individual clinician can go through a deep change in how they approach their work, but the institutional demands create a moral conflict within them and how they can approach their work. Therefore, you cannot look at things in isolation. Everything is interconnected. We know that from the Buddhist perspective. We also have a very strong emphasis on neuroscience, direct and structural violence, and ethics, relationship, and communication. In this way, our training, especially the chaplaincy program, is basically in socially engaged Buddhism.

The way people are sustained after they leave the training is that we have a cohort system of around 12-24 people. These cohorts are broken into smaller groups that are mentored by students from the preceding cohort. Students who have already been through the program mentor 4-5 people. They form a mindful community, a mini-cohort. They use e-mail, the phone, and the Ning social networking web site. They are a complete support and learning group. It has been a powerful process overseeing these micro-communities as they have developed. We also have another network based on discipline. Many people who come into the program are very interested and committed to end of life care, so there is a learning group on end of life care.

We do not use this cohort model with the Being With Dying program. The way the BWD network gets supported is that we attract people from the same institution. For example, we have a large group of people from the University of Virginia who train every year, as well as clinicians from Duke University and San Diego Hospice, which is the largest hospice in the U.S. These are regional groups who then ask our faculty to continue the training process in those venues. This is necessary because isolated individual training does not work. You cannot sustain it.

I think that our model is a powerful one, because it has Buddhism, systems theory, neuroscience, and finally community development sitting on a contemplative base. I think we have been successful in introducing this work into the culture, because we see more and more of our curriculum appearing out there in the landscape. We are not proprietary about our curriculum or about our faculty, so people have a chance to develop the curriculum in their own terms and make it appropriate to who they are and the institution which they serve. Our work at Upaya is a model of a possibility in bringing Buddhism into Western culture in a very pragmatic way. As time passes, we have seen more programs around the country that are following our model. This bodes well for an engaged and applied Buddhism that is not only national but global.